General Purpose Standing Committee No. 2

Complaints handling within NSW Health

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Terms of Reference

That General Purpose Standing Committee No. 2 inquire into and report upon the complaints handling procedures within NSW Health, and in particular:

- the culture of learning and the willingness to share information about errors and the failure of systems, and
- an assessment of whether the system encourages open and active discussion and improvement in clinical care.[1]

These terms of reference were self-referred by the Committee.

[1] See Minutes No. 6, 29 October 2003 and Minutes No. 12, 15 December 2003, regarding the process of establishing this inquiry, contained in Appendix 4.

Committee Membership

Revd Hon Dr Gordon Moyes MLC	Christian Democratic Party	*Chair*
Hon Patricia Forsythe MLC	Liberal Party	*Deputy Chair*
Hon Dr Arthur Chesterfield-Evans MLC	Australian Democrats	
Hon Amanda Fazio MLC	Australian Labor Party	
Hon Peter Primrose MLC	Australian Labor Party	
Hon Robyn Parker MLC	Liberal Party	
Hon Christine Robertson MLC	Australian Labor Party	

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Chair's Foreword

> …simply being an inpatient in an Australian acute-care hospital is forty times more dangerous than being in traffic, and only ten times safer than leaping out of an aircraft equipped with a parachute.[2]

The above quote demonstrates the pressing need to work towards a safer health system. It is not intended to alarm readers, but rather to acknowledge the inherent risks of modern medicine.

One of the most important factors in patient safety is being open about health care incidents and adverse events, many of which are revealed via complaints handling systems. Unfortunately, as the evidence to our inquiry suggests, we have quite a way to go in developing a health care culture that is open about mistakes and willing and able to learn from them.

While the Committee has identified serious problems regarding complaint management at Campbelltown and Camden Hospitals, similar problems undoubtedly exist across the health system. NSW Health has some good systems in place to encourage reporting but these will only work if supported by the necessary cultural change.

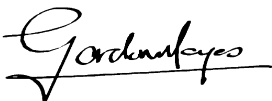
The Committee would like to thank everyone who participated in the inquiry, either by making a submission, giving evidence or attending a public hearing. We recognise that many people shared information about sensitive personal and professional issues and that some witnesses were subject to vigorous questioning from Committee members. We are grateful for your contribution.

Given the nature of this inquiry, it has been necessary for the secretariat to liaise extensively with officers from NSW Health and South West Sydney Area Health Service. These officers were cooperative and helpful in their prompt response to requests for information and to making witnesses available for hearings. In thanking these officers I would also like to acknowledge the Director General, Ms Robyn Kruk who appeared before this Committee on several occasions.

Health care is a highly charged and complex issue and so I am particularly appreciative of my Committee colleagues who have undertaken this inquiry with great commitment. On their behalf I would like to thank the secretariat staff for their dedication and professionalism.

A final note of gratitude is due to the nurse informants from South West Sydney Area Health Service. They have made considerable sacrifices in seeking to raise their concerns about patient safety. I hope they gain consolation from the fact that that their actions have contributed to major reforms of complaint handling systems in New South Wales.

There is no shame in making a mistake but it is in no one's interest to ignore or hide these incidents, at either an individual or systemic level. Having the courage to be open about adverse medical events is essential to improving patient safety and well being.



Revd Dr Gordon Moyes AC, MLC
Committee Chair

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2 Runciman W.B and Moller J, *Iatrogenic Inquiry in Australia,* Australian Patient Safety Foundation, Canberra, August 2001, p9.

Summary of Recommendations

Recommendation 1 *Page 23*

That the NSW Minister for Health raise with his counterparts on the Australian Health Ministers' Advisory Council whether the criteria used by the Australian Council on HealthCare Standards in its accreditation surveys of health services is an appropriate measure of quality.

Recommendation 2 *Page 33*

That NSW Health discuss with the relevant health professional bodies in New South Wales to ensure that all training programs incorporate competencies regarding quality and safety issues, including the Open Disclosure Standard, as part of the registration process.

That evidence of ongoing professional development in these issues should be an essential requirement of registration.

Recommendation 3 *Page 34*

That Area Health Service boards formally adopt the principles of open disclosure via performance agreements with NSW Health and affirm their commitment to the full implementation of the Open Disclosure Standard developed by the Australian Council for Safety and Quality in Health Care.

Recommendation 4 *Page 35*

That the NSW Minister for Health raise with his counterparts on the Australian Health Ministers' Advisory Council the possible elevation of complaints handling in the Evaluation and Quality Improvement Program, conducted by the Australian Council on Healthcare Standards.

Recommendation 5 *Page 35*

That the NSW Minister for Health raise with his counterparts on the Australian Health Ministers' Advisory Council incorporation of the Open Disclosure Standard in the current version of the Evaluation and Quality Improvement Program conducted by the Australian Council on Healthcare Standards.

Recommendation 6 *Page 35*

That the NSW Minister for Health raise with his counterparts on the Australian Health Ministers' Advisory Council the provision of an annual update on the implementation of the Open Disclosure Standard, for the first two years following its incorporation into the Evaluation and Quality Improvement Program conducted by the Australian Council on Healthcare Standards.

Recommendation 7 *Page 35*

That as part of their performance agreements all health managers in NSW undergo training in quality and safety principles, including the Open Disclosure Standard, and that this become an essential requirement of their continued employment.

Recommendation 8 *Page 36*

That the proposed Clinical Excellence Commission in conjunction with NSW Health undertake an extensive public education campaign to inform the community about:

- simple steps to make health complaints
- the nature and extent of adverse events in the health care system

- realistic expectations of health care
- changes to the regulatory framework for health care complaints and consumers rights.

Recommendation 9 *Page 38*

That NSW Health publish comparative data on adverse events in Area Health Services across New South Wales in Annual Reports and on its Website.

Recommendation 10 *Page 38*

That the New South Wales Government convene a summit on medical adverse events within the next 12 months.

Recommendation 11 *Page 39*

That a suitable mechanism be identified by NSW Health to ensure the results of accreditation surveys conducted by the Australian Council on Healthcare Standards be provided to the Department within two weeks of their completion.

Recommendation 12 *Page 39*

That NSW Health publish all accreditation reports prepared by the Australian Council on Healthcare Standards and any rectification reviews prepared by health services in response to these reports.

Recommendation 13 *Page 40*

That NSW Health take steps to ensure senior health managers are aware of the existing protocols in relation to notifying family members about the referral of a death to the Coroner.

Recommendation 14 *Page 41*

That NSW Health implement a State-wide protocol to ensure that the patient or next of kin of a patient whose treatment is the subject of a Root Cause Analysis is informed of the conduct and results of this analysis by a suitable clinician.

Recommendation 15 *Page 43*

That the NSW Clinical Excellence Commission conduct a study on the feasibility of introducing mandatory reporting of all or certain classes of incidents to health service management and to the Department of Health.

Recommendation 16 *Page 43*

That NSW Health ensure that in all area health services each clinical team should have regular review meetings on a protocol set up by management and audited by the Clinical Excellence Commission.

Recommendation 17 *Page 55*

The *Health Care Complaints Act 1993* and the *Protected Disclosures Act 1994* be amended to protect the identity of whistleblowers when they require it and to provide protected disclosure safeguards for health practitioners, including nurses in both the public and private sectors.

Recommendation 18 *Page 61*

That the NSW Medical Board be asked to clarify why the practitioner who treated Mrs Daly-Hamilton has not been referred to the South Australian Medical Board.

Recommendation 19 *Page 84*

That the proposal to split responsibility for the investigation of systemic and individual complaints between the Clinical Excellence Commission and the Health Care Complaints Commission, be reassessed following the release of the final report of the Special Commission of Inquiry into Campbelltown and Camden Hospitals.

Glossary

The following definitions are from Submission 66, NSW Health; Review of Professional Indemnity Arrangements for Health Care Professionals, *Compensation and Professional Indemnity in Healthcare: Final Report*, November 1995; and Walton M, *Open Disclosure to Patients or Families after an Adverse Event: A Literature Review,* November 2001

Adverse event	An unintended injury to a patient which resulted in a temporary or permanent disability, prolonged length of stay or death, and which was caused by health care management and not the underlying disease.
Complaint	An expression of dissatisfaction by a complainant. The complainant can be a consumer (a patient, their family or a member of the public) or staff.
Complaints handling	The structures, guidelines and procedures that are used to report and respond to complaints.
Grievance	A personal complaint or difficulty about a work-related issue that affects a staff member, and which they consider to be discriminatory, unfair or unjustified.
Health professional	Includes medical and nursing staff, as well as administrative, management and allied health professionals.
Incident	Any unplanned event resulting in, or with the potential to result in, death, injury, ill health, damage or other loss.
Medical error	An unintended act (either of omission or commission) or an act that does not achieve its intended outcome. Excluded from this definition is the natural history of a disease that does not respond to treatment and the foreseeable complications of a correctly performed procedure with a background of informed consent.
Open disclosure	Proactively providing a patient or their family with a full explanation of the cause or causes of their, or their family member's condition, and discussing their future care and treatment and the implications.
Patient-centred care	Health care that establishes a partnership among practitioners, patients, and their families (where appropriate) to ensure that decisions respect patients' wants, needs and preferences and that patients have the education and support they need to make decisions and participate in their own care.
Reporting	Informing appropriate hospital authorities about actual or potential adverse events and/or medication discrepancies.
Systems failure	Consequence, often delayed, of technical design and organisational decisions. They relate to the design and construction of a system, the structure of an organisation, planning and scheduling, training and selection, budgeting and allocating resources. The adverse effects of these decisions may lie dormant for a very long time.

Whistleblower	The informal term to describe someone who makes a legitimate disclosure about corrupt conduct, maladministration or serious waste in the public sector. The *Protected Disclosures Act 1994* protects public sector employees who make voluntary protected disclosures and who follow certain steps set out in the legislation.

Abbreviations

AIMS	Adverse Incident Monitoring System
ACHS	Australian Council on Healthcare Standards
CEC	Clinical Excellence Commission
CMO	Career Medical Officer
HCCC	Health Care Complaints Commission
ICE	Institute Clinical Excellence
MHS	Macarthur Health Service
RCA	Root Cause Analysis
SAC	Severity Assessment Code
SWSAHS	South West Sydney Area Health Service
VMO	Visiting Medical Officer

Chapter 1 Introduction

This chapter provides an overview of the inquiry background and its key findings. It also includes a chronology of key events relating to Campbelltown and Camden Hospitals and a list of various other investigations concerning patient safety currently in progress. Details regarding the methods used to invite public participation in the inquiry process, via submissions and public hearings, are included at Appendix1 and 2.

Background to the Inquiry

Health Care Complaints Commission investigation into Macarthur Health Service

1.1 Throughout 2003 there was intense media interest in relation to serious allegations about inadequate patient care at Campbelltown and Camden Hospitals,[3] leading to a major investigation by the Health Care Complaints Commission (HCCC).

1.2 On 9 December 2003 the HCCC released its final investigation report into Macarthur Health Service.[4] The Commission's inquiry examined the allegations by several nurses about patient care and management issues. Soon after the release of the report, several other investigations were announced to explore aspects of the nurses' claims and the role of the HCCC, including the Special Commission of Inquiry into Campbelltown and Camden Hospitals (the Special Commission).

General Purpose Standing Committee No 2 complaints handling inquiry

1.3 The inquiry established by General Purpose Standing Committee No 2 into complaints handling in NSW Health was also initiated following the release of the HCCC report into Campbelltown and Camden Hospitals. Committee members were concerned that none of the inquiries announced in the wake of the HCCC report were intending to examine the *systemic* issues relevant to complaint handling in the health system, as noted by the Committee Chair:

> We want to examine what happens when individuals within the health system raise problems: does it lead to improvements and improved quality of care, or is the treatment experienced by the nurses who raised concerns at Campbelltown and Camden typical of what happens in other areas? [5]

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3 Campbelltown and Camden Hospitals are part of Macarthur Health Service, which is part of the South West Sydney Area Health Service (SWSAHS).

4 HCCC, *Investigation Report, Campbelltown and Camden Hospitals, Macarthur Health Service*, December 2003

5 Rev Hon Dr Gordon Moyes MLC, 'Inquiry into Complaints Handling Procedures within NSW Health,' *Media Release*, 15 December 2003

1.4 While the inquiry is mainly concerned with complaints by health professionals,[6] we acknowledge that some of the issues that have been raised in evidence and submissions are also relevant to consumer complaints.[7] For example, health professionals' reluctance to report adverse events, delays in investigating complaints and the inappropriate response of certain managers when complaints were received. We envisage that some of the recommendations made in this report will also improve complaint handling procedures for consumer complainants.

1.5 Given the emphasis on 'systemic' issues in the terms of reference, the Committee has not sought to make findings on specific incidents or allegations regarding patient safety, many of which are being examined by the appropriate investigatory agencies, including the Police, Coroner, ICAC and the Special Commission.

Key findings of this inquiry

Building a 'best practice' complaints handling system

1.6 The Committee received a large volume of evidence about what constitutes 'best practice' complaints handling. In brief, a health service that meets the requirements of international best practice will address two phases:

- understanding the complaint and developing sound solutions
- making sure solutions are put in practice.[8]

1.7 An organisation with a 'culture of learning' will encourage staff to report incidents, as well as analyse the mistakes in order to prevent their recurrence. It will view complaints as a rich source of information with which to improve the quality of patient care. For such an organisation, an increase in the number of reported incidents is not necessarily an indication of declining quality, but rather a positive sign of a service which is concerned about patient safety.

1.8 Effective complaints handling is not only about having the right systems or policies in place. Cultural issues, the attitudes and beliefs of health service staff and management, are equally if not more important.[9] The following chapters demonstrate that, while NSW Health and some health services have made considerable efforts to introduce effective complaints handling systems and changing attitudes to complaints, it is some distance from attaining best practice across the State.

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[6] Throughout this report, the term 'health professional' includes medical and nursing staff, as well as administrative, management and allied health professionals.

[7] The inquiry is not examining the system for handling staff grievances. A grievance is a personal complaint about a work related issue that affects a staff member and that he/she considers to be discriminatory, unfair or unjustified. (Submission 66, NSW Health, p2)

[8] Submission 66, NSW Health, p8

[9] Ms Fiona Tito-Wheatland, PhD Scholar, Evidence, 23 March 2004, p26

What do patients want when something goes wrong?

1.9 Research indicates that when something goes wrong with their healthcare, patients want to know about it.[10]

> The interpretation of all the literature about what patients want when things go wrong is, "Please tell us what is happening?"[11]

1.10 In the health system this is usually referred to as 'open disclosure': proactively providing patients or families with a full explanation of the cause(s) of their condition and entering discussions with the patient about their future care and treatment implications[12] (see Chapter 2 for a description of the Open Disclosure Project).

1.11 The provision of timely and frank information about an adverse event not only helps patients come to terms with their situation, but if properly managed, may reduce the likelihood that they will take legal action,[13] contradicting the generally held view that admitting mistakes is likely to lead to litigation.[14] NSW Health acknowledged that many of the complaints arising from Campbelltown and Camden hospitals were due to poor communication by doctors to families about the patient's condition and treatment.[15] NSW Health has also indicated that communication is a key area in which improvements need to be made and are committed to this, which is acknowledged by the Committee.

1.12 During the inquiry the Committee has heard of many instances of where either NSW Health or health professionals have failed to communicate effectively with relatives affected by adverse events. As the case studies in the following chapters show, the failure to adequately consult with or inform patients or their families about their treatment can have far reaching and damaging consequences.

Open disclosure and professional accountability

1.13 One of the most important findings of this inquiry is the routine non disclosure of adverse events in the health system. No matter how impressive a complaint handling system may look on paper, unless doctors and nurses report health care incidents, and managers act on these reports, the effectiveness of such systems will be severely compromised. For this to occur, we need a major 'paradigm shift' within NSW Health and the professions. Unrealistic notions of error free medicine need to make way for more constructive and candid approaches to patient safety. As many witnesses told us, facilitating this much needed cultural change will be far more difficult and worthwhile than producing more documents or manuals on complaint

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10 Australian Council on Quality and Safety in Healthcare, Open Disclosure Consortium, *When things go wrong: an open approach to adverse events: Issues Paper,* February 2002

11 Professor Stewart Dunn, Department of Psychological Medicine, University of Sydney and Director of ErroMed, Evidence, 30 April 2004, p6

12 Walton M, *Open Disclosure to Patients or Families after an Adverse Event: A Literature Review,* November 2001, p53

13 Walton M (November 2001), op cit, p5

14 Walton, M, 'What do patients want? Part 2, *RACP News*, May 2001, Vol 20 No 3, pp10-14

15 Submission 66, NSW Health, p14

handling. A further key finding was that health managers need to respond appropriately when complaints are made.

1.14 NSW Health could encourage greater openness by practicing open disclosure at a systemic level. Our report identifies many instances where the Department has been less than frank with the public or families, about adverse events. This sends the wrong message to individual practitioners about the fundamental importance of open disclosure.

1.15 There is increasing recognition that most adverse events are the result of systems errors and that blaming individuals may be counterproductive because it will discourage reporting among health professionals. However, what is less clear is how to strike a balance between an appreciation of the systemic nature of medical error with the need to ensure individuals are held accountable for their actions. It is fair to say that this has been one of the most vexed issues confronting our inquiry and the Special Commission and one which will continue to be debated even after the finalisation of both inquiries.

Recent events in South West Sydney Area Health Service

1.16 While this inquiry is primarily about complaint handling *systems*, much of the evidence received by the Committee focuses on allegations about patient care and management issues in South West Sydney Area Health Service (SWSAHS). While this material provides a very useful insight into systemic issues concerning complaints, it should be understood within the following context.

1.17 There were undoubtedly serious cultural and system-related problems concerning complaint handling in south west Sydney. There was, however, no evidence before this Committee that the level of adverse events at Camden and Campbelltown Hospitals was substantially different than in other public hospitals across the State. The available data does not allow anyone to draw such a conclusion. Similarly, there was no evidence that the way in which complaints were managed in this area health service was any worse than other areas. Evidence about the cultural barriers to incident reporting suggest that similar problems regarding both adverse incidents and complaint handling exist across NSW. [16] We believe these are systemic issues, not problems isolated to one area health service.

1.18 The Committee noted that the vast bulk of clinicians and staff at SWSAHS are good at their jobs and that patient outcomes were generally also good. Issues particular to SWSAHS that required addressing included a combination of avoidable incidents, poor treatment of staff and no culture of open disclosure. Along with these particular issues goes the need to acknowledge that errors and adverse incidents will always occur within any health system.

1.19 It should also be acknowledged that while Macarthur Health Service in particular has been subject to considerable criticism, the HCCC report and the expert review conducted by Professor Bruce Barraclough in 2003 both concluded that the health service had done much in recent years to improve performance. Professor Barraclough noted that some sections within the service such as Paediatrics, Ambulatory Care and Palliative Care, were functioning

[16] Cultural issues concerning complaints are discussed in Chapter 3.

very well.[17] In addition, the HCCC noted that SWSAHS has had to manage increasing demand for services and a major capital works program, despite having a considerably smaller number of appropriately qualified clinical staff than similar hospitals.[18]

1.20 This is not to diminish the serious problems concerning patient safety and complaint handling in SWSAHS. Our inquiry, the Barraclough review and the HCCC identified serious deficiencies in both clinical care and complaint handling by health service management, many of which are discussed in this report. However, many of the problems that beset SWSAHS are unfortunately not unique to one area of New South Wales.

1.21 The staff and management at SWSAHS and Macarthur have been subject to intense and unprecedented media and public scrutiny over the past year and a half. Restoring staff morale and public trust is a major challenge to be addressed by the new management team that has been put in place. Suggesting that SWSAHS is markedly worse than many other area health services, when there is no evidence to support this view, will not help rebuild morale, nor will it encourage other health services reflect on their own quality systems and culture.

1.22 The various inquiries and reforms that have flowed into Campbelltown and Camden Hospitals over the past 12 months would not have occurred had it not been for the determination of the original nurse informants. The nurses came up against an ingrained culture of cover-up and denial in the health service. Had it not been for the nurse informants at Camden and Campbelltown Hospitals, the problems they exposed may still be continuing today.

Report structure

1.23 Chapter 2 provides an overview of the 'quality and safety in health care' movement which has developed over the past 30 years. The chapter describes the key initiatives introduced in NSW and Australia in response to a greater understanding of the intrinsic risks of health care. Since this inquiry commenced NSW Health has informed us that they have introduced a number of changes in SWSAHS. These are listed in Appendix 3.

1.24 Chapter 3 examines cultural issues relevant to complaint handling, including the taboos surrounding incident reporting among health professionals, especially doctors. Advocates of a 'no blame' approach to medical error argue that focussing on individual culpability discourages incident reporting. However, some commentators believe the pendulum has swung too far away from professional accountability with serious implications for patient safety. The final section of the chapter seeks to identify ways to overcome some of the cultural barriers to incident reporting.

1.25 Recent events in SWSAHS illustrate what happens when health workers perceive they are unable to use formal channels for incident reporting. Chapter 4 discusses the impact of whistleblowing on informants, patients, colleagues and communities. Chapter 5 is about the relationship between resources and adverse events. While cultural issues are at the heart of

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17 Barraclough B, Baker K, Burrell T, Wallace M, *Working Papers of the Review of Standards of Patient Care and Services at Macarthur Health Service* (henceforth referred to as the Barraclough Review), 16 October 2003, p6

18 HCCC (2003), op cit, Part 1, pp2-3

patient safety, it is important to acknowledge the link between financial and clinical resources and the incidence of adverse events.

1.26 The final chapter, Chapter 6, concludes the report and includes the Committee's provisional assessment of some of the proposed changes to the quality and safety agenda and the regulation of health complaints in NSW.

Table: 1.1 Chronology of key events relating to Campbelltown and Camden Hospitals

Date	Event
5 Nov 2002	Meeting between four nurses and the Minister for Health, Craig Knowles. Nurses raise serious allegations about patient safety at Campbelltown and Camden Hospitals. Minister refers allegations to the Director-General of NSW Health.
18 Nov 2002	Director of Audit, NSW Health provides interim report on the nurses' allegations to Director General.
18 Nov 2002	Director-General makes a formal complaint to the HCCC and refers certain allegations to the ICAC, Coroner and Police.
29 Jan 2003	HCCC interim Phase 1 report provided to SWSAHS and NSW Health, detailing the issues surrounding the disciplinary action taken against some of the nurses. In her letter to the CEO of SWSAHS accompanying the interim report, the Commissioner stated: 'there have been no substantiated allegations of significant departures from State or national standards in health care.'
Feb 2003	Nurse informants approach radio commentator Mr Alan Jones, leading to significant media coverage of allegations about patient care and safety at Campbelltown and Camden Hospitals.
June 2003	HCCC provides information on all clinical incidents to SWSAHS and NSW Health.
18 Aug 2003	HCCC provides preliminary investigation report (section 43 report) to SWSAHS and NSW Health on a confidential basis.
Aug 2003	Director-General commissions an Expert Clinical Review Team, lead by Professor Bruce Barraclough to review standards of patient care and services at Macarthur Health Service.
Oct 2003	HCCC section 43 Report leaked to the media. The report revealed that at least 17 patients had died after receiving unsafe, inadequate or questionable care.
15 Oct 2003	Professor Barraclough presents his team's recommendations to the Director-General, recommending 'a significant change in leadership approach.'
17 Oct 2003	Central Sydney Area Health Service offers an SES 3 equivalent position to Ms Jennifer Collins, General Manager Macarthur Health Service, which she accepts.
9 Dec 2003	HCCC provides its final Investigation Report into Macarthur Health Service to Director-General and SWSAHS.
11 Dec 2003	Minister Iemma announces: the termination of Ms Amanda Adrian's appointment as HCCC Commissioner and the appointment of an Interim HCC Commissioner; establishment of the Special Commission headed by Mr Bret Walker SC; dissolution of SWSAHS Board; referral by the Director General of 19 deaths at Macarthur Health Service to the Coroner; Ms Collins given one week to show cause why she should not be removed from the health system (she was dismissed one week later).
15 Dec 2003	GPSC No. 2 establishes Inquiry into Complaints Handling in NSW Health.
31 Mar 2004	First Interim Report of the Special Commission of Inquiry. Commissioner refers 12 doctors to the HCCC for investigation with a view to disciplinary action, and five doctors to the HCCC with a view to performance assessment by the Medical Board.
1 June 2004	Second Interim Report of the Special Commission of Inquiry. Commissioner refers additional doctors and nurses to the HCCC and the Medical Board for investigation or performance assessment.

Table 1.2 Other inquiries examining issues relating to patient safety issues in SWSAHS

Inquiry	Issue
Special Commission of Inquiry into Campbelltown and Camden Hospitals, headed by Bret Walker SC	Inquiring into allegations of unsafe or inadequate care or treatment at Campbelltown and Camden Hospitals, and regulatory and administrative arrangements of the HCCC; due to report by 31 July 2004.
NSW Coroner	Investigating at least 22 patient deaths at Campbelltown and Camden Hospitals.
ICAC	Investigating claims of victimisation by the nurse informants, and conduct in relation to the former Health Minister. Several other confidential inquiries may also be in progress.
The Cabinet Office	Reviewing the legislation governing the HCCC.
Health Care Complaints Commission	Investigating individual cases of unsafe or inadequate care or treatment at Campbelltown and Camden Hospitals.
Joint Parliamentary Committee on the Health Care Complaints Commission	Currently conducting an Inquiry into *Alternative Dispute Resolution of Health Care Complaints in NSW* and a *Review of the 2002-2003 Annual Report of the HCCC*.

Chapter 2 Quality and safety in health care

> The quality in health care movement acknowledges that health care services are inherently risky and to err is human. It supports the reporting of adverse events so that deficiencies in the systems of care can be identified and changed. The information can be used to improve the quality of care and to make the health sector safer for consumers by changing work processes, staff training and development.[19]

The quality in health care movement is a relatively recent phenomenon. Its genesis is linked to the first international studies into patient safety, which revealed high numbers of adverse events that resulted in patient harm and a series of public health care scandals in Australia and overseas. This chapter briefly outlines the rise of this movement, and how the health system, in New South Wales and nationally, has attempted to provide safer and better health care.

Quality and safety in health care movement

2.1 The landmark *Quality in Australian Health Care Study* was published in 1995. It was the first study to investigate the number of adverse events[20] in Australian hospitals and was modelled on the *Harvard Medical Practice Study* conducted in the US in the early 1980s.[21]

2.2 The study was commissioned by the Professional Indemnity Review[22] chaired by Ms Fiona Tito-Wheatland for the Commonwealth Department of Health. It examined the records of over 14,000 patients admitted to hospitals in New South Wales and South Australia in 1992.[23] The investigation revealed that 16.6% of hospital admissions were associated with an adverse event, and 18.5% of these adverse events resulted in permanent disability or death.[24] When these results were extrapolated to all hospital admissions in Australia in 1992, it was found that:

- 470,000 admissions would have been associated with an adverse event
- 50,000 patients would have suffered permanent disability as a result of their health care
- 18,000 patients would have died as a result of their health care

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19 HCCC, *Better Practice Guidelines on Complaint Management by Health Care Services* (for Turning Wrongs into Rights project), October 2003, p1

20 An adverse event is 'an unintended injury to a patient which resulted in a temporary or permanent disability, prolonged length of stay or death, and which was caused by health care management and not the underlying disease.' Review of Professional Indemnity Arrangements for Health Care Professionals, *Compensation and Professional Indemnity in Healthcare: Final Report*, November 1995, p59

21 The *Harvard Medical Practice Study* looked at 30,000 patient records from 1984 in New York State. See *Professional Indemnity Review*, pp57-58.

22 Also known as the *Review of Professional Indemnity Arrangements for Health Care Professionals*, op cit

23 *Professional Indemnity Review*, op cit, p59

24 For the findings of the Study, see Wilson R, Runciman W, Gibberd R, Harrison B, Newby L and Hamilton J, 'The Quality in Australian Health Care Study,' in *Medical Journal of Australia*, vol. 163, 1995, p467

- 3.3 million bed days were attributable to adverse events.

2.3 The findings of the *Quality in Australian Health Care Study* show that Australia has a comparable rate of adverse events to that of other modern health systems.[25] The quality of health care in New South Wales is also similar to that of other modern health systems.[26]

2.4 The high number of adverse events in all health systems reflects the growing complexity of health care. Technological advances in medicine, coupled with a widening array of available tests and treatments and a greater number of clinicians involved in the care of an individual, increases the chances of something going wrong. Considering the ever-increasing complexity of health care, the potential for adverse events will only continue to grow.[27] It is clear that Australia and New South Wales are not alone in facing the challenge of improving patient safety.

2.5 The publication of the *Quality in Australian Health Care Study* was accompanied by widespread media coverage,[28] providing a major impetus for government to find ways to improve patient safety. Policymakers began to look to other high-risk industries, such as aviation, industrial safety, diving, road and rail travel and nuclear power, which all have a long history of incident monitoring and systems analysis to minimise risk and prevent the recurrence of errors, rather than focusing on individual blame.[29]

Evolution of a systems approach

2.6 A widely held view among patient safety advocates is that a 'systems' or 'no blame' approach to adverse incidents can facilitate greater openness about errors. A 'systems' approach to medical error recognises that most adverse events in health care are not attributable to any one individual, but are the result of a chain of errors or omissions in the systems of care. Unless the system is fixed, the same or similar error is likely to occur again.[30]

2.7 Supporters of a no blame approach believe that, given the systemic nature of many adverse events, it is both unfair to blame individuals and it is also counter-productive. They argue that this approach will discourage health professionals from being open about near misses and errors, and consequently limit access to important data necessary for quality improvement.[31]

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25 International studies into patient safety have consistently shown that adverse events occur in about 10% of all admissions, are associated with avoidable serious harm in 2% of admissions, and are associated with the avoidable death of a patient in 0.3% of admissions. Submission 66, NSW Health, p4

26 Submission 66, NSW Health, p4

27 McNeill PM and Walton M, 'Medical harm and the consequences of error for doctors,' in *Medical Journal of Australia*, vol 176, 2002, p222

28 Van Der Weyden M, 'Politics and publishing: the Quality in Australian Health Care Study,' in *Medical Journal of Australia*, vol. 163, 1995, pp453-454

29 *Professional Indemnity Review*, op cit, p148

30 Submission 66, NSW Health, p5

31 Ms Merrilyn Walton, Associate Professor of Ethical Practice, Department of Medical Education, University of Sydney, told the Committee that a 'blame and shame' approach to medical error first appeared in the 1930s, partly in response to the malpractice environment in the United States. Ms Walton, Evidence, 29 March 2004, p57

> … there is evidence from the past that, having a blame approach, if you like to call it that, of pointing the finger at the lowest person in the food chain involved in the case would lead to those people not openly talking about when they've done something that was wrong.[32]

2.8 Support for a systems approach to incident reporting is evident in background papers provided by NSW Health to this inquiry:

> Although the majority of problems that occur in health care result from human error, they are best seen as a failure of systems, not of individuals.[33]

2.9 Ms Amanda Adrian, former HCCC Commissioner, gave evidence that the HCCC was also supportive of a systems approach:

> … the Health Care Complaints Commission (HCCC) was moving towards a more systemic view of the health system, with a focus on leadership, governance and the criticality of adequate intellectual resourcing as well as financial resourcing … Once the focus shifts to individuals and individual acts there is the serious risk of losing sight of the long-term and far more pervasive systemic changes that are needed requiring bipartisan support and long-term commitment.[34]

2.10 Some witnesses to this inquiry argue that this systems approach to patient safety has downplayed the importance of individual professional accountability. This concern is discussed further in Chapters 3 and 6.

Improving patient safety in NSW

2.11 Although the safety and quality agenda is a relatively recent phenomenon, New South Wales Health has made considerable progress within a relatively short time frame:

> NSW Health has made substantial progress during the last decade in the implementation of system-wide complaints handling guidelines and quality frameworks and policies. Many of these initiatives are in fact recognised internationally as world-class.[35]

2.12 The most important initiatives designed to promote patient safety include the establishment of a Quality and Safety Branch within the Department and the development of a *Framework for Managing Quality and Safety in Health Services in New South Wales,* both of which were introduced in 1999. More recently, in 2002, the Department set up the Patient Safety Improvement Program. These changes were designed to include a systematic clinical process involving the entire health team, not individual professional groups. NSW Health's key policies and programs to progress the quality agenda are listed at the end of this chapter in Table 2.1.

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[32] Associate Professor Brad Frankum, Director of Medicine, Macarthur Health Service, Evidence, Special Commission, 16 April 2004, p149

[33] NSW Health, *Complaints Handling Procedures and the Quality Agenda in the NSW Health System: Background Paper*, February 2004, p4

[34] Ms Amanda Adrian, Evidence, 29 March 2004, p64

[35] Ms Robyn Kruk, Director General, NSW Health, Evidence, 19 March 2004, pp2-3

Safety Improvement Program and Root Cause Analysis

2.13 The Patient Safety Improvement Program is based on a program developed by Professor Jim Bagian, a former NASA astronaut, for the Veterans Health Administration in the USA. The program is considered world's best practice and its value has been highlighted by a number of key witnesses during this inquiry.[36] It is currently being implemented throughout NSW Health.

2.14 The Patient Safety Improvement Program allows health practitioners to 'identify the exact causes of health systems errors and identity appropriate corrective action.'[37] Once a complaint has been received from a patient or staff member, managers use a Severity Assessment Code (SAC 1-4) to assess the incident according to its consequence and likelihood of it occurring again. Key questions are also asked to identify if the incident involves individual performance issues.[38] For all incidents given the highest rating (1), managers must undertake Root Cause Analysis to identify systemic causes and what action should be taken to correct systems weaknesses to prevent recurrence. All of the highest-rating incidents must be reported to NSW Health. For less serious incidents, health services conduct an internal analysis, and use this information to identify trends and systemic issues that need to be addressed. Since its introduction in late 2002, 2,000 doctors, nurses and managers have been trained in Root Cause Analysis.[39] For more information on the SAC and best-practice complaints handling, see Tables 2.2 and 2.3 at the end of this chapter.

Role of consumer participation in quality

2.15 When patients enter the health system they often feel vulnerable and reticent about making complaints. This may be exacerbated by communication problems, with patients from culturally and linguistically diverse backgrounds facing 'additional barriers of language and culture each time they interact with the health system.'[40]

2.16 The Health Participation Council was established in 2002 to give consumers a formal role in decision-making about health service delivery at a Department level, and in its supplementary submission to this inquiry, NSW Health recognised that there is scope for the Council to provide a community perspective on complaints handling.[41] Area Health Services also facilitate consumer feedback and advice at a local level through various mechanisms, such as having consumer representatives on Health Councils and health advisory groups.[42] Such consumer input is vital to developing accessible and effective quality processes, especially for those

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36 Professor Bruce Barraclough, Chair, NSW Institute for Clinical Excellence, Evidence, 19 March 2004, pp38-39; Ms Fiona Tito-Wheatland, PhD Scholar, Evidence, 23 March 2004, p27; Associate Professor Merrilyn Walton, Ethical Practice, University of Sydney, Evidence, 29 March 2004, pp59-60; Associate Professor John Cartmill, Department of Surgery, University of Sydney and Director of ErroMed, Evidence, 30 April 2004, pp3&7.

37 Submission 66, NSW Health, p4

38 For information on the Patient Safety Improvement Program, see Submission 66, NSW Health, pp8-10

39 Submission 66, NSW Health, p13

40 Submission 25, Ethnic Communities Council of NSW, p2

41 Submission 66a (Supplementary), NSW Health, p5

42 NSW Health (February 2004), *Complaints Handling*, op cit, p24

consumers who are least likely to complain about their health care. The whole hospital system or area health service must be more responsive to the community.

NSW Institute for Clinical Excellence

2.17 The Institute for Clinical Excellence (ICE) was established in 2001 and is chaired by Professor Bruce Barraclough. ICE's role is to improve patient safety practices, and systems that underpin the delivery of health care services.[43] It focuses on training and education to promote best practice, together with initiating and funding targeted research to underpin this training.[44] In conjunction with NSW Health, ICE is providing training on the Patient Safety Improvement Program and Root Cause Analysis to all Area Health Services.[45]

Clinical Excellence Commission

2.18 In response to concerns raised through the investigation of problems at Campbelltown and Camden Hospitals, Hon Premier Bob Carr MP announced that ICE will be given additional powers and functions from July 2004 to become the Clinical Excellence Commission.[46] In addition to the current responsibilities of ICE, the new Commission will:

- provide a system-wide monitoring and audit function to ensure standards are met, and to enable identification of problem areas in each Area Health Service
- provide an expert clinical support team to Area Health Services on a needs basis to assist them to review and improve their systems and practices.[47]

2.19 The new Clinical Excellence Commission will complement the role of the HCCC: the HCCC will be responsible for investigating individual complaints, while the CEC will focus on systems issues identified by the HCCC.[48] For a further description of the roles of the HCCC and the Clinical Excellence Commission, see Chapter 6.

National initiatives in patient safety

2.20 Following the Quality in Australian Health Care Study, many complementary national and state-based bodies have been established to improve patient safety. The main national bodies are the Australian Council for Safety and Quality in Healthcare, and the Australian Council on Healthcare Standards.

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43 NSW Health, *Information Paper: Providing the Best Health Care*, April 2004, p5

44 http://www.ice.nsw.gov.au/corporate.htm (accessed 21 April 2003)

45 ICE, *Annual Report 2002-03*, p6

46 NSW Health, 'Premier Carr announces new $55 million Clinical Excellence Commission to improve health standards,' *Media Release*, 8 April 2004

47 NSW Health, (April 2004), *Information Paper*, op cit

48 NSW Health, (April 2004), *Information Paper*, op cit, p6

Safety and Quality Council

2.21 The Australian Council for Safety and Quality in Health Care was established in 2000 by Health Ministers from the States and the Commonwealth, to lead and coordinate national efforts to improve safety and quality in health care.[49] The Council is chaired by Professor Bruce Barraclough. The role of the Council includes developing a national strategy and priorities, as well as coordinating safety and quality initiatives.

2.22 The Council has sponsored or initiated a number of important projects, including a national Open Disclosure project and the Turning Wrongs into Rights project.

Open Disclosure

2.23 The Open Disclosure project commenced in December 2001. The central idea behind Open Disclosure is that clinicians and administrators need to acknowledge when adverse events occur, to show genuine regret, and to provide reassurance to patients and their carers that lessons learned will help prevent their recurrence. The aim of the Open Disclosure project is to remove barriers to open disclosure, including fear of litigation, a culture of infallibility among health practitioners and inadequate systems for learning from mistakes. By facilitating open disclosure, the project aims to restore trust between clinicians and consumers and improve the quality of health care provided to patients.[50]

2.24 One of the tasks of the project was to develop a national Open Disclosure Standard, published in 2003. The Standard provides recommendations to improve open communication with patients following an adverse event, and discusses ways to ensure that adverse events are used to facilitate improvements in patient safety.[51]

2.25 The need for practitioners to implement open disclosure was broadly supported by witnesses, including United Medical Protection.[52] Ms Beth Wilson, Victorian Health Services Commissioner believes it has enormous potential:

> The thing that has really heartened me in recent years is the Open Disclosure project that has been undertaken by the Commonwealth. That I think is the most important quality initiative that I have seen … We have all been saying these things; the Open Disclosure project is actually trying to find a way of doing it.[53]

Turning Wrongs into Rights

2.26 The Turning Wrongs into Rights project commenced in 2003 and is being conducted by the HCCC in conjunction with the Health Issues Centre and the Royal Australasian College of

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49 www.safetyandquality.org (accessed 21 April 2004)

50 www.nsh.nsw.gov.au/teachresearch/cpiu/CPIUwebdocs/Issues_paper.pdf (accessed 10 May 2003)

51 www.safetyandquality.org/articles/publications/OpenDisclosure_web.pdf (accessed 21 April 2004)

52 Mr David Brown, General Manager, Legal Division, United Medical Protection, Evidence, 24 March 2004, pp12-13

53 Ms Wilson, Evidence, 29 March 2004, p28

Physicians.[54] The project aims to ensure that consumer complaints are recognised as an essential source of information about adverse events and are linked to quality improvement programs.

2.27 The project has produced *Better Practice Guidelines on Complaint Management by Health Care Services*, which provide a framework for health services to improve their systems for consumer feedback, complaint management and quality improvement. The Guidelines are supported in principle by the Safety and Quality Council and will be considered for endorsement by the Australian Health Ministers Conference in July 2004.[55] The HCCC is currently developing a *Complaints Management Handbook* to provide practical assistance on how to implement the *Guidelines*.[56]

2.28 While the Open Disclosure project can be seen as a way to improve the way clinicians deal with adverse events, and possibly reduce complaints, Turning Wrongs into Rights is a way to ensure that when consumer complaints are made, the information gained is utilised effectively for systems improvement.

Australian Council on Healthcare Standards

2.29 The Australian Council on Healthcare Standards was established in 1974. The Council comprises representatives of all state and territory governments, professional colleges, peak industry organisations and consumers.[57]

2.30 The Council administers the Evaluation and Quality Improvement Program (EQuIP), which is used to accredit health care services in both the public and private sectors and thereby improve quality of care through performance review and assessment.[58] In 2003, 228 organisations participated in the EQuIP survey, of which 89 were from New South Wales.[59]

Medical accountability

2.31 The development of the quality and safety movement over the past thirty years has been accompanied by a 'growing public clamour for medical accountability.'[60] This demand was fuelled by public health care scandals, such as the Chelmsford Hospital Royal Commission in New South Wales into deep sleep therapy for psychiatric patients,[61] and was supported by the

54 Australian Council for Safety and Quality in Health Care, *Better Practice Guidelines on Complaints Management for Health Care Services*, Version 7, 2004, pp1-2

55 Email from Ms Amanda Cornwall to Project Officer, 10 May 2004

56 Submission 58, HCCC, p3

57 Submission 61, Australian Council on Healthcare Standards, p1

58 www.achs.org.au (accessed 27 April 2004)

59 Submission 61, Australian Council on Healthcare Standards, *Attachment B*, p1

60 Thomas D, 'Introductory Overview,' in D Thomas (ed), *Medicine called to account: health complaints mechanisms in Australia*, School of Health Services Management, UNSW, Kensington, 2002, p4

61 Slattery J, Report of the Royal Commission into Deep Sleep Therapy, NSW Government Printer, 1990

first studies into patient safety. The 1980s saw the 'steady progression of the idea of giving health consumers a statutory right to register complaints and call providers to account,'[62] leading to the establishment of health complaints bodies across Australia, including New South Wales.

Health complaints mechanisms in NSW

2.32 The precursor to the HCCC, the Complaints Unit of the NSW Department of Health, was established in 1984.[63] It was the first body of its kind in the world. Other states and territories followed by establishing health complaints agencies from the late 1980s. The Complaints Unit continued as a departmental sub-section of the NSW Department of Health until 1994, when the HCCC was established as a statutory authority.

2.33 A system of co-regulation exists in New South Wales whereby the HCCC and the relevant professional body representing doctors, nurses, dentists and other allied health professionals such as the Medical Board or Nurses Registration Board jointly assess complaints against individual practitioners and decide on a course of action.[64]

2.34 The Complaints Unit was established in the aftermath of the Chelmsford scandal of the 1970s. It has been suggested that a strongly prosecutorial approach to the functions of the Complaints Unit, followed by the HCCC, was a consequence of this foundation. A prosecutorial approach has been described as one is one which 'demands the invocation of legal penalties against practitioners as well as institutions in which negligence, incompetence or abuse of medical power has been found to occur.'[65] This contrasts with the approach adopted in the other states and territories which is based on conciliation:

> The Health Care Complaints Commission (HCCC) is a slightly different model from that in Victoria. In New South Wales conciliation is conducted outside of the Commission and the Commission has the role of prosecuting before the registration boards. That does not happen in Victoria. Conciliation is the heart and soul of our office and prosecutions are done separately, but I work very closely with the registration boards and refer matters to them.[66]

2.35 Unlike the other states and territories, the HCCC in New South Wales has the power to investigate and prosecute practitioners, where the other states and territories can only refer cases to their respective Medical Boards. Despite its traditional prosecutorial approach, former Commissioner Amanda Adrian told the Committee that she had tried to steer the HCCC towards a more systems-oriented focus.[67] As a result of the problems at SWSAHS, however,

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62 D Thomas, op cit, p1

63 For information on the background to the establishment of the HCCC, see Thomas D, 'New South Wales: The Complaints Unit/Health Care Complaints Commission,' in D Thomas, op cit, pp15-26

64 Submission 54, Nurses Registration Board, p1, and D Thomas, 'New South Wales,' op cit, p22

65 D Thomas, 'Introductory Overview,' op cit, p6

66 Ms Wilson, Evidence, 29 March 2004, p25

67 Ms Adrian, Evidence, 29 March 2004, p63

there is increasing recognition of the need to strike a balance between a systems-focus and professional accountability. In the first Interim Report, the Special Commissioner noted:

> … this Inquiry to date discredits the notion that individual accountability through professional discipline is inconsistent with systemic improvement of clinical care and institutional administration.[68]

Implementing the safety and quality agenda

2.36 The evidence presented to the Committee suggests that NSW Health has made a strong commitment to the safety and quality agenda and to developing clinical governance frameworks to improve patient safety. In particular, we have been impressed by the recent initiatives under the Patient Safety Improvement Program.

2.37 Much remains to be done to improve patient safety, especially in Area Health Services, most of which are in the early stages of implementing clinical governance frameworks.[69] As Dr Greg Stewart, Chief Health Officer NSW Health, noted, 'frameworks and policies are one thing but implementation is another and it is necessary for the whole system to turn its attention to implementation.'[70]

2.38 What has become clear during this Inquiry is that even the best systems and quality programs have minimal impact if the culture of the work environment supports covering up of mistakes, and 'blaming' of those who highlight areas for improvement. The cultural and resource issues relevant to the full implementation of the quality agenda are discussed in Chapters 3 and 5.

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68 Walker B, *Interim Report of the Special Commission of Inquiry into Campbelltown and Camden Hospitals*, 31 March 2004, p26

69 HCCC (2003), op cit, Part 7, December 2003, pp7-8

70 Dr Stewart, Evidence, 19 March 2004, p14. See the discussion in Chapter 6 in this report regarding accountability for further information on implementation of quality and safety agenda.

Table 2.1: NSW Health - key safety and quality policies and programs

Year	Policy/program
1998	**Better Practice Guidelines for Frontline Complaints Handling**: Provides a framework for a consistent and continuous improvement approach to handling complaints and requires quarterly reporting of complaints data to the NSW Health Department.
1999	**Framework for Managing the Quality of Health Services in New South Wales**: Identifies essential elements of clinical governance required of each Area Health Service, including the establishment of a Quality Council.
	Policy Framework and Best Practice Guidelines for the Development of Health Service Grievance Management Systems: Assists managers to manage workplace grievances in an effective and fair way.
2000	**Managing for Performance: A Better Practice Approach for NSW Health**: Assists health services with regular review and evaluation of staff performance, and supporting performance improvement when required.
2001	**Clinicians Toolkit for Improving Patient Care**: Assists clinicians to understand human factors (ie how humans perform in the workplace, both individually and in teams), identity and analyse problems, and use this information to improve patient care.
	Model Policy on the Management of a Complaint or Concern about a Clinician: Assists each Area Health Service to develop policies for managing complaints about clinicians.
2002	**Effective Incident Response: A Framework for Prevention and Management in the Health Workplace**: Assists each Area Health Service to fulfil their responsibilities under the Occupational Health and Safety Act 2000.
	Easy Guide to Clinical Practice Improvement: A Guide for Healthcare Professionals: Assists clinicians and managers to act on the information gained through use of the Clinicians Toolkit in a sound scientific way to improve patient care.
2003	**Patient Safety Improvement Program**: Provides a state-wide, consistent approach to managing health care incidents based on a program developed by the US Veterans Health Administration, including use of Severity Assessment Codes, Root Cause Analysis and centralised reporting of the most serious adverse incidents.

Table 2.2 Severity Assessment Code[71]

Severity Assessment Code

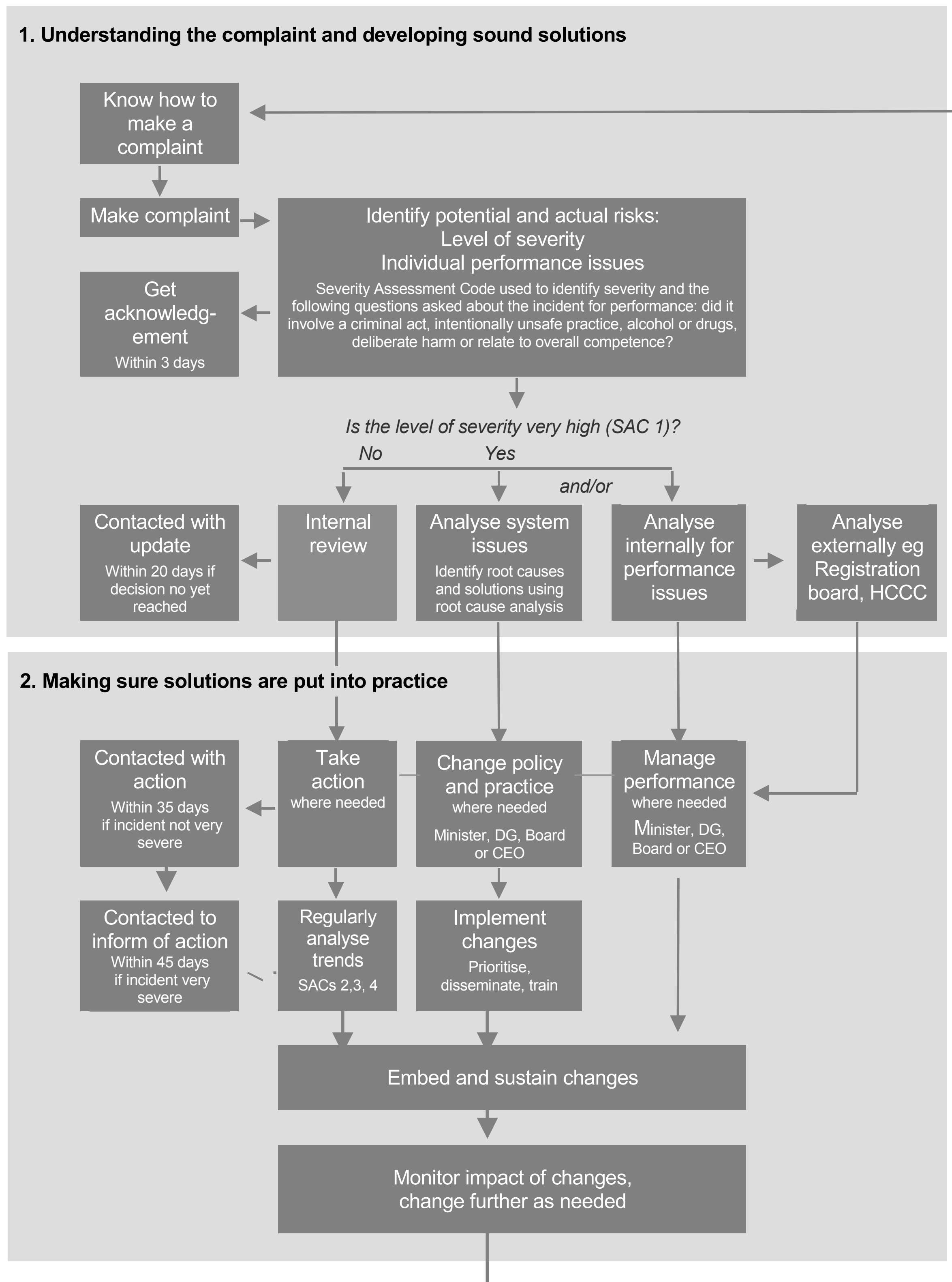
The Severity Assessment Code (SAC) below is a simple method that allows health services to stratify the risks associated with an incident. This ensures that appropriate management takes place.

CONSEQUENCE / LIKEHOOD	Extreme	Major	Moderate	Minor	Insignificant
Frequent	1	1	2	3	3
Probable	1	1	2	3	3
Occasional	1	2	2	3	4
Uncommon	1	2	3	4	4
Remote	2	3	3	4	4

A rating of 1 will always require investigation, a rating of 2 requires notification and investigation at the discretion of management, a rating of 3 or 4 is managed at the local level, unless the incident is likely to evoke external interest in which case it should be referred to management.

71 Submission 66, NSW Health, p11

Table 2.3 Elements of a 'best practice' complaints handling system[72]



72 Submission 66, NSW Health, p13

Chapter 3 Developing a culture of learning

> At the heart of effective complaints management are both good systems but also cultural issues. There has been a consistent feedback that the cultural issues are the more difficult in the longer term to address ...[73]

The following chapter discusses the key cultural barriers to 'best practice' complaints handling in New South Wales. An effective complaints handling system requires comprehensive policies and most importantly, a supportive culture. A key barrier to effective complaint handling is health professionals' reluctance to report adverse incidents. The hierarchical structures within the health system and the general reluctance by health professionals to report adverse incidents must be overcome.

The Committee has been told that in order to encourage more reporting among practitioners, it is imperative that a 'systemic' or 'just' approach to medical error be adopted, as distinct from one characterised by 'blame and shame'. The need to strike a balance between identifying the systemic cause of medical error and professional accountability is a central theme of this inquiry. The Committee believes that health managers should play a critical and proactive role in developing a culture of learning and implementing responsive practices.

The relationship between culture and systems

3.1 The 'culture' of an organisation comprises the attitudes, beliefs and practices of people within that organisation whereas the 'system' describes the policies and procedures that guide the way things are supposed to be done and by whom. There is no single culture within the health system, but several, including the medical culture, nursing culture and hospital culture.[74] An effective organisation needs sound policies as well as a culture that supports these polices. While NSW Health has made a significant effort in recent years to introduce policies and guidelines to improve complaint and incident handling,[75] their successful implementation is highly dependent on generating cultural change:

> South East Health is developing a culture of learning … Only when we achieve this can we improve our systems and the way in which we deliver health care to our community.[76]

3.2 Good systems are undoubtedly important, but as many witnesses have emphasised during this inquiry, shaping cultural change is the more challenging task:

> Effective implementation of … quality initiatives is reliant on a culture in which clinicians, healthcare workers and patients can report errors or adverse events without

[73] Ms Robyn Kruk, Director General NSW Health, Evidence, 30 April 2004, p34

[74] Ms Merrilyn Walton, Associate Professor of Ethical Practice, Department of Medical Practice, University of Sydney, Evidence, 29 March 2004, p57

[75] According to the NSW Branch of the AMA, the NSW Health website identifies a total of 396 documents that refer to quality assurance. Submission 65, AMA (NSW)

[76] Green D, 'CEO's Update,' *The South Easterly*, Issue 1, vol 10, February 2004, p2

> fear and with the knowledge that these reports will be analysed and acted upon … This involves more than policy: it requires a commitment from clinical staff, patients and the community to openness, and to an acceptance that humans err.[77]

> … my opinion on this has never wavered, that the policies and procedures and guidelines that New South Wales Health have in place are very appropriate. The problem was the management at the South West Sydney Area Health Service chose not to follow them.[78]

3.3 A stark example of the mismatch between systems and culture is provided by recent events in south west Sydney. In May 2003, the Australian Council on Healthcare Standards (ACHS) surveyed Macarthur Health Service. Their focus, according to ACHS Chief Executive, Mr Brian Johnston, was 'on the systems that were in place' at Macarthur [79] although he stated that he is also interested in the culture that is created within an organisation.[80] The survey found that overall, Macarthur was probably performing better than a number of other health services.[81] It did not identify any major issues in relation to management and human resources[82] and it was awarded accreditation for two years out of a maximum period of four years. In terms of incident reporting and complaints, Macarthur appears to have been performing well:

> Reporting of adverse events, complaints and incidents is system wide and extensive with good documented processes and analysis of data, action and outcomes. Considerable effort has been made in developing a culture of recording and reporting with effective outcomes in increased reporting ... The comprehensiveness of this approach, the development of a culture that encourages reporting and innovative involvement of consumers in evaluating organisational effectiveness, is commended.[83]

3.4 Not long after the survey was completed, the Expert Review Team and the HCCC offered a far less positive report card on complaint handling in Macarthur. As Mr Malcolm Masso, the former Director of Nursing and Health Services at Macarthur concluded, 'It is hard to believe that the HCCC and the ACHS were talking about the same organisation.' [84]

3.5 The disparity between the findings of the accreditation survey on the one hand, and the HCCC and Expert Review Team on the other, demonstrate the importance of ensuring well thought out systems are supported by appropriate attitudes and beliefs. It also demonstrates that accreditation bodies such as the ACHS need to consider the validity of their survey methods. The role of the ACHS is discussed later in this chapter.

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77 Ms Kruk, Evidence, 19 March, p3

78 Ms Yvonne Quinn, Clinical Nurse Specialist, Operating Theatres, Campbelltown Hospital, Evidence, 12 March 2004, p7

79 Mr Johnston, Evidence, 23 March 2004, p45

80 Mr Johnston, Evidence, 23 March 2004, P50

81 Mr Johnston, Evidence, 23 March 2004, P50

82 Mr Johnston, Evidence, 23 March 2004, p46

83 Australian Council on Healthcare Standards, *Report of the Organisation-wide survey for the ACHS Evaluation and Quality Improvement Program, Macarthur Health Service, Campbelltown, NSW,* 26 August 2003, p45

84 Mr Masso, Evidence, 19 March 2004, p49

Recommendation 1

That the NSW Minister for Health raise with his counterparts on the Australian Health Ministers' Advisory Council whether the criteria used by the Australian Council on HealthCare Standards in its accreditation surveys of health services is an appropriate measure of quality.

Health professionals' attitudes to errors and complaints

3.6 Most adverse incidents in the health system are not reported. According to NSW Health:

> International experience has revealed significant underreporting of incidents. The rates of reporting of adverse events, for example, are substantially lower than the 10% expected based on the retrospective medical record studies. A similar situation is likely to exist in NSW.[85]

3.7 The disinclination to report or admit mistakes is particularly evident among doctors. Recent studies conducted both here and overseas indicate that doctors routinely fail to admit to errors, and in some cases, seek to hide complaints from management.[86] Inquiry participants described how cultural beliefs have a powerful inhibiting effect on the willingness to admit error. This is partly related to what has been described as the 'infallibility of medicine:'

> …the culture has been traditionally to say that there are no errors in healthcare…'[87]

3.8 Several witnesses mentioned that fear, especially of the possible consequences for their career, is a powerful incentive to remain silent about error:

> We tell all our junior health practitioners, nurses and doctors, "You will learn by your mistakes," and that is just bunkum. They do not learn by their mistakes, because there is a silence around mistakes. There is a whole fear of litigation, fear that their careers will be affected, fear that they will be blamed if they have made a mistake.[88]

3.9 Dr Anthony Llewellyn, a member of the Health Services Union (HSU) which represents junior medical officers suggests that his own observations reinforce the empirical evidence of a 'culture of cover up:' [89]

> Most junior doctors are threatened about voicing criticism in front of more senior clinicians … Personal career paths may be threatened or perceived to be threatened by speaking up or speaking out of turn. I have been witness to many occasions where a

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85 Submission 66, NSW Health, p17

86 Mulcahy L, Turning wrongs into rights, Paper presented to Form on Complaints Management and Quality Improvement in Health Care Services, 15 October 2003, North Sydney, p14.

87 Ms Fiona Tito-Wheatland, PhD Scholar, Evidence, 23 March 2004, p 28

88 Ms Walton, Evidence, 29 March 2004, p58

89 Dr Llewellyn, Evidence, 23 March 2004,p4

> brave junior doctor attempted to raise a genuine criticism in an appropriate meeting only to be rebuked by a senior clinician. [90]

3.10 Dr Llewellyn believes this culture starts in the medical student years and continues thereafter, fuelled by high pressure workplaces. Once they enter their 'tribal' group, doctors adopt certain behaviours to deal with the burdens of their profession.[91] In relation to a good complaint handling system, he said:

> …particularly at the registrar level, that is, where career paths are most important, a culture of openness about the complaint process would lead to an improvement.[92]

3.11 In her study of British doctors, Ms Marilynn Rosenthal discusses how all doctors have made mistakes, often serious ones and these experiences:

> … create a powerful pool of mutual empathy and an unforgettable sense of shared personal vulnerability … Where uncertainly surrounds all members of the profession daily and all see themselves vulnerable to accidents it is not difficult to understand a tacit norm of non-criticism, a conspiracy of tolerance.[93]

3.12 Professor Stewart Dunn from the University of Sydney and a Director of ErroMed, believes the reluctance of many doctors to comment on their colleagues' performance, especially those in more senior positions, is not confined to the medical profession but rather a characteristic of human nature.[94] This is a view supported by Professor Bruce Barraclough:

> There are many inhibitions for humans to admit their mistakes. I mean, next time you scratch the car you may not admit it the moment you get home. There are lots of fears about people being open about problems, and I am not trivialising the harm that occurs in medicine by giving that analogy.[95]

3.13 As Professor Barraclough admits, the consequences of doctors failing to speak up about their own or their colleagues' performance are far from trivial. This is illustrated by the following example provided by Professor Dunn:

> … as a psychologist I was called to see a patient of mine. This lady has had a long and tragic history with a cancer and she went for a procedure. The procedure was very brutally handled – not mismanaged, no negligence but just very brutally handled for a patient who was extraordinarily vulnerable. I went up to see her because she had developed a full-blown panic attack. When I talked to doctors involved, they said, "We know about this person [the doctor]. She's always like that" … What struck me was that doctors were aware that there was very poor communication by this particular [doctor] but had no way of feeding that back.[96]

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[90] Submission 59, HSU/Llewellyn, p3 (Llewellyn)

[91] Dr Llewellyn, Evidence, 23 March 2004, p4

[92] Llewellyn Evidence, 23 March 2004, p3

[93] Smith R, 'Preface,' in P Lens and G van der Wal (eds), *Problem Doctors: A Conspiracy of Silence*, IOS Press, Amsterdam, 1997, p.ix

[94] Professor Dunn, Evidence, 30 April 2004, p6

[95] Professor Barraclough, Chair, ICE, Evidence, 19 March 2004, p42

[96] Professor Dunn, Evidence, 30 April 2004, p6

3.14 That doctors may try to hide their mistakes does not mean they do not feel deep regret and concern about their performance. The self-doubt, disappointment and self-blame many doctors experience following an adverse incident[97] is heightened by the unrealistic expectations of their profession:

> Once they arrive, medical students are put through a gruelling course and exposed much younger than their non-medical friends to death, pain, sickness and the perplexity of the soul. And all this within an environment where "real doctors" get on with the job and only the weak weep or feel distressed. After qualification, doctors work absurdly hard, are encouraged to tackle problems with inadequate support, and then face a lifetime of pretending they have more powers than they actually do.[98]

3.15 While a small proportion of doctors may acknowledge incidents to their managers or colleagues, an even smaller number will inform their patients. The impact of non disclosure by practitioners can be extremely damaging for patients and their families, as the following example provided by Professor Dunn affirms. The example is used for training purposes in New South Wales but refers to an incident in another State.

The impact of non disclosure on patients and families

An 18-month-old child was given an accidental overdose of an anticonvulsant by an inexperienced team in an emergency department.[99] The child arrested and died despite 30 minutes attempted resuscitation, from which the parents were excluded. The hospital management expressly prohibited staff from approaching the parents. This is a brief extract from the statement by the child's mother. She is talking about the Coroner's Court 10 months later:

> We later found out that the doctor wanted to be the one to tell us. He wanted to tell us then and there but the hospital protocol did not allow it. I had to wait 10 months to hear, "I'm sorry."
>
> The nurse that was involved in the procedure … we had to wait 10 months to meet her, and she was banned from approaching us. And we were actually at the Coroner's Court. I am standing in the line to the ladies toilet. I am in a public toilet and the lady's standing behind me, I happened to recognise her, and I said, "You are one of the nurses from the hospital, aren't you?" She said, "I am the nurse." She breaks down and cries and I break down and cry. And this is all happening in the public toilet, the last place this should happen. It is one of the most emotional meetings I have ever had, and all she ever wanted to say to me was, "I'm sorry" and all she could keep saying was, "I'm sorry, I'm so sorry." We ended up embracing and it was something we needed to do. I needed to hear that "I'm sorry" and she needed to say it. And it is happening in the public toilet. It is something the hospital should have organised.

[97] Australian Council on Quality and Safety in Healthcare, Open Disclosure Consortium, *When things go wrong: an open approach to adverse events: Issues Paper,* February 2002, p7

[98] Smith R, op cit, in Lens and van der Wal, op cit, 1997, pviii (Preface)

[99] Australian Council for Safety and Quality in Health Care, Open Disclosure Educational CD-ROM, cited by Professor Dunn, Evidence, 30 April 2004. N.b this incident did not occur in New South Wales

The role of nurses in incident reporting

3.16 Unlike their doctor colleagues, nurses are more likely to report adverse incidents and errors:

> Incident monitoring has also been criticised for its unidisciplinary nature, having become the domain of nursing staff. If incident monitoring and management is to be effective, it must be team based, multidisciplinary and involve both senior and junior staff.[100]

3.17 According to the Royal College of Nursing of Australia (RCNA), nurses are more likely to report because they spend more time with patients and are more involved in quality improvement initiatives.[101] During its investigation of Macarthur Health Service, the HCCC identified a 'markedly' different usage of incident reporting between doctors and nurses, with the latter being far more likely to report.[102] However, this does not mean they are immune from strong cultural factors which inhibit reporting, including their status within the hospital hierarchy:

> There is still a huge power imbalance between doctors and nurses in the system. For nursing staff to come up and say, "I am sorry, can you stop, I do not think that is a great idea?" is far away from the reality of a lot of the positions in which nurses find themselves.[103]

3.18 Dr David Hugelmeyer, the Director of Emergency Medicine at Macarthur Health Service believes that the cultural differences between nurses and doctors account for the variability in incident reporting:

> Nurses in general tend to be more patient focussed … they tend to be a lot more proactive in terms of their desire to try to rectify the situation and so may actually report things more frequently … I think what needs to happen is basically that same sort of philosophy and bias, if you will, needs to occur with doctors so that they feel more comfortable, they feel more empathetic with patients and their families and it would be a nice world if they could freely say "I simply made a mistake, and I am very sorry and this is what we will do to try to rectify the situation to try to make this up." There are certainly doctors who do that – there is no question – but I think it is less common.[104]

3.19 Dr Thomas Faunce, from the Australian National University, notes that while nurses are often in the best position to complain on behalf of patients about adverse incidents, they receive little institutional support for doing so. Even nurses whose complaints are vindicated, he argues, are not promoted as role models.[105]

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100 NSW Health, *The Clinician's Toolkit for Improving Patient Care*, 2001, p4

101 Submission 51, RCNA, p6

102 HCCC (2003), op cit, Part 7, p20

103 Ms Tito-Wheatland, Evidence, 23 March 2004, p24

104 Dr Hugelmeyer, Evidence, 29 April 2004, p6

105 Submission 28, Dr Thomas Faunce, ANU, p1

Obstacles to incident reporting by nurses

Ms Giselle Simmons, a former Acting Nurse Unit Manager at Fairfield Hospital told the Committee about the obstacles nurses may face when seeking to raise patient safety issues with medical staff.[106] She recalled one incident where a nurse noticed that a patient on the ward was critically ill and required immediate attention:

The patient was eventually transferred to intensive care. However, it was still not recognised that he was critically ill by the medical staff on duty.

> The nurse recognised that the patient was in acute renal failure and required fluid therapy and, obviously, ongoing treatment. She rang me at home very distressed and in tears. She told me what she had done. She put fluid up against a doctor's order. I was disappointed because she challenged the doctor and the doctor would not have it. He told the nurses in question that she had no right to question his treatment. I said to her that I would like to speak to the nursing supervisor on duty. We had that patient transferred to another intensive care unit where he was intubated and ventilated. He required a lot of fluid therapy and so on and he went on to dialysis. The nurse saved that man's life … That is when it all started … I suppose you would call it harassment, bullying.

In drawing attention to this incident, Ms Simmons was told by the medical superintendent that nurses were not allowed to question doctors and that she did not have enough knowledge to be able to question a doctor.

3.20 The following chapter examines the experience of several nurses from south west Sydney who, far from being promoted as role models, were severely penalized for seeking to raise concerns about patient safety.

Health managers' attitudes to complaints

Closing the loop: implementing lessons learnt from incident reports

3.21 A significant disincentive for medical professionals to report adverse events is the perception that complaints do not lead to positive change.

> … a lot of people in hospitals collect lots of bits of paper and make reports, but they seem to go into some kind of black hole. We are all facing the challenge of trying to close that loop, to make sure that the information we gather about incidents is acted on to improve systems.[107]

3.22 If staff do not receive feedback on the outcome of their complaint or reforms are not implemented, they are unlikely to continue making reports as one of the nurse informants from SWSAHS, Ms Vanessa Bragg confirmed:

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[106] Ms Simmons, Evidence, 23 March, 2004, pp3-4

[107] Ms Wilson, Evidence, 29 March 2004, p31

> I used to write out the incident forms initially, my first few years that I was there, and in my later few years I stopped writing incident forms. It was general talk that it did nothing anyway.[108]

3.23 In its Final Investigation Report, the HCCC noted that elements of a 'blame' culture persisted among some members of the management team at Macarthur:

> Some staff also felt that reporting problems led to them being seen by management as the problem. Evidence of this approach was seen in a few incidents where the reporting of a problem led to the reporter being officially criticised – this criticism was then used as evidence in a process that led to the disciplining of some staff.[109]

3.24 As the Commission points out, a few poorly managed complaints can do a lot of damage:

> Even a perception that a collateral outcome of reporting will be personal censure is a significant disincentive to people using the reporting system.[110]

3.25 The nurse informants, including Ms Valerie Quinn are testament to the potentially damaging consequences of incident reporting for health professionals:

> Unfortunately, the pursuit of my concerns led me to being shackled by management and thrown on the scrap heap.[111]

3.26 While there may be significant cultural barriers to implementing system changes following the analysis of an adverse event, this phase of the incident handling process is also more resource intensive. Even in a health service that is enthusiastic about the quality assurance aspects of incident reporting, finding staff with the time and expertise to implement changes is likely to be a significant challenge. It is, as noted by Dr James Cracknell, the Director of Emergency Medicine at Liverpool Hospital states, a problem in all hospitals he has worked in:

> … the implementation phase of any recommendations made seemed to be where things stopped … it seems that it is often passed back to the clinician to then identify and implement change, where perhaps that is at the cost of the other roles in direct patient care.[112]

3.27 The role of resources in effective complaints handling systems is discussed in Chapter 5.

Balancing professional accountability in a 'no blame' culture

3.28 A 'systems' approach to medical error is considered to be a far more effective way to increase incident reporting than one focussed on blaming individuals. Quality and safety advocates argue that a blame approach discourages health professionals from being open about near

108 Ms Bragg, former Clinical Nurse Specialist, Intensive and Coronary Care, Campbelltown Hospital, Evidence, 12 March 2004, p11

109 HCCC 2003, op cit, p23

110 HCCC (2003), p23

111 Quinn Evidence, 12 March 2004, p3

112 Dr Cracknell, Evidence, 19 March 2004, p73

misses and errors, and so limits access to important quality improvement data. While the rationale for a no blame approach is persuasive, there appears to be confusion as to whether this perspective *precludes* disciplinary action against professionals:

> There is a misunderstanding about the concept of "no blame"… I think "no blame" has become a confusing and potentially misleading concept.[113]

3.29 The Director General, Ms Kruk prefers to use the term a 'just' culture, coined by James Reason, a leading researcher in the science of human error. A just culture acknowledges that in a complex system like health, it is more than likely that system-wide issues will be responsible for an adverse event but individuals still need to be made accountable for their own actions.[114]

> Trust is a key element of a reporting culture and this, in turn, requires the existence of a just culture – one possessing a collective understanding of where the line would be drawn between blameless and blameworthy actions. Engineering a just culture is an essential early step in creating a safe culture.[115]

3.30 Few would disagree that individual accountability is an essential element in the development of a safe health system, including Professor Brian McCaughan, President of the NSW Medical Board:

> ... we cannot let the reckless, the unethical, the wilful or the criminal go in a no blame culture. There are some doctors who have to be dealt with through a strict conduct arm. You cannot sleep with your patients. We cannot go into a no blame culture and sing Kumbaya or something, they have to be dealt with down the conduct pathway.[116]

3.31 However, 'marrying' professional accountability and an appreciation of the systemic nature of medical error, is, according to Professor Jeremy Wilson, Chair of the SWSAHS Clinical Council, a difficult exercise:

> It is a fundamental paradox system, on the one hand wanting to try and maximise participation for system reform and on the other hand having the need to institute disciplinary procedures for performances thought to be inadequate. It is a conflict and I'm not sure how to best marry it … [117]

3.32 Ms Merrilyn Walton argues that in making the necessary switch in recent years to looking at the influence of system factors on error, the pendulum has swung too far away from professional accountability. Given the medical profession's traditional lack of support for strong accountability mechanisms,[118] she believes this trend has serious implications for patient safety:

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113 Ms Kruk, Evidence, 30 April 2004, p38

114 Ms Kruk, Evidence, 30 April 2004, p38

115 Reason J, 'Human Error: Models and management,' in *British Medical Journal*, vol. 320, pp768-769

116 Professor McCaughan, Evidence, 12 March 2004, p57

117 Professor Wilson, Director of Medicine, Bankstown Hospital, Evidence, Special Commission of Inquiry, 16 April 2004, pp199-200

118 Ms Walton, Evidence, 29 March 2004, p58

> … professional accountability has become the 'black sheep' of safety improvement … The failure to urge professional responsibility concurrently with calls for a 'blame free' approach to error sends the public the message that the health system favours one above the other.[119]

3.33 The HCCC investigation into Macarthur Health Service has brought the apparent conflict between systemic and professional accountability into the public realm,[120] as the Director General pointed out at the final public hearing:

> This is probably the most difficult policy and legal issue that has come up in your inquiry and also arguably in relation to the Walker inquiry.[121]

3.34 Ms Amanda Adrian told the Special Commission that the debate about what is blameworthy and blame-free conduct within the health system has not yet happened but is essential, she argues, in order to progress to the next and more difficult part of the debate: 'How is it to be done:'

> … the first thing that has to happen is that debate across the system about … where are the edges of blameworthy and blame-free … I think until that happens we are going to have extreme tension, whoever investigates or looks at matters, be it through root cause analysis, be it the Commission, be it anyone.[122]

3.35 The Committee's inquiry and in particular, the Special Commission of Inquiry into Campbelltown and Camden hospitals have an important role in ensuring this will be an informed and productive debate.

Supporting a culture of learning in NSW

3.36 The remainder of this chapter focuses on how to encourage health professionals to report adverse events and health services to implement the lessons learnt from these incidents.

The Open Disclosure Standard

3.37 Health professionals are ethically obliged to maintain honest communication with their patients.[123] That doctors *do not* routinely disclose to patients when something goes wrong with their health care may surprise people outside of the health system, and even some within it:

> … it strikes me as bizarre that you have a contract between a doctor and a patient, a nurse and a patient … which stops the moment a mistake occurs, and that is crazy.[124]

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119 Walton M, 'Creating a 'No Blame' culture: Have we got the balance right?, *Quality & Safety in Health Care,* Vol 13, Issue 3, pp162-7

120 HCCC (2003), op cit, *Foreword*

121 Ms Kruk, Evidence, 21 May 2004, p17

122 Ms Adrian, Evidence, Special Commission, 14 May 2004, p453, see also p451

123 Associate Professor Debora Picone, Administrator SWSAHS, Evidence, 19 March 2004, p46

124 Professor Dunn, Evidence, 30 April 2004, p8

3.38 Patient safety advocates argue that the 'wall of silence' around adverse events erodes public confidence and trust in the medical profession[125] and must be demolished if we are to have a safer health system. If open disclosure was routinely practised in health services across the State, it may very well prevent complaints from being made in the first place. We believe that encouraging open disclosure is the vital first step in creating a safer health system.

3.39 One of the most promising recent initiatives to promote trust and openness in the health system is the Open Disclosure Project. The project has produced a standard to assist health to use adverse events to facilitate improvements in patient safety.[126] According to Professor Bruce Barraclough, the standard is currently being rolled out across Australia (see Chapter 2).[127]

3.40 While the *principles* of open disclosure are broadly accepted, it is difficult to gauge how extensively these are being implemented. NSW Health told us that while some services, such as intensive care units, have well developed processes, other services are yet to regularly use open disclosure.[128] The Council of Social Services of NSW stated that many community and public sector groups do not know what open disclosure is or if their Area Health Service has a commitment to it.[129] Publicly the medical defence organisations support the principles of open disclosure[130] however, according to Ms Merrilyn Walton, a former Health Care Complaints Commissioner, in practice these organisations send mixed messages to their members, leaving many clinicians in a state of uncertainty.[131]

3.41 Given the significant cultural barriers to openness about adverse events, the evidence to this inquiry indicates it is highly unlikely open disclosure is being practiced routinely in hospitals across the State.

> There is a lot of policy around open disclosure but it is not necessarily seen as practised at the bedside even though, thankfully, it seems that clinicians will sit down in a specific area and look at issues. But it is not generalised or it is not systematised across the service or the facility. It just depends on the culture of the unit.[132]
>
> …it is starting to take root in area health services across the State, but we have quite a way to go on that.[133]

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125 Professor Dunn, Evidence, 30 April 2004, p4

126 www.safetyandquality.org/articles/publications/OpenDisclosure_web.pdf (accessed 21 April 2004)

127 Professor Barraclough, Evidence, 19 March 2004, p41. The CEO of South Eastern Sydney Area Health Service told the Committee that the principles of open disclosure had been adopted by the Area's Board and Quality Council.. Ms Deborah Green, Evidence, 19 March 2004, p5

128 Submission 66, NSW Health, p14

129 Submission 35, Council of Social Service of NSW, pp5-6

130 Mr Brown, United Medical Protection, Evidence, 24 March 2004, p12

131 Walton, M, 'Do the right thing: a new way to manage mistakes,' *Australian Anaesthesia 2003*, Australian and New Zealand College of Anaesthetists, pp41-49

132 Mr Geoff Dulhunty, Acting Executive Director, The College of Nursing (NSW), Evidence, 23 March 2004, p59

133 Associate Professor Picone, Evidence, 19 March 2004, p50

3.42 Unless open disclosure becomes routine, the myth of 'infallible' medicine will persist. Secrecy will further erode trust between professionals and their patients so that when things go wrong, patients and families may be far less willing to accept negative outcomes. The arguments in favour of open disclosure are strong, but making it happen is difficult. It will require a seachange in attitudes to error in healthcare, facilitated by appropriate education, clinical and policy leadership. Most importantly a broad acknowledgement is needed that mistakes happen, and that the community has a right to know why they happen and what is being done to reduce their recurrence.

3.43 The Committee acknowledges the frictions between doctors, nurses, managers and other health professionals in reporting adverse events and the role of NSW Health to encourage open cultures and working environments.

Educating practitioners about quality

3.44 Appropriate medical education about patient safety and quality is seen as an important way to promote cultural change. Dr Llewellyn believes that young doctors' lack of knowledge about the principles of quality assurance reduces the frequency of incident reporting:

> Most junior doctors are unaware that the philosophy of quality assurance is improvements of systems, not bringing recalcitrant individuals into line; they are similarly unaware of the … philosophy of open-discussion without repercussion.[134]

3.45 Dr Llewellyn argues this education needs to be ongoing as it is easy for young doctors to forget what they have been taught at medical school once they enter a highly pressures workplace where the culture is not attuned to such ideas. He supports including junior practitioners in quality issues, including root cause analysis.[135]

3.46 The Committee heard that one approach was to emphasise the carrot rather than the stick when educating professionals about incident reporting.[136]

3.47 The Committee notes and welcomes the Department's recent announcement to fast track the introduction of Root Cause Analysis training and the appointment of additional personnel in each health service to train management and staff in the implementation of the Safety Improvement Program.[137] And while undergraduate medical degrees now include modules on communication and patient safety and quality issues, the more difficult task is educating earlier generations of practitioners, both nurses and doctors, who may have had very little exposure to these relatively new concepts.

3.48 Ensuring senior clinicians are exposed to education about quality and safety issues is an extremely important way to encourage an appropriate understanding and appreciation of the

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134 Submission 59, HSU/Llewellyn, p4 (Llewellyn)

135 Dr Llewellyn, Evidence, 23 March 2004, p7

136 *The Health Report*, Radio National, Norman Swan, 'Minimising Harm to Patients In Hospital', an interview with Brent James, Monday 1 October 2001

137 Submission 66a (Supplementary), NSW Health, p8

principles of patient safety. According to Beth Wilson, the Victorian Health Complaints Commissioner:

> The problem is that we train these young professionals and we expect them to go out into the health services, which are heavily enculturated with role models who sometimes I would not want anyone to have as a role model, and we expect them to be the front-line troops who fix up the whole system. That is a huge ask. Medical and nursing education has to be at all levels so that the consultants, the senior people, are involved, as well as the new people.[138]

3.49 Professor McGrath, who was involved in the development of the incident monitoring system in Hunter Health, noted that engaging busy senior clinicians in training was a 'very challenging task.'[139]

3.50 The Committee has heard a good deal about what NSW Health could and should do to change the culture of learning, however we have received very little evidence regarding the role of the relevant professional organisations, including the colleges, and registration authorities, in encouraging cultural change through appropriate education. At the very least these bodies should ensure that their training programs incorporate quality and safety principles, including open disclosure.

3.51 The Committee believes that a compulsory standard and performance measure should be introduced for all health managers relating to open disclosure and the effects of their decisions on clinical outcomes. The Committee also believes that proof of implementation of this compulsory standard and performance measure form part of the annual performance review by the Director General.

Recommendation 2

That NSW Health discuss with the relevant health professional bodies in New South Wales to ensure that all training programs incorporate competencies regarding quality and safety issues, including the Open Disclosure Standard, as part of the registration process.

That evidence of ongoing professional development in these issues should be an essential requirement of registration.

The importance of leadership in encouraging cultural change

3.52 The review led by Professor Barraclough responsible for examining Macarthur Health Service highlighted the paramount importance of leadership in affecting cultural change:

> Leaders significantly influence the culture of the organisation and the values and goals they establish for the organisation, provide direction for staff and for organisational behaviour. Patient centred safety focussed values need to be paramount.[140]

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138 Ms Wilson, Evidence, 29 March 2003, p28

139 Professor McGrath, Evidence, 29 March 2004, p39

140 Barraclough Review, op cit, p27

3.53 According to Dr Thomas Faunce of the Australian National University, there are few if any institutional incentives to encourage incident reporting and the system makes little effort to put forward professionals who have made complaints as good role models.[141] In her submission, Ms Jennie Burrows, a consumer representative on the Clinical Council of a metropolitan Area Health Service, argued that:

> Commitment to self analysis must be demonstrated at the top and reflected at all levels of the organisation.[142]

3.54 Senior clinicians should 'lead by example' by encouraging junior doctors and nurses to report incidents and most importantly, by reporting their own errors and omissions. Observing their colleagues, including their supervisors, being open with their patients and management about medical mishaps would also help to relieve the burden of unrealistic expectations from practitioners' shoulders, especially junior doctors.

3.55 The Committee has been told of several ways to encourage health managers to take the lead in incident monitoring. For example the Board and Quality Council of South East Sydney Area Health Service recently adopted the principles of open disclosure. This is a valuable first step in demonstrating organisational commitment to openness about adverse events and should be encouraged. One way to do this would be via performance agreements between the Department and Area Health Service boards.

3.56 The Chair of the Australian Council of Healthcare Standards, Mr Brian Johnston, told the Committee that given the focus on complaints handling in recent times, the Council was considering giving complaints handling a higher priority in the its accreditation program.[143] The Committee supports this suggestion and urges the Council to implement this change as soon as practicable. We also note that the Open Disclosure Standard has not been formally incorporated into the current edition of the EQuIP Standards but would also urge the Council to do so as soon as practicable.

Recommendation 3

That Area Health Service boards formally adopt the principles of open disclosure via performance agreements with NSW Health and affirm their commitment to the full implementation of the Open Disclosure Standard developed by the Australian Council for Safety and Quality in Health Care.

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141 Submission 28, Dr Thomas Faunce, p1

142 Submission 3, Ms Burrows, p1

143 Mr Johnston, Evidence, 23 March 2004, p44. The Council's accreditation program is known as EQuIP (Evaluation and Quality Improvement Program). For more information see Chapter 2.

Recommendation 4

That the NSW Minister for Health raise with his counterparts on the Australian Health Ministers' Advisory Council the possible elevation of complaints handling in the Evaluation and Quality Improvement Program, conducted by the Australian Council on Healthcare Standards.

Recommendation 5

That the NSW Minister for Health raise with his counterparts on the Australian Health Ministers' Advisory Council incorporation of the Open Disclosure Standard in the current version of the Evaluation and Quality Improvement Program conducted by the Australian Council on Healthcare Standards.

Recommendation 6

That the NSW Minister for Health raise with his counterparts on the Australian Health Ministers' Advisory Council the provision of an annual update on the implementation of the Open Disclosure Standard, for the first two years following its incorporation into the Evaluation and Quality Improvement Program conducted by the Australian Council on Healthcare Standards.

Recommendation 7

That as part of their performance agreements all health managers in NSW undergo training in quality and safety principles, including the Open Disclosure Standard, and that this become an essential requirement of their continued employment.

'Systemic' open disclosure

3.57 Throughout the inquiry, several witnesses have observed that unrealistic expectations of what medicine can deliver, both in terms of resources and science, feeds public dissatisfaction about health care. If individual professionals ought to become more open with their patients it is essential for the 'system' to also be honest with the community about the limitations of medicine and the existence of error. Mr Brett Holmes, the General Secretary of the NSW Nurses Association and a former midwife told the Committee:

> There is an expectation that every mother and child that gets delivered in our hospital system is going to come out with a perfect baby and a perfect delivery. It is very tragic but two percent of those occasions result in a tragedy … The fact is that tragedy occurs … The fact that people go to hospital, they are acutely ill, in years gone by they would have died before they even got to hospital. They now survive for much longer. The expectation of the community is that our health system can save almost everyone. That is a false perception.[144]

[144] Mr Holmes, Evidence, 12 March 2004, p38

3.58 In evidence, the Director General of NSW Health argued that a safer health system was not only dependent on ensuring managers and clinicians report errors, but also requires an acceptance on the part of patients and the community that humans err. [145]

3.59 A health system which is truly committed to the principles of consumer participation needs to find creative and non threatening ways to involve the community in the difficult debates concerning contemporary health care. Promoting 'good' news stories about the miracles of modern medicine has its place, but should be accompanied by informed discussion about the limitations of health care.

3.60 Community understanding of the nature and extent of adverse events in the health system is strongly influenced by media reporting generated by public 'scandals' such as occurred recently in south west Sydney. An important first step in educating the community about the government's proposed new patient safety and quality initiatives, including the establishment of the Clinical Excellence Commission, should be the conduct of a high profile public awareness campaign.

Recommendation 8

That the proposed Clinical Excellence Commission in conjunction with NSW Health undertake an extensive public education campaign to inform the community about:

- simple steps to make health complaints
- the nature and extent of adverse events in the health care system
- realistic expectations of health care
- changes to the regulatory framework for health care complaints and consumers rights.

Comparative data on adverse events and performance

3.61 If NSW Health is committed to being open and transparent about the existence of adverse events, it is imperative that it publish available relevant information to enhance community understanding of this issue, including data on adverse events as well as the accreditation reports prepared by the Australian Council on Healthcare Standards.

3.62 The Adverse Incident Monitoring System (AIMS) is a new information management system which ensures incidents are reported, monitored, investigated and result in appropriate action. The system was trialled in Hunter Health and will be delivered to health services by November 2004. Under the new system, health services will be required to provide information about adverse events and the data will contribute to an aggregated database that enables the analysis of trends across the State.[146]

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[145] Ms Kruk, Evidence, 19 March 2004, p3

[146] Submission 66a, NSW Health (Supplementary), pp8-9

3.63 While in its first submission NSW Health undertook to 'publish information for the public about incidents and support its appropriate interpretation'[147] this commitment appears to have been revised. In its supplementary submission, the Department cautioned against a 'count and compare' approach to incidents in different health services suggesting that this is a poor guide to the quality of care.[148] For example, the Department argues, an increase in the number of reported incidents does not necessarily mean there has been an increase in the actual number of adverse events. Professor Barraclough told the Committee:

> By virtue of this safety improvement program and other programs of ICE, there has been a dramatic increase in the reporting of severe adverse events to the Department of Health and to individual health areas. This is what we aim to do: We aim for a dramatic increase in reporting so that we can know where problems exist and so that the vulnerabilities can be corrected.[149]

3.64 On the contrary, a health service with more reported incidents than its peers may be performing at a higher standard than a health service with poor complaints handling systems and an apathetic culture. NSW Health advocates greater reliance on other 'dashboard' indicators such as 'responsiveness to complaints' as a more reliable measure of performance. In addition, qualitative measures developed by the audits proposed by the Clinical Excellence Commission will also be a useful way to assess relative performance and areas of concern. Dr Christley, the CEO of Northern Sydney Area Health Service told the Committee:

> …to give people an understanding of how you look at health care systematically, how you can measure and how you can improve…try to look at it in a way of how to improve the process of the interaction between different parts of the health system rather than historically people living in silos of occasions and if anything went wrong it was somebody else's fault rather than something about the way the system was working systematically.[150]

3.65 We do not agree that the Department should withhold comparative data on healthcare incidents or adverse events. The events in SWSAHS are testament to damage that may be caused by failing to disclose information about adverse events in a timely manner. In a recent article in the *Medical Journal of Australia*, Martin Marshall and Robert Brook argue that while information in most other areas of modern life have become more freely available, healthcare has become the 'last bastion of protectionism:'

> When millions of dollars are spent on healthcare, those who pay have a right to know that the money is being spent effectively, and the publication of comparative data sends a strong message about the willingness of health professionals and organisations to be accountable.[151]

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147 Submission 66, NSW Health, p16

148 Submission 66a, NSW Health (Supplementary), p11

149 Prof Barraclough Evidence, 19 March 2004, p38

150 Dr Christley Evidence, NSAHS, 23 March 2004, p19

151 Marshall M N and Brook, R H, 'Public reporting of comparative information about quality of healthcare', *The Medical Journal of Australia*, Vol 176, no 5, 4 March 2002, pp205-206

3.66 They also suggest that public disclosure appears to be an effective way of improving quality:

> There is a growing body of evidence that…quality-improvement initiatives that use confidential data have been largely ineffective at changing the behaviour of health professionals. When comparative data are released to the public, it appears to remind providers of the issues and refocuses them towards taking action.[152]

3.67 Finally they argue that arguments in support of the status quo – that the data is inadequate, the public won't understand them, and the media will misuse them – are not sustainable if public disclosure is introduced properly.[153]

3.68 To demonstrate its commitment to systemic open disclosure, NSW Health should publish comparative data on adverse incidents. Recent events in south west Sydney have shown how a lack of transparency about health care incidents can disadvantage both patients and staff.

3.69 If the Department does not publish this material, members of the public may look to other sources for this information. While the Committee acknowledges the potential misuse of comparative data, particularly by the media, this does not justify withholding this information from the community. The publication of data regarding the performance of health services and individual practitioners is becoming increasingly common in other jurisdictions. NSW Health should not avoid the inevitable but rather spend its intellectual resources on presenting the material in a way that reduces its possible misinterpretation.

Recommendation 9

That NSW Health publish comparative data on adverse events in Area Health Services across New South Wales in Annual Reports and on its Website.

Recommendation 10

That the New South Wales Government convene a summit on medical adverse events within the next 12 months.

Publishing accreditation survey results

3.70 At present, the results of accreditation surveys conducted by the Australian Council on Healthcare Standards *may* be provided by an Area Health Service to NSW Health, but this is not required. This arrangement contrasts with most other States where health areas are obliged to make the results of their accreditation reports available to the relevant department, via performance agreements or administrative decree. For example, in Queensland the various districts report on the outcome of their surveys to the Department of Health, including information about the more serious recommendations that have been made and what actions have been taken to correct those shortcomings.[154] Mr Johnston, while not wanting to make a

152 Marshall M N and Brook, 2002, op cit, pp205-206

153 Marshall M N and Brook, 2002, op cit, pp205-206

154 Mr Johnston, Evidence, 23 March 2004, p47

specific recommendation to government, told the Committee that he thought the Queensland system worked well.[155]

3.71 Accreditation reports are not made public as a matter of course. Mr Johnston indicated that while a decision to publish these reports would be a question for Council members, he could see no administrative reason not to publish them:

> If they are of a mind, particularly the government representatives, that they would like more transparency in terms of making available the reports that we produce, organisationally I certainly would have no problem and neither would my senior staff.[156]

3.72 While the Committee did not canvass the views of NSW Health regarding the routine publication of ACHS reports, it can see no reason why this should not occur for all health services. The Committee also considers that the rectification reviews, prepared by health services in response to these reports, should also be published.

Recommendation 11

That a suitable mechanism be identified by NSW Health to ensure the results of accreditation surveys conducted by the Australian Council on Healthcare Standards be provided to the Department within two weeks of their completion.

Recommendation 12

That NSW Health publish all accreditation reports prepared by the Australian Council on Healthcare Standards and any rectification reviews prepared by health services in response to these reports.

Communication with patients about complaints

3.73 An important issue raised during the inquiry was the failure on the part of health service management and the HCCC to communicate with patients about the investigation of a health care complaint. Many patients and families in south west Sydney had no idea their treatment had been reviewed by the hospital or referred to the HCCC until they were contacted by the newly established Professional Practice Unit at SWSAHS, after the release of the Final Investigation Report into Macarthur in December 2003. Many of these people were surprised and concerned when told that their cases had been investigated.[157]

3.74 At the Committee's final public hearing this issue was raised in relation to the referral to the coroner of an additional three deaths at Liverpool Hospital in February 2004. None of the families of these patients had been informed of this action by the health service management

[155] Mr Johnston, Evidence, 23 March 2004, p48

[156] Mr Johnston, Evidence, 23 March 2004, p50

[157] Associate Professor Picone, Evidence, 19 March, p46

because, according to Associate Professor Debora Picone, she had been advised by the police that the coroner is the appropriate body to contact the next of kin.[158]

3.75 This comment appears to contradict the instructions in relation to coroner's cases, set out in NSW Health Circular 2004/23:

> Where deaths are reported to the Coroner, whether immediately after death or anytime thereafter, a senior Hospital Officer should make all reasonable efforts to contact and, where possible, to interview relatives to explain to them the formalities required by the Corner's Act.[159]

3.76 In the Committee's view, the Department's policy is highly appropriate. As the policy states, it can be very distressing for relatives to be questioned by police on behalf of the Coroner, without having been advised in advance for the reason for police inquiries by senior hospital staff.

Recommendation 13

That NSW Health take steps to ensure senior health managers are aware of the existing protocols in relation to notifying family members about the referral of a death to the Coroner.

Case study: Ms Sarita Yakub

> I have been through a complete U-turn in my life finding out the truth. We already had a tragedy to deal with at home, but this compounded everything and took a toll on our health … I don't want to see others go through this suffering.[160]

The circumstances surrounding the death of Ms Sarita Yakub at Nepean Hospital epitomise the often devastating impact of poor communication with patients and their relatives about the circumstances of the death of their family member.

Ms Sarita Yakub and her husband arrived at Nepean Hospital (Wentworth Area Health Service) at 12.42am on 3 August 2002. According to Mr Yakub, after a two-hour wait in the Emergency Department without being seen by a doctor, they left the hospital. Ms Yakub died that same night of meningococcal disease, a bacterial infection that can kill within hours if untreated. She was forty-five years old. The initial advice to the Department, based on a report from Wentworth Area Health Service was that a doctor had called Ms Yakub's name at 1am but she had already left the hospital, contradicting her husband's version of events.

NSW Health commissioned a review of Ms Yakub's death, meeting with Mr Yakub on 30 October 2002 to discuss the draft report. The final report was given to the Director General in November 2002, the Coroner in December 2002, and the HCCC in January 2003.

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158 Associate Professor Picone, Evidence, 21 May, 2004 p5

159 NSW Health, Circular 2004/23, *Coroner's Cases and Amendments to Coroner's Act 1980*

160 Patty, A, 'Pain goes on but at last the truth is revealed,' *Daily Telegraph*, 31 May 2004, p19

Mr Yakub did not receive a copy of the final report until 20 May 2003, *nine months* after his wife's death and *five months* after it had been sent to the Coroner. [161]

In May 2004, the HCCC confirmed Mr Yakub's account and concluded that that the information provided to the media had the unfortunate effect of focussing blame for Ms Yakub's death on Ms Yakub and her husband. The HCCC concluded that 'This must have in the circumstances have caused a great deal of grief and confusion for Mr Yakub and his family at a time when they had experienced a catastrophic loss.'[162]

3.77 In evidence, Associate Professor Picone expressed regret that the findings of the review were not made available to Mr Yakub earlier.[163] She believes that the introduction of Root Cause Analysis will improve the handling of such matters including that of Sarita Yakub:

> Had that system been in place when Mrs Yakub contracted meningococcal disease, the matter would have been handled quite differently. The death would have been the subject of a reportable incident brief and would have triggered an RCA. Mr Yakub would have been promptly advised at the time of the process. The case would have been referred to the area's Professional Practice Unit, which would then take carriage of the matter and liaise directly with the family. A family conference would have been conducted at the conclusion of the RCA within the benchmark timeframe of 45 days. This would have provided an opportunity for the hospital staff to explain how the death occurred and what action had been taken and what other action would be taken to address any issues and to address any outstanding matters of concern that family members might have. In this case the matter would ordinarily have been satisfactorily resolved at the local level and would not have necessitated the investigation to be overseen by the department of health.[164]

Recommendation 14

That NSW Health implement a State-wide protocol to ensure that the patient or next of kin of a patient whose treatment is the subject of a Root Cause Analysis is informed of the conduct and results of this analysis by a suitable clinician.

Mandatory reporting

3.78 Several inquiry participants called for the introduction of mandatory reporting as a means of increasing incident reporting. At present, it is mandatory for health services to report certain incidents to health service management, NSW Health or the relevant professional boards. For example all Severity Assessment Code 1 incidents, and some Severity Assessment Code 2 incidents must be reported to NSW Health (although there is no requirement that potential

161 Correspondence from Dr Tamsin Waterhouse, A/Director, Structural Reform Branch, NSW Health, to Director, GPSC 2, 24 May 2004

162 Patty, A, op cit, p19

163 Associate Professor Picone, Evidence, 21 May 2004, p22

164 Associate Professor Picone, Evidence 21 May 2004, p23

Severity Assessment Code 1 or Severity Assessment Code 2 events are reported by a practitioner to the health service). NSW Health policy states that anyone who has a concern or receives a complaint about a clinician's performance must report this to his or her supervisor. In addition, codes of conduct developed by the relevant nursing and medical professional bodies have developed or are in the process of being developed which recognise practitioners' responsibilities to notify the appropriate authority when there are concerns about questionable or unethical conduct.[165]

3.79 In its supplementary submission, NSW Health notes that the advocates of mandatory reporting were not clear about what this should entail. Were they referring to the mandatory reporting of under-performing clinicians or of all incidents? Should enforcement would be via policy or legislation? [166] The Committee's impression of what was being called for by advocates of mandatory reporting, including the nurse informants, was that *all incidents* should be reported at the Area Health Service level:

> If we are able to help or change the system, we should be obligated to do that, and we really believe that legislation should be brought in to say to the doctors and nurses: Hey, it is not dobbing any more, it is something that we require of you as part of your job.[167]

3.80 In its Macarthur investigation report the HCCC suggests that given the institutional and structural barriers to reporting, a mandatory regime may provide an impetus to people who are reluctant to report and change the prevailing attitude towards whistleblowers in the health system as being disloyal. It recommends that:

> The Health Care Complaints Act 1993, the Health Services Act 1997 and the Health Professional Registration Acts be amended to provide for mandatory reporting by health practitioners of unsafe conduct, performance and impairment on the part of health providers or management. [168]

3.81 NSW Health does not support a legislated requirement of mandatory reporting of all incidents at the clinical level because it:

- would be resource intensive and difficult to monitor
- may not overcome staff fears of being victimised
- would penalise staff who do not realise a particular event constitutes an incident
- would penalise staff who may not have been told of the steps they need to take to report an incident
- would remove the protections afforded to health service staff under the Protected Disclosures Act 1994 which only protects people who make voluntary disclosures.[169]

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165 Submission 66a (Supplementary),NSW Health, pp3-4

166 Submission 66a (Supplementary),NSW Health, p3

167 Ms Sheree Martin, Enrolled Nurse Camden Hospital, Evidence, 12 March 2004, p21

168 HCCC (2003), op cit, Part7, p72

169 Submission 66a (Supplementary), NSW Health, p4

3.82 The Committee acknowledges the disadvantages of a mandatory regime identified by the Department, but does not believe these are insurmountable. For example, a relatively minor legislative change could address concerns regarding the application of the protected disclosures legislation. We are conscious of the significant cultural barriers that need to be overcome in order to increase voluntary reporting and the potential role mandatory reporting could play in breaking down these barriers. However, as we have received a relatively small amount of evidence on this issue it is difficult to express a firm view on this proposal, but feel this issue deserves further attention from the Clinical Excellence Commission.

Recommendation 15

That the NSW Clinical Excellence Commission conduct a study on the feasibility of introducing mandatory reporting of all or certain classes of incidents to health service management and to the Department of Health.

3.83 The Committee notes that a top-down approach will lead to a perception of an inquisitorial system. Clinicians who are actively involved in patient care need to participate in meetings that openly discuss patient outcomes and recommendations for systemic change.

Recommendation 16

That NSW Health ensure that in all area health services each clinical team should have regular review meetings on a protocol set up by management and audited by the Clinical Excellence Commission.

No fault compensation

3.84 As we have noted, the threat of litigation is a significant disincentive for clinicians to report errors or to speak openly about an incident with patients or families. This is especially unfortunate, given that less than half of one per cent of all adverse events are compensated through the courts. As Professor Barraclough informed the Committee, in relation to the practice of open disclosure:

> There is some evidence in health care, even with an aggressive tort system such as in the United States of America, that there will not be an increase in litigation, but possibly a decrease.[170]

3.85 It seems the very small number of actual cases per year is acting as a powerful disincentive for doctors to be open and honest with their patients. Given this scenario, several witnesses including Ms Beth Wilson, indicated their support for the abolition of the tort system for medical negligence in favour of a no fault compensation scheme:

170 Professor Barraclough, Evidence, 19 March 2004, p42

> … I still prefer the no-fault system. I do not think politically it is going to happen, but that is what I think is the best system.[171]

3.86 For Dr David Hugelmeyer, the threat of litigation is a 'two-edged sword,' posing a threat but at the same maintaining high standards of practice:

> When I came here I was very anti lawyer based on my experience in the States, where basically I thought they were all out to get doctors. Here I somewhat relished the idea that that sword of Damocles was not hanging over your head all the time. However, I came to realise that one of the benefits of the system we have is that it tends to make doctors a bit more pedantic and obsessive about the care they provide—for example, something as simple as documentation. I find documentation abysmal here in terms of patient encounters. No matter how good the doctor, there is a lot to be desired compared with what I was taught and what I was used to. Our documentation is far more detailed…that is an offshoot of this sort of tort problem. Basically, doctors practise on a daily basis knowing that what they have to do must have a certain standard and that if it does not they are exposing themselves considerably. ..But they do not do so because they have not practised in that sort of environment and culture. It is a balance. I think we have gone over the other end and perhaps, with all due respect, there could be a little more here.[172]

3.87 While supportive of the concept, Ms Merrilyn Walton suggests that the introduction of no fault compensation would need to be accompanied by enhanced accountability measures:

> I am on the record as supporting no-fault compensation. If you go down a no-fault path there needs to be very strong professional accountability mechanisms. Some problems with the New Zealand model of no-fault compensation have been the weak regulatory frameworks underpinning it …. I do not think it is much money. If you ask the New Zealand victims, I do not think they would be very happy with how much they get.[173]

Conclusion

3.88 The clear message from inquiry participants is that for many health services, a culture of learning remains an aspiration rather than the reality:

> I think we are stepping on the road but we are not yet there by any stretch.[174]

3.89 While NSW Health has developed comprehensive policies to guide complaint handling systems, achieving the cultural change to implement these policies is the more challenging task. NSW Health should trial ways of breaking the hierarchical barriers that currently work against a culture of learning by such things as: the use of teams of professionals, ensuring that junior medical staff are aware of their role delineations; and safeguards to ensure that doctors take accountability for their actions.

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171 Ms Wilson, Evidence, 29 March 2004, p27

172 Dr Hugelmeyer, Evidence, 29 April 2004, pp6-7

173 Ms Walton, Evidence, 29 March 2004, p58

174 Ms Tito-Wheatland, Evidence, 23 March 2004, p24

3.90 NSW Health is but one, albeit crucial part of the solution. Senior clinicians, their professional organisations and medical insurers need to join with NSW Health to transform the culture of health. Recent events in south west Sydney have provided an important impetus to changing attitudes and systems, but they have had a profound impact on the people concerned. The consequences of whistleblowing, for professionals, patients and communities, is the theme of the next chapter in this report.

Chapter 4 Whistleblower issues in south west Sydney

> This sequence of events has resulted in enormous collateral damage to staff, patients and their relatives that will require years of healing. Some people may never recover.[175]

One of the most important 'cultural' issues raised by this inquiry is the need to encourage health professionals to report adverse events. Making sure practitioners are not 'blamed' for identifying patient safety issues is a prerequisite of a safe reporting culture. While the revelations of the whistleblower[176] nurses have led to significant and important health reforms, they have also had a profound impact on those nurses, their former colleagues and their communities. Finding ways to ensure health professionals are able to use formal channels for incident reporting, and therefore do not have to resort to whistleblowing, is an important challenge for this inquiry.

The nurse informants (whistleblowers) are highly critical of the way South West Sydney Area Health Service responded to their concerns. However they are also dissatisfied with how several other agencies dealt with their complaints, including the NSW Nurses Association, the Health Care Complaints Commission and NSW Health. As these organisations have a vital role to play in developing a 'culture of learning' in the health system, some of these issues are also discussed in this chapter.

A culture of learning in south west Sydney?

4.1 While this chapter focuses on SWSAHS, the Committee acknowledges that similar concerns about management response to staff complaints were raised in submissions from health care workers in other Area Health Services, including Central Coast, Central Sydney, Greater Murray, Mid-North Coast, Mid-Western and Southern.[177]

4.2 In November 2002, four nurses from south west Sydney met with the former Minister for Health, Craig Knowles to discuss their concerns about patient safety at Macarthur Health Service. As a consequence of this meeting, the nurses' allegations became the subject of a complaint to the HCCC by the Director General of NSW Health, an investigation by an Expert Review Team, lead by Professor Bruce Barraclough and the establishment of a Special Commission of Inquiry.[178] The Expert Review Team and the HCCC found that there were major obstacles to a culture of learning at Macarthur Health Service. For example, the Expert Clinical Review Team identified:

> …a strong perception among some staff that once incidents are drawn to management attention, a blame and investigative approach is adopted. There is fear of

[175] Mr Malcolm Masso, Former Director of Nursing and Health Services, Macarthur Health Service, Evidence, 19 March 2004, p49

[176] 'Whistleblower' is the informal term to describe someone who makes a legitimate disclosure about corrupt conduct, maladministration or serious waste in the public sector. The *Protected Disclosures Act 1994* protects public sector employees who make voluntary protected disclosures and who follow certain steps set out in the legislation.

[177] See submissions 10, 16, 22, 38, 40, 50, 62 and 64

[178] The Special Commission is due to finalise its investigation on 31 July 2004

> reprisals for reporting incidents. These perceptions do not indicate an open and fair culture that values reports of incidents so that improvements can be made.[179]

4.3 While acknowledging that Macarthur Health Service had introduced significant reforms to its incident reporting systems in recent years, the HCCC's Macarthur Investigation Report concluded that the new system was inhibited by a culture that did not consistently encourage reporting and a perception by some staff that they would be blamed for reporting their concerns.[180] The report argues that the lack of openness was particularly evident in the way the health service responded to the Commission during its investigation:

> Macarthur Health Service and South Western Sydney Area Health Service provided defensive responses to the Commission throughout the course of the investigation. This was indicative of the organisation's culture and the lack of openness in dealing with reported concerns about the safe care and treatment of patients. They did not hear the message from the nurse informants at the time of its original sending, at its first airing in the public media, nor during the course of most of this investigation.[181]

Attitudes to incident reporting

4.4 The nurse informants told the Committee that their attempts to report patient safety concerns were discouraged. One of the nurse informants, Ms Valerie Owen, formerly Clinical Nurse Specialist at Campbelltown Hospital operating theatres, described the attitude to incident reporting in Macarthur Health Service:

> Within the first few months I came across an experience which horrified me and I submitted a complaint and on the advice of my Nurse Unit Manager I was told to withhold my name from this complaint because, "You are now working in a small hospital and complaints, if nurses make complaints against doctors they stand a very high chance of losing their job."[182]

4.5 As a member of the Critical Care Committee at Campbelltown Hospital, Ms Nola Fraser said that while she raised concerns about patient safety, these issues:

> … were never minuted because the administrators felt that my standards were too high and that Campbelltown Hospital has its own rules and I need to either get on the bus or get off. They were not minuted because they did not think that it was a problem. They really thought I was the problem.[183]

4.6 In further evidence Dr Lim refuted this evidence.[184]

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179 Barraclough B, Baker K, Burrell T, Wallace M, *Working Papers of the Review of Standards of Patient Care and Services at Macarthur Health Service* (henceforth referred to as the Barraclough Review), 16 October 2003, p 7

180 HCCC, *Investigation Report, Campbelltown and Camden Hospitals, Macarthur Health Service*, December 2003, part 7, p74

181 HCCC (2003), op cit, Foreword

182 Ms Owen, Evidence, 12 March, 2004, p7

183 Ms Fraser, After Hours Hospital Manager, Campbelltown and Camden Hospitals, Evidence, 12 March 2004, p10

184 Lim Evidence, SWSAHS, 19 March 2004, p65

4.7 Some of the nurses stopped completing incident reports because they felt it rarely led to positive action, even if it could be shown that minor changes could lead to significant improvements. For example, Ms Kathrine Grover, formerly Senior Nurse Manager After-Hours at Liverpool Hospital, told the Committee about the unnecessary spread of infections as a result of staff failing to follow routine infection control procedures:

> … I spoke to the director of nursing and she suggested I write a paper on MRSA [Staph infection] and its spread, which I did. I described what I had seen in terms of contamination of surfaces and suggested that if that practice were to change there could be considerable improvement in the contamination rates of MRSA. The infection control clinical nurse consultant took great umbrage at the fact that I had raised concerns about the spread of MRSA, so rather than deal with the problem at hand, which was a significant problem, it was suggested that I let it go and not upset her any more, and that was the end of that.[185]

4.8 Ms Vanessa Bragg, formerly Clinical Nurse Specialist, Intensive and Coronary Care, Campbelltown Hospital described how the treatment of Ms Sarah Flegg exemplified the prevailing view of incident reporting as ineffectual and unwelcome.

Case study: Ms Sarah Flegg

Ms Flegg presented to the Maternity Department of Campbelltown Hospital and was then transferred to the Intensive Care Unit (ICU) in June 1999. She was 34 weeks pregnant and suffering acute respiratory distress. Ms Flegg required a caesarean section operation, which the obstetrics registrar refused to perform. The ICU registrar decided to transfer Ms Flegg to another hospital by CareFlight but this was cancelled by the obstetrics registrar who called a general duties ambulance instead. She was then transferred to Liverpool Hospital where her daughter Jessica was born. Jessica has cerebral palsy. According to Ms Vanessa Bragg:

> The worst part about that was, after all was said and done, there was a meeting about it and I saw the minutes of the meeting afterwards and the outcome was that there be better communication between the registrar and the VMO, which actually had nothing to do with the incident itself. What happened in the incident was that it was poor management. It was under diagnosis. The outcome was a way of obscuring what actually happened and therefore it was never going to resolve anything, which is actually what used to happen all the time at Campbelltown.[186]

Ms Bragg subsequently referred Ms Flegg's case to the HCCC. Ms Flegg was unaware of any problems with her care at Campbelltown Hospital or that the HCCC was investigating her treatment until January 2004, almost *four years* later.[187]

The relationship between disciplinary action and incident reporting

4.9 One of the most troubling aspects of the response of Macarthur Health Service to the nurse informants was the use of disciplinary action against four of the nurses: Ms Valerie Owen, Ms Yvonne Quinn, Ms Sheree Martin, and another (unnamed) nurse. The details of these matters

185 Ms Grover, Evidence, 12 March 2004, p7

186 Ms Bragg, Evidence, 12 March 2004, p20

187 Ms Flegg Evidence, 12 March 2004, p22

are set out in Part 6 of the HCCC Investigation Report. Suffice to say, the Commission found that the disciplinary action against them was 'heavy handed and confrontational.'[188]

4.10 Two of the nurse informants from the Campbelltown operating theatres, Ms Valerie Owen and Ms Yvonne Quinn, also a Clinical Nurse Specialist, were suspended following allegations of bullying and harassment. In relation to these charges, the Commission found that the nurses had been denied a fair and impartial investigation of the allegations and that the service had breached its own policies concerning staff discipline. Ms Owen told the Committee about the day she and Ms Quinn were suspended from work and 'marched off the premises:'

> We were told that we were being stood down, given that there were serious allegations made against us. We were not to report to duty. We were not to contact our colleagues either socially or with regard to work related matters … Neither myself nor my colleagues had any clue about the detail of the allegations made against us …. We were prohibited from contacting our colleagues and we learned over time that in the absence of any accurate and concrete statements from management we had been regarded within the rumour mill of the work place as drug dealers, drug addicts, fraudsters, alcoholics, indeed very undesirable personalities.[189]

4.11 Ms Sheree Martin, an enrolled nurse at Camden Hospital, was disciplined following an allegation that on various occasions she had exceeded her role as an enrolled nurse. The Commission was also critical of the handling of disciplinary action against Ms Martin, which it said demonstrated a failure on the part of Macarthur to consider that she was working under difficult conditions with significant staffing shortages and her conduct had been permitted by more senior nursing staff.[190]

4.12 While each of the four nurses had completed incident reports on various occasions, the Commission did not identify a causal relationship between incident reporting by the nurses and subsequent disciplinary action. Nevertheless, it found that the actions of Macarthur Health Service in relation to the nurses could inhibit staff from preparing incident reports:

> The effect of MHS's actions in finding Nurses N2, N4 and N6 guilty of disciplinary charges in relation to their dealings with a medical officer about patient safety concerns was a failure to support a culture of open disclosure. A very likely consequence of these actions is that other MHS staff will feel discouraged from raising concerns in similar circumstances.[191]

4.13 The other three nurse informants appearing before the Committee, Ms Nola Fraser, Ms Kathrine Grover and Ms Giselle Simmons, gave evidence of their experiences of informal disciplinary measures as retribution for raising concerns about patient safety including intimidation, bullying and harassment by staff and management:

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188 HCCC (2003), op cit, Part 6, p37

189 Ms Owen, Evidence, 12 March 2004, p1

190 Ms Adrian, Evidence, 29 March 2004, Opening Statement, p7

191 HCCC (2003), op cit, Part 6, p36

> The administrators accused me of stealing and accessing human resources files, all of which has been found to be untrue. The administrators were attempting to fabricate evidence against me to dismiss me for raising concerns re patient safety.[192]
>
> … I suffered extreme harassment, lack of support, and lack of process during the Workers Compensation phase of my employment resulting in my ultimate forced resignation from the Liverpool Health Service.[193]
>
> It had been hinted by the Director of Nursing and the Deputy Director of Nursing that I would never work as a nursing manager again … You cannot get a job as a nursing manager unless you can have a reference, and they were not prepared to do that because of the way I had stood up for patient care.[194]

The deed of release offered to Valerie Owen and Yvonne Quinn

4.14 Soon after their suspension from Campbelltown operating theatres, Ms Valerie Owen and Ms Yvonne Quinn were asked to sign a deed of release drafted by SWSAHS, apparently with input from the NSW Nurses Association.[195] A deed of release is a legally enforceable agreement by which a person discharges another person from a claim.[196] In this case it was proposed that the nurses would be paid $3,241.20,[197] a sum of money equivalent to the shift penalties and allowances they would have received if they had not been suspended, on condition that neither side would criticise the other.[198] The offer of a deed of release was interpreted by the nurses as further evidence of a lack of openness on the part of management.

4.15 Neither nurse accepted the offer, determined to pursue the injustices in their case.[199] During his testimony before the committee, the Deputy Director General of NSW Health, Mr McGregor mentioned that offering such deeds of release without approval from the Department was prohibited and that this matter was currently before the Independent Commission Against Corruption.[200]

Evidence from the former General Manager, Jennifer Collins

4.16 Ms Jennifer Collins, the former General Manager of Macarthur Health Service appeared before the Committee on 29 March 2004. In her opening statement Ms Collins responded to

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192 Submission 23, Ms Nola Fraser, p2

193 Submission 55, Ms Kathrine Grover, pp2-3

194 Ms Simmons, formerly Acting Nursing Unit Manager, Fairfield Hospital, Evidence, 23 March 2004, pp5-6

195 Ms Quinn, Evidence, 12 March 2004, p3

196 Nygh, P E and Butt, P (eds) *Butterworth's Concise Australian Legal Dictionary*, Butterworths, 2nd Edition, Sydney 1998, p374

197 Ms Owen Evidence, 12 March 2004, p4

198 Mr McGregor, Evidence, 19 March 2004, p19

199 Ms Owen and Ms Quinn, Evidence, 12 March 2004, p4

200 Mr McGregor, Evidence, 30 April 2004, p30

many of the criticisms against her and the management of Macarthur Health Service.[201] Ms Collins claimed that the HCCC investigation of Macarthur Health Service was disorganised and haphazard and that the HCCC was ill equipped to undertake such a large and complex inquiry of this nature:

> … this was the first time the HCCC had undertaken a multiple case investigation and systems review. My view is that the HCCC lacked the resources and the HCCC staff lacked the skills and experience to attempt a review of this nature.[202]

4.17 Ms Collins claimed that she was a victim of the failure of the HCCC to investigate the maters fairly and accurately**.** She told the Committee that she believes the Final Investigation Report in December 2003 included many inaccuracies, and excluded some of the positive comments that appeared in the earlier section 43 report.[203] This is not easily reconciled with the investigation process outlined in the HCCC report of December 2003.

4.18 While defending many of the claims regarding the management of Macarthur Health Service Ms Collins acknowledged that 'No organisation is perfect, and Macarthur Health Service is no exception.'[204] She admits there were significant problems with the reporting culture in the Campbelltown operating theatres and that the lack of clinical staff, especially senior clinicians was a constant source of difficulty for the health service, despite innovative strategies to attract experienced medical staff.[205] Ms Collins disputed the findings of the HCCC that the investigation against the nurses, initiated by Ms Collins was not fair, impartial or complete and that the nurses were denied procedural fairness.[206] The Committee supports the recommendation of the HCCC that 'the Department of Health reviews the disciplinary action and processes taken by Macarthur Area Health Service against the four nurses who underwent formal disciplinary action as a matter of urgency.[207]

4.19 Ms Collins' evidence in relation to the deeds of release was evasive at best. Ms Collins stated that in relation to the deeds of release that had been drawn up and offered to Ms Owen and Ms Quinn:

> That person did not report to me. That was at the area structure. That is part of the area HR department. That was not part of Macarthur HR department. I was not involved in the deed of release ... This particular deed of release I have never seen. [208]

201 Ms Collins, Evidence, 29 March 2004, pp 2-6

202 Ms Collins, Evidence, 29 March 2004, p3

203 Ms Collins, Evidence, 29 March 2004, p3. If at the end of an investigation of a complaint against a health organisation the HCCC proposes to make recommendations, it must first inform the health organisation of the grounds for its recommendations. This is known as a s43 Report.

204 Ms Collins, Evidence, 29 March 2004, p2

205 Ms Collins, Evidence, 29 March 2004, p4

206 Ms Collins Evidence, 29 March 2004, p14 and HCCC 2003, op cit, part 1, page 5

207 HCCC (2003), op cit, Part 2, p9, Recommendation 6.1

208 Ms Collins Evidence, 29 March 2004, p15

4.20 Following further questioning by the Committee, Ms Collins advised:

> I did not say the director of HR had not discussed the contents of the deed of release, but I never saw it … I have never eyeballed it. [209]

4.21 The Committee is critical of former Macarthur Health Service General Manager Jennifer Collins and believes her management approach hindered efforts to bring forward complaints about health care. An example was the evidence of the Director of Emergency Medicine, Dr Hugelmeyer:

> To deny that I was "dressed down" or rebuked is a gross inaccuracy that I must strenuously refute. The encounter I experienced on 23 October 2002 with Ms Jennifer Collins and Ms Greer Jones, acting Director of Acute Services, in the general manager's office at Macarthur Health Service was so traumatic to me that it caused me to immediately elect to resign my position as director of emergency medicine. That decision was to take effect immediately, without notice, and would have resulted in my family returning to the United States within a week or so. Such plans were discussed with my wife and were in force. To move a family of five back 10,000 miles suggests the degree of discomfort I felt. It poisoned my relationship with management and I believe it was a clear insight – although just one example – into the management culture that existed at the hospital.[210]

4.22 The Committee notes that Ms Collins was dismissed by the CEO of Central Sydney Area Health Service in December 2003, and this dismissal is the subject of legal proceedings in the Industrial Relations Commission.

Discrepancies between assessments of Macarthur Health Service

4.23 The Committee has been struck by apparently conflicting assessments of the management at Macarthur Health Service. For example, in January 2003 the HCCC confirmed that its investigation had not resulted in any findings to support any loss of confidence in Macarthur. However, by February 2003, following a period of extensive media coverage, it took a very different approach to the complaint, eventually producing a highly critical report into patient safety and management at Macarthur in December 2003.

4.24 The June 2003 accreditation survey by the Australian Council on Healthcare Services commented positively on many aspects of the health service management, including complaint handling. Soon after this positive assessment, the culture and systems concerning complaint handling at Macarthur were strongly criticised by the Barraclough Review and the HCCC. The apparently conflicting assessments of the management at Macarthur and of complaints handling raise important issues about the appropriateness of comparing methodologies used by the different agencies conducting reviews. In assessing the performance of a health service the focus should be on complaints rather than adverse events.

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209 Ms Collins Evidence, 29 March 2004, p15

210 Dr Hugelmeyer, Evidence, 29 April 2004, p1. See also correspondence from Ms Collins, 8 June 2004, to Chair, responding to Dr Hugelmeyer's evidence of 29 April 2004.

The response of other agencies to the nurse informants

4.25 The nurse informants were not only disillusioned with the way management at Macarthur and SWSAHS responded to their concerns but are also highly critical of how the NSW Nurses Association, HCCC and NSW Health dealt with their complaints.

NSW Nurses Association

4.26 The nurse informants claim the response of the NSW Nurses Association to their complaints was inadequate, both in terms of protecting their individual employment rights, as well as in relation to broader quality and safety issues. Ms Sheree Martin told the Committee:

> At first I contacted them over the issue of the unsafe practices and the lady told me over the phone, "This is pretty huge. There is really not anything I can do. You need to take your concerns to management." The next time I contacted them I was called for a fact finding interview and I asked them for representation. They said they were too busy, I had not given them enough notice. I said, "I only got 24 hours. That is all I get. That is all I can give you." They said, "You go, you will be fine." I went to that. I was called for a disciplinary interview. I rang them about the disciplinary interview and they refused to come with me to the disciplinary interview because they said they did not come to the fact finding interview and they cannot come in halfway in the investigation.[211]

4.27 On 26 March 2004, the NSW Nurses Association provided supplementary information to the Committee which indicated that at the time Ms Martin contacted the Association for assistance (14 June 2002) she was not a member of the Association and did not join the Association until 12 July 2002. Mr Holmes advised that assistance was being provided to all members in the Special Commission of Inquiry. Further, Mr Holmes stated that the Association had been hampered in providing assistance to some of the nurse informants as they engaged their own legal advisers. When they approached the Association again after dispensing with their private legal advice, the Association then provided assistance.[212]

4.28 Ms Nola Fraser felt that the Association was pro-management:

> Their attitude to me was when I attempted to call them, "You know what they are like there, we have lots of complaints", you know, "The general manager is a very powerful person. We do not want to get her offside. You are not going to change anything. You are better off just to leave, and basically they can do whatever they like to you."[213]

4.29 Ms Quinn and Ms Owen interpreted the union's support for the deed of release as further evidence of its disinterest in their allegations about patient care. This is strenuously denied by Mr Brett Holmes, General Secretary who told the Committee that the Association was unaware that the nurses were 'trying to blow the whistle' about patient care when first asked to

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211 Ms Martin, Evidence, 12 March 2004, p19

212 Correspondence from Mr Brett Holmes, NSW Nurses Association, 26 March 2004

213 Ms Fraser, Evidence, 12 March 2004, p17

assist them.[214] He stated that the deed of release was intended to preserve the 'dignity' of all of the parties, not suppress allegations about patient safety:

> It was a standard deed of release … and it relates to trying to preserve everyone's dignity … it had no affect on their rights to disclose or to complain about other matters with regard to patient care or their own self. They still would have maintained those rights.[215]

Health Care Complaints Commission

4.30 The nurses were also dissatisfied with the way their complaints were handled by the HCCC. Ms Sheree Martin said the Commission's initial response to them was negative and discouraging:

> In December 2002 we were interviewed by a solicitor from the HCCC. The interview for me was more an interrogation. The solicitor from the HCCC informed us our testimony was not protected and we needed to be careful as to what we revealed. Yet again we were warned off. We had some angry and distressing telephone conversations with the HCCC over the next two months.[216]

4.31 The former HCCC Commissioner, Ms Amanda Adrian pointed out that Commission officers were obliged to warn the nurses that if they provided documents to the HCCC, they may not be protected under the protected disclosure legislation.[217] The agencies nominated to receive protected disclosures under the *Protected Disclosures Act 1994*, include the ICAC and the Ombudsman, but not the HCCC. In its report the Commission recommended that this anomaly be addressed, especially as none of the other nominated agencies are responsible for investigating complaints about health care and treatment. It also suggested that the protection offered under the legislation to public officials be extended to non public officials (such as private practitioners, including nurses).[218]

4.32 A similar view was expressed by the Acting Commissioner, Mr Bill Grant, who believes the issue should be resolved by the legislative review of the *Health Care Complaints Act*.

> That was done out of fairness; it was not done to frighten them off. It was not done to alarm them, although I can well understand why someone would be alarmed to get that information. But there was no particular statutory protection for people producing records that were not their records.[219]

4.33 The Committee supports the view and the recommendation made by former and Acting Commissioners.

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214 Mr Holmes, Evidence, 12 March 2004, p40

215 Mr Holmes, Evidence, 12 March 2004, p34

216 Ms Martin, Evidence, 12 March, p3

217 Ms Adrian, Evidence, 29 March 2004, p67

218 HCCC 2003, op cit, Part 7, p71

219 Mr Grant, Evidence, 23 March 2004, p38

Recommendation 17

The *Health Care Complaints Act 1993* and the *Protected Disclosures Act 1994* be amended to protect the identity of whistleblowers when they require it and to provide protected disclosure safeguards for health practitioners, including nurses in both the public and private sectors.

Leak of HCCC's interim phase 1 report

4.34 In February 2003, the HCCCs interim phase 1 report regarding disciplinary action against several of the nurses was leaked to the media. In a letter accompanying this report the HCC Commissioner concluded that the investigation had not substantiated any 'significant departures from State or national standards in health care.'[220] The nurses, not surprisingly, felt the Commission was signalling the closure of its Macarthur investigation, as Ms Sheree Martin recalls:

> We had not given evidence to the HCCC investigators. We had not been interviewed by the independent panel of experts. We had not passed on our documentary evidence. We were crushed. We had now been fighting this for ten months. In our opinion the HCCC had no interest in conducting this investigation. We had exhausted all the appropriate health services, Government statutory regulatory bodies, they had effectively silenced us.[221]

4.35 The Committee can understand why the nurses thought that the HCCC was not intending to examine their allegations about patient safety and that their concerns. The Committee believes this was a major error of judgement on the part of the HCCC, with unfortunate consequences for the nurses, Macarthur Health Service and the HCCC.

4.36 The former Commissioner, Ms Amanda Adrian believes the nurses were misled by inaccurate media reports that the investigation had been closed:

> The investigation at no time was closed. I think there was some misunderstanding about the nature of the early interim report that we sent to the area health service about the disciplinary action pertaining to the nurses. The investigation was closed the day that I sent it to the Department of Health and to the area health service, which was 9 December 2003.[222]

4.37 In her evidence to the Special Commission Ms Adrian acknowledged that in the initial stages of the investigation the relationship between the HCCC and nurse informants was problematic, partly because they were perceived as witnesses to the complaint rather than the complainants:

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220 Correspondence to Ian Southwell, CEO of SWSAHS, from HCC Commissioner Amanda Adrian, 29 January 2003

221 Ms Martin, Evidence, 12 March 2004, p3

222 Ms Adrian, Evidence, 29 March 2004, p67

> … at that stage in the investigation the Commission was interviewing many, many people in relation to that, and I think it was when the Commission realised that there was a perception that they were not being heard that we certainly moved into a much more active stakeholder management process with the informants …[223]

4.38 Whatever the intentions of the HCCC, it is clear that in the eyes of the nurse informants the Commission was not perceived as being supportive of them or their specific concerns about patient safety. The Committee believes that the HCCC failed in its statutory obligations to investigate the nurse whistleblowers' complaints against practitioners. Former Commissioner Merrilyn Walton confirmed this view:

> The reason we are in this mess is because there is a misunderstanding of the no-blame culture and professional responsibility. It is not one or the other … Quality and safety is the right way to approach it as a no-blame thing, but it does not mean that people do not have to be accountable.[224]

NSW Health

4.39 A major grievance expressed by the nurse informants is that NSW Health 'watered down' their allegations before referring them to the HCCC. While initially encouraged by the seriousness with which the Director of Audit, Ms Victoria Walker, responded to their allegations, Ms Nola Fraser said that 'a lot of things that she [Ms Walker] said would happen did not happen.'[225] Ms Fraser said that Ms Walker's recommendations to the Director General were very strong, and included that certain matters should be referred to the Police and ICAC. However, at some point between seeing the audit section of NSW Health and the referral of the complaint by the Department to the HCCC, the Department decided against referring these matters to the relevant investigatory agencies.

4.40 Ms Victoria Walker stated in evidence in regard to the statements of Ms Fraser:

> I read the transcript and I just thought it was completely muddled. It was completely false, from my point of view. I never had any view that any specific matters should go to the police. I deal with the police in another part of my administration. We deal with the police on criminal matters. They are busy people. You do not send them a bundle of emails or allegations until it has been assessed properly that they were criminal matters. No, when I read that in the transcript I was completely puzzled about it. It was not correct.[226]

4.41 The Director General refuted Ms Fraser's claim that she had not referred the matters appropriately:

> On 18 November I subsequently referred the allegations to the HCCC. The same day I made a reference under section 11 of the Independent Commission Against Corruption Act 1998 to the ICAC regarding possible corrupt conduct. I also formally

223 Ms Adrian, Evidence, Special Commission, 14 May 2004, pp430-431

224 Ms Walton, Evidence, 29 March 2004, p58

225 Ms Fraser, Evidence, 12 March 2004, p7

226 Ms Walker, Evidence, 19 March 2004, p15

> advised the New South Wales Coroner and NSW Police by telephone and in writing of the allegations and the actions being taken. I am advised by the director of audit that all documents provided to the Department by the nurses, including the official transcripts of interview between the nurses and the Department, were provided to both the HCCC and to the ICAC. This is also recorded in correspondence from the New South Wales Health Department to those two agencies.[227]

4.42 Ms Kruk referred to a memo from Ms Walker to herself, providing preliminary advice on the seriousness of the nurses' allegations and recommending they be referred to the HCCC. Ms Kruk gave evidence that, in referring the allegations to the ICAC, Police and Coroner, 'what I took was action that went beyond the recommendation that she [Ms Walker] gave me.'[228]

4.43 Another criticism of the Department's handling of their complaints concerns the leaking of the HCCCs interim Phase 1 report. Ms Martin said that the Department issued a press release in February 2003 saying that it could not substantiate any significant departures from national or State health care standards.[229] Ms Kruk responded to this claim in her evidence, stating that:

> The New South Wales Health Department did not make those statements. I believe that Ms Martin may have mistakenly attributed a statement by the HCCC to the Department. I have copies of the articles in which the statements Ms Martin refers to appear. These statements are clearly attributed to the HCCC.[230]

4.44 While disputing several of the criticisms levelled by the nurse informants, Ms Kruk acknowledged that the complaint should have been resolved more swiftly, although it is unclear to what extent, if at all, she believes the Department may have contributed to the delays:

> … I think there are lessons for the health system that came out of the Camden-Campbelltown situation ... In reflecting back, I think the time frames that have occurred are regrettable. It is important that we now have a process that gives that independent scrutiny to the kind of claims that they raised. My major concern is the grief that the families have incurred through this lengthy process, and I think that is a regret that all parties that have been involved in this incident would share. If we could have avoided that, we would all have endeavoured to do so.[231]

4.45 We welcome the Director General's statement of regret and interpret her comments as a sincere commitment to addressing the culture of 'cover up' that appears to be present in many parts of the health system, not just south west Sydney. The Committee believes that the communication from NSW Health to Ms Fraser was inadequate.

[227] Ms Robyn Kruk, Evidence, 19 March 2004, p4

[228] Ms Kruk, Evidence, 19 March 2004, p7

[229] Ms Martin, Evidence, 12 March 2004, p3

[230] Ms Kruk, Evidence, 19 March 2004, p4

[231] Ms Kruk Evidence 19 March 2004, p6

Meeting between the nurse informants and the former Minister for Health

4.46 On 5 November 2002 four of the nurse informants (Ms Sheree Martin, Ms Nola Fraser, Ms Yvonne Quinn and Ms Valerie Owen) met with the former Minster for Health, Craig Knowles, to discuss their concerns regarding patient care at Macarthur Health Service. The Committee received conflicting accounts about the Minister's manner during this meeting. Ms Nola Fraser said she felt 'bullied and threatened by him [the Minister] for raising allegations about the administrators'[232] and Ms Sheree Martin said that after the meeting she 'felt effectively warned off.'[233] Ms Valerie Owen and Ms Yvonne Quinn, however, had a different experience:

> … Mr Knowles appeared to be taking our concerns very seriously. He informed us that he was going to contact the Director General that afternoon. He asked if we were happy for him to convey to her our names and contact details and we all said 'yes'. He told us that we needed to have evidence … He said, again, it is a very serious matter, he was going to have an investigation. We would be involved in that investigation and that it could be long and we could be in for a rough ride … He did say, "Once the train leaves the station it is going all the way through and once you are on it you are on it." That seemed perfectly reasonable in my mind. The meeting was then ended and we all went off in separate directions until we were contacted by New South Wales Health a couple of weeks later.[234]

4.47 However another nurse Ms Giselle Simmons told the Committee about her encounter with the former Minister, which occurred at least three months later than the November meeting. Ms Simmons told the Committee about her experience in raising a complaint with the Minister at a nurse practitioner workshop at UTS:

> I told him what was happening at Fairfield and that people were dying who should not be dying. He asked me for my name and where I worked and I am very proud of that. I am not going to hide that so I told him who I was and where I worked, quivering in my boots ... He just bullied me, he harassed me, he spoke over the top of me, he told that I did not know what I was talking about, and he was quite rude.[235]

4.48 Ms Simmons told the Committee that she was removed from a senior position at Fairfield Hospital shortly after speaking to the former Minister.

> The Director of Nursing also told me, "You don't say what you said to the Minister for Health and expect to have a job at the end of it." I knew. It was the area Director of Nursing that really put me in the picture. She told me that after that meeting, he then went to the people in the Department of Health that he needed to speak to. He then spoke to people from the South Western Sydney Area Health Service and he had me removed from my position.[236]

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232 Submission 23, Ms Fraser, p3

233 Ms Martin, Evidence, 12 March 2004, p3

234 Ms Quinn, Evidence, 12 March 2004, p6

235 Ms Simmons, Evidence, 23 March 2004, p6

236 Ms Simmons, Evidence, 23 March 2004, p7

4.49 The Committee invited the former Health Minister, the Hon Craig Knowles MP, to provide evidence but this invitation was declined.[237] The Committee is disappointed that the Minister took this decision as it represents some contempt for the accountability that parliamentary committees give to the people. Clearly he wished to avoid public questioning.

Is there evidence of cultural change at Macarthur?

4.50 While there has been a major focus on improving the systems and culture concerning incident reports since the release of the HCCC report, has this lead to real change? According to Dr David Hugelmeyer, Director of Emergency Medicine, Macarthur Health Service, while there is room for improvement, there have been some encouraging signs of improvement:

> Yes, I have seen some improvement, that is for sure, in it being almost an expectation now that we will proceed with a new era, if you will, and searching for new mechanisms. However, there are still what I consider to be remnants of the old that tend to stand in the way of the kind of reporting that from a personal point of view I think is needed to ensure that.[238]

4.51 The Committee heard that there have been improvements in the Area Health Service in recent times. Nursing Unit Manager at Camden Hospital Emergency Department, Ms Lisa Kremmer stated:

> Yes, there have been recent improvements and they may be in staff morale, which varies depending on what it is we are being scrutinised for or how we are being scrutinised at the time. Recently staff morale has been much improved.[239]

4.52 Despite these changes, several witnesses claim that there are few if any discernible improvements to patient safety and complaint handling at Macarthur. Ms Valerie Owen and Ms Yvonne Quin told the Committee that over the past two years it was common for both of them to receive distressed calls from staff about incidents they were too afraid to report.[240]

4.53 Dr Mary Prendergast, a VMO obstetrician at Campbelltown Hospital and Dr Jim Parker, the former Chairperson of the Medical Staff Council, also felt little had changed since the release of the HCCC report:

> Certainly as far as my practice goes, I have made four complaints in writing to the medical superintendent dating back to March last year … and I have yet to receive a reply or any indication that those particular cases have been discussed …I think the principle that they have made complaints and that there has been no action, I think that still resonates … [241]

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[237] Correspondence from the Hon Craig Knowles MP, Minister for Infrastructure and Planning and Natural Resources, to the Chair, received via facsimile on 30 April 2004

[238] Dr Hugelmeyer, Evidence, 19 March 2004, p64

[239] Ms Kremmer, Evidence, 19 March 2004, p56

[240] Ms Owen, Evidence, 12 March 2004, p2

[241] Dr Prendergast, Evidence, 19 March 2004, p64

> It is hard to get a response and I think it is difficult in the position that managers are in for them to make responses, make decisions and implement change … I think there is a lot of passing around of things but not action.[242]

4.54 One month after her first appearance, Dr Prendergast told the Committee she was still awaiting a substantive response from health service management about her complaints:

> … I got a letter from Professor Picone asking me to outline these complaints, and I sent her that letter in detail, even including one of the letters from my patient who wrote about her situation … That was a case of a lady who had a miscarriage and was sent home from casualty to miscarry at home. She is still undergoing psychological treatment for the distress that that caused her. I have not heard. Professor Picone said that Dr Saxton, our medical director, has discussed them with me. I have not heard from him about any of these cases to date. [243]

Patient deaths in Liverpool Hospital

4.55 The circumstances surrounding the alleged euthanasia of Mrs Audrey Daly-Hamilton at Liverpool Hospital have been raised throughout the inquiry as an example of a lack of transparency on the part of SWSAHS. A copy of handwritten notes of a meeting between the then Director of Intensive Care and a nurse, about the treatment provided to Mrs Daly-Hamilton, was apparently discarded following the departure from Liverpool Hospital of the clinician involved in her treatment.[244]

4.56 Associate Professor Debora Picone told the Committee that while these were not clinical records, she was surprised that the transcript of such a meeting was not kept and that a protocol regarding the retention of such documents has now been established.

> That did not occur at the time. I can assure you in future it will. I think people have learnt from that.[245]

4.57 At the last hearing day on 21 May 2004, the Committee also discussed the issuing of a media release by Associate Professor Picone the day before regarding the referral of an additional three deaths at Liverpool Hospital to the Coroner.[246]

4.58 The Committee expressed disappointment that it had not been informed about these additional referrals by Associate Professor Picone when she appeared before the Committee on two previous occasions. It was felt this was further evidence of a failure on the part of the Area Health Service to be open about adverse events. It was also revealed at the hearing that the additional three cases involve the same doctor who treated Mrs Daly-Hamilton.

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242 Dr Parker, VMO, SWSAHS, Evidence, 19 March 2004, p66

243 Dr Prendergast, Evidence, 30 April 2004, p84

244 Correspondence from Associate Professor Picone, Administrator SWSAHS, to the Secretariat, 24 April 2004

245 Associate Professor Picone, Evidence, 21 May 2004, p6

246 Associate Professor Picone, Evidence, 21 May 2004, pp5-6

4.59 Ms Picone advised that on 10 February she referred the medical practitioner involved in the treatment of Ms Daly-Hamilton, and the other three patients, to the NSW Medical Board. The practitioner is now apparently residing in South Australia.[247] We have been informed by Associate Professor Picone that as at 21 May 2004, the NSW Medical Board had not referred the matter to the South Australian Medical Board.[248] Given the seriousness of the allegations against this doctor, the Committee is deeply concerned that this matter was not referred immediately by the NSW Medical Board.

4.60 The Committee noted Associate Professor Picone's repeated obfuscation to answer questions over the investigation into the death of Ms Sarita Yakub. Associate Professor Picone was the main contact between Mr Yakub and the Health Department and in the Committee's opinion exercised poor judgement in not keeping him fully informed.

Recommendation 18

That the NSW Medical Board be asked to clarify why the practitioner who treated Mrs Daly-Hamilton has not been referred to the South Australian Medical Board.

Handling of recent cases of poor patient care

4.61 Two allegations regarding very poor patient care in SWSAHS came to light in April 2004. The first incident occurred in November 2003 when it was alleged that a staff member swore at a patient. The matter was immediately referred to the Professional Practice Unit. While some form of verbal exchange seems to have occurred, the allegation was not substantiated by the patient. According to Associate Professor Picone, the investigation is continuing however because of concerns about professional practice.[249]

4.62 The second incident involved the alleged abuse of a 94 year-old dementia patient at Campbelltown Hospital. In this case SWSAHS took the following action:

- the Registered Nurse involved has had her employment terminated, and the Enrolled Nurse who witnessed but neglected to report the incident has been formally warned and is undergoing retraining in her professional responsibilities
- the matter was referred to the NSW Police and the NSW Nurses Registration Board
- an independent external review of the care and treatment plan for the patient was completed by the Professional Practice Unit
- ongoing communication with the patient's family has been maintained by the acting CEO.[250]

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247 Associate Professor Picone, Evidence, 21 May 2004, p5 & 28

248 Correspondence from Associate Professor Picone to the Chair, 21 May 2004

249 Associate Professor Picone, Evidence, 21 May 2004, p11

250 Correspondence from Associate Professor Picone, to Director, 10 June 2004, in response to a question taken on notice on 21 May 2004

4.63 This appears to be an appropriate response to a very serious incident. The Committee wonders however whether there would have been such swift and thorough action if the incident had happened *before* the spotlight had been focused on south west Sydney, or if it had occurred in another busy, under resourced health service?

4.64 Given the significant cultural barriers to reporting discussed in Chapter 3, and the critical role of clinical resources in developing effective complaint handling systems, we do not envisage that change will occur overnight in south west Sydney. While it is important to maintain a watching brief over SWSAHS, given the evidence we have received about the impact of recent events on morale, this scrutiny needs to be conducted with considerable care and sensitivity. We hope that change in other Area Health Services can occur without the significant collateral damage suffered by SWSAHS over the past two years.

The impact of whistleblowing

4.65 Whistleblowers have a vital role to play in the development of an open and effective public sector. Indeed, in NSW, public officials are urged to view legitimate disclosures about problematic aspects of public administration as a valuable management tool.[251] While legislation designed to protect whistleblowers has been introduced in recent years, in practice, their contribution is often resented. Regrettably, according to the NSW Ombudsman, the prevalent attitude towards whistleblowers is one of 'rats under the house.'[252]

4.66 In its final report, the HCCC concluded that the allegations raised by the nurse informants, many of which were eventually substantiated, fell on institutional deaf ears. Their credibility was continually challenged, leading them to believe they had to take their concerns outside of the organisation.[253]

> The nurse informants were unwilling to take their concerns to anyone in management at MHS. They did approach the area health service but, for whatever reason, felt that their concerns would not be taken seriously or acted upon. Given the negative views expressed by SWSAHS and MHS about the informants, their instincts may not have been without a rational basis. The nurses decide that their only avenue was to go to the Minister for Health.[254]

4.67 The events in SWSAHS highlight the consequences of whistleblowing, not just for whistleblowers whose career, reputation and relationships may be irreparably damaged, but also for the employees and users of an agency subject to such disclosures. In their evidence to the Committee, the nurse informants described the profound ways in which their lives had been affected as a consequence of their disclosures:

251 NSW Ombudsman, *Protected Disclosures Guidelines 4th edition*, January 2002, piii

252 NSW Ombudsman, op cit, piv

253 HCCC (2003), Part 7, pp68-69

254 HCCC 2003, Part 7, pp70-71

> I feel compelled to convey to you people the overwhelming sadness and despair that we feel. We experience this and continue to on an ongoing basis. I never set out to be a whistleblower. I am just a nurse and I have been a nurse since I was 17.[255]
>
> Because of this cause we have lost sleep, homes, friends, faith in the system and in some cases even family. [256]

4.68 At the time, the nurses may not have appreciated how far reaching the consequences of their actions would be. As Ms Yvonne Quinn told us:

> … Looking back I don't know that we actually did understand how long and rough it was going to be.[257]

4.69 One of the most difficult issues confronting the nurses is the impact of their disclosures on their careers:

> I have been unable since to secure a management position anywhere in Sydney and it has been proven to me that my worker's compensation details have been shared with directors of nursing when I have applied for positions at other hospitals.[258]
>
> … you do not work hard at a career after 18 years and at the end of it go back on the floor. Like I love looking after patients … but the reason why I wanted to go into management was because I realised that I could do more as a leader than as one person nursing a patient on the floor, and that is what I was setting myself up for.[259]
>
> …So going back, even though that is all I ever wanted, I have had to accept for my own sanity that it just isn't going to ever be a reality. My career is finished.[260]

4.70 Current staff at SWSAHS have also been affected by the constant media and public attention particularly employees at Campbelltown and Camden Hospitals. Ms Lisa Kremmer, Nursing Unit Manager, Camden Hospital Emergency Department, and Associate Professor Brad Frankum, Director of Medicine, Macarthur Health service, told the Committee:

> … allegations that nurses turn their backs on patients and withhold care with the intention of causing harm, injury or death are abhorrent and offensive.[261]
>
> … there is no evil conspiracy at Macarthur health service … We are deeply offended at the suggestion that numerous patients are dying unnecessarily in our hospitals.[262]

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255 Ms Quinn, Evidence, 12 March 2004, p3

256 Ms Martin, Evidence, 12 March 2004, p4

257 Ms Quinn, Evidence, 12 March 2004, p6

258 Ms Grover, Evidence, 12 March 2004, p5

259 Ms Simmons, Evidence, 23 March 2004, p8

260 Ms Quinn, Evidence, 12 March 2004, pp8-9

261 Ms Kremmer, Evidence, 19 March 2004, p48

262 Associate Professor Frankum, Evidence, 30 April 2004, p76

4.71 Ms Kremmer noted that the climate of fear engendered by recent events may compromise patient care:

> …the unrelenting media publicity has made it extremely difficult to provide quality care to our patients … The impact of the last 18 months has been to create a climate of fear that threatens the agenda of open disclosure, and will significantly hinder our progress.[263]

4.72 Dr Amanda Walker, Director of the Palliative Care Unit at Camden Hospital, told us that patients' trust has been seriously undermined as a result of the intense and negative focus on her hospital:

> A doctor-patient relationship is always dependent on trust …We start so far behind the eight-ball it is unimaginable … People assume incompetence and, in fact, sometimes they assume malevolence ... I personally have been spat at as I have walked in to work, I presume for wearing a stethoscope and a name badge … It is has been really hard.[264]

4.73 Dr Walker's experience of being assaulted by a patient is not an isolated incident. According to Associate Professor Picone, there has been a significant increase in assaults and abuse of staff as a consequence of the intense media and public attention:

> Incidents of abuse, including violent abuse, of staff have increased markedly in frequency and severity since these issues became public … I think honourable members will agree that this is a deeply disturbing development which I find totally unacceptable in our public health service.[265]

4.74 Patients and the families of patients whose cases have been referred to the HCCC or Special Commission, have endured considerable hardship over the past two and a half years. Their difficulties have been exacerbated by protracted investigation of their cases. The evidence of Ms Sarah Flegg illustrates the tragic consequences of the delay in being informed that her treatment was the subject of a complaint, and its ultimate resolution.

> I don't know if it would have been different if I was told when it happened, but four and a half years later? That is disgraceful. The perinatal and morbidity meeting was held six months after Jessica was born. Why didn't they contact me then?[266]

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[263] Ms Kremmer, Evidence, 19 March 2004, pp47-48

[264] Dr Walker, Evidence, 30 April 2004 p82

[265] Associate Professor Picone, Evidence, 30 April 2004, pp60-61

[266] Ms Flegg, Evidence, 12 March 2004, p26

Case Study: Mrs Audrey Daly-Hamilton

Mrs Audrey Daly-Hamilton was admitted to Liverpool Hospital on 15 January 1999 with an 'ischaemic left foot and aorto-femoral bypass. Ms Daly-Hamilton developed four limb weakness and breathing difficulties in her first post-operative day.'[267] She was initially ventilated, but respiratory support was withdrawn after discussion with the family. Mrs Daly-Hamilton's treatment was one of the cases provided by the nurse informants to the HCCC.

On 23 January, 2003 the *Daily Telegraph* reported the alleged euthanasia of a patient at Liverpool Hospital. The patient's details accorded with those of Mrs Daly-Hamilton. On that same day Liverpool Hospital contacted Mrs Daly-Hamilton's son to make him aware of the allegation, and gained his permission to state publicly that he was happy with his mother's care. However, later that same day, Mrs Daly-Hamilton's daughter in law also contacted the Hospital to inform them she *was not happy* with her mother in law's care.

At 5pm SWSAHS released a media statement regarding the euthanasia allegations, stating that:

> The next of kin have been contacted and the son of the patient concerned has authorised the hospital to state publicly that he had no concerns about the care provided to his mother at Liverpool Hospital.[268]

The release made no mention at all of the concerns expressed by Mrs Daly-Hamilton's daughter in law.

4.75 The Committee is deeply concerned that Associate Professor Picone authorised a press release that may have prejudiced the inquiry into Mrs Audrey Daly-Hamilton's death. Asking a grieving family member to comment on the adequacy or otherwise of the treatment afforded to their relative, as occurred in the Daly-Hamilton matter, is highly inappropriate. Given the likelihood that such a case would be referred to either the Coroner or the HCCC, the relevant parties should refrain from commenting on the details of particular cases until the completion of an independent investigation. Throughout this inquiry, NSW Health has been keen to remind committee members of the need to respect sub judice conventions and to avoid prejudging the findings of other inquiries, yet in the case of Mrs Daly-Hamilton, the health service encouraged such comments from a grieving family member. The Department should act to ensure this type of incident does not reoccur.

Events in south west Sydney - a return to blame and shame?

4.76 Despite the difficulties experienced by all who have been affected by the 'fallout' from the nurses' allegations, it is important to acknowledge their courage in the face of serious attacks on their credibility, integrity and ability and the positive aspects of their actions:[269]

> This investigation has demonstrated the value of whistleblowing. We were alerted to concerns about patient care and ineffective safety systems. Our findings and

267 Correspondence from Associate Professor Picone of 24 April 2004, providing answers to questions taken on notice on 19 March 2004

268 SWSAHS Public Affairs, *Media Statement Liverpool Hospital*, 23 January 2004

269 HCCC (2003), op cit, Part 7, p69

> recommendations have the potential to inform and enhance safety within MHS and the NSW Health System.[270]
>
> … in my view – this is a personal view – many of those patient care issues raised by the nurse complainants have led to positive improvements in the system and in many of the cases that they raised there were areas, in my view also, of professional concerns. The standard of patient care was not good enough.[271]

4.77 Some inquiry participants, including the Royal College of Nursing of Australia, have suggested that the Government's response to the Macarthur Investigation Report, particularly the decision to terminate Commissioner Amanda Adrian's contract, will have a deleterious impact on the culture of learning in NSW Health:

> The NSW Health Minister's ill-informed indictment of the systemic approach of the Macarthur Investigation Report shows a lack of understanding and recognition of his own Department's international "best practice" campaign of teaching staff and consumers how to take a systems based approach to safety and quality issues in health care …Witch hunts to find individuals who can be expelled from the system have demonstrably not worked to bring about the necessary cultural change in health care.[272]

4.78 The Committee believes that by exclusively focussing on systemic issues at Macarthur Health Service and failing to investigate specific allegations against individual practitioners, the HCCC acted outside of its legislated role.

4.79 Participants raised concerns that individual health practitioners would be increasingly targeted:

> The Health Minister's call for individual clinicians to be held accountable for the events at Campbelltown and Camden Hospitals … sends a chilling message.[273]
>
> Be very afraid. The precedent is set – blame is back on the agenda.[274]

4.80 Is it accurate however, to portray recent events at SWSAHS as an example of a 'blame' approach to medical error in which individual clinicians become scapegoats for systemic problems? It may be argued that if Macarthur, SWSAHS and the HCCC had sought to address some of the issues regarding professional accountability in a more timely manner, some of the 'fallout' from these events could have been avoided, including the frustrating delay experienced by patients and families in resolving these matters. The Committee hopes that as further evidence becomes available appropriate action will be taken in respect of individuals who are found to have transgressed.

4.81 Since this Inquiry has commenced the Government has called certain individuals to account. It has also announced significant changes to complaint handling practices and additional

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[270] HCCC (2003), op cit, Part 7, p70

[271] Associate Professor Picone, Evidence, 21 May 2004, p15

[272] Submission 51, RCNA , p7

[273] Submission 51, RCNA p8

[274] Frankum B, Attree D, Gatenby A, Eagar S, Aouad A, 'Be Very Afraid,' in *Medical Journal of Australia*, vol. 180, 2004, pp362-366

quality and safety initiatives, including the provision of an additional $55 million over the next 4 years to support:

- the establishment of the Clinical Excellence Commission
- fast tracking of Root Cause Analysis training
- setting up Professional Practice Units in Area Health Services across the State.[275]

4.82 It is difficult to imagine that systemic reforms of this nature and extent would have occurred without the impetus provided by recent events in south west Sydney and the actions of the nurse informants. Indeed, the Director General acknowledged that 'the issues raised by the nurses no doubt have pushed the reforms on far more quickly.'[276] To portray the response to the Macarthur report as a reversion to blame and shame ignores the important systemic reforms introduced by the Government. It also ignores strong views within the community that health consumers expect and are entitled to have their complaints investigated in a fair and transparent manner and for medical professionals, like any other professionals, to be held to account.

Conclusion

4.83 The actions of the 'whistleblower' nurses from south west Sydney have had a major impact on the safety and quality agenda in this State, but they and their communities have paid a high price for these reforms. Finding ways to ensure that people who raise concerns about patient safety are not vilified but rather seen as making a positive contribution to the provision of quality health care, is a vital challenge for the NSW Health system. If it was routine for clinicians to base their practices on the principles of open disclosure much of the anguish generated in Macarthur may have been resolved promptly, rather than developing into a lengthy and difficult process for all of the parties.

275 NSW Health, 'Premier Carr Announces new $55 million Clinical Excellence Commission to improve health standards,' *Media Release*, 8 April 2004

276 Ms Kruk, Evidence, 21 May 2004, p15

Chapter 5 Resources and adverse events

Inadequate resources, especially clinical resources, are inextricably linked to patient safety and quality of care. If the level and quality of resources is poor, this is likely to lead to a greater number of adverse events. Once an adverse event has occurred in a resource-poor health service, it is more likely that the immediate priority of direct service delivery will take precedence. Inadequate resources thus support the cultural barriers to reporting adverse events and hinder the development of a culture of learning.

Resource constraints and adverse events

5.1 The Australian Medical Association (NSW) has outlined a strong link between budget pressures and the occurrence of adverse events.

> … the main budget driver is service delivery. Within the context of seeking more and more (service delivery) for less and less (hours and dollars available), it is inevitable that system and human error will occur. This may be attributed to system failure eg: … impairment arising from fatigue …[277]

5.2 Resource pressures have a flow-on effect, by impeding continuous learning and improvement:

> We are encouraged to treat patients more quickly every day and to discharge them more quickly from the system because the system is under strain. One of the first things to go in a system under strain is the process of good clinical teaching, which is important. It leads to improvements in the long term. But if you are under pressure often it is the first thing to go.[278]

5.3 Once adverse events occur, staff in resource-poor areas may be less open to analysing adverse events, and implementing systems improvements. Considering the link between lack of resources and the occurrence of adverse events, it seems inevitable that the services with the most adverse events are the very services least able to learn from their occurrence.

The impact of workforce shortages at Macarthur

5.4 Recent events in SWSAHS illustrate the strong link between resources and patient safety and the effective analysis of adverse events. Ms Jennifer Collins, former General Manager of Macarthur Health Service, in describing the effects of a budget shortfall for SWSAHS of $27 million, commented that:

> While I fought as hard as I could for additional resources, and I managed the risk as best I could, it is unreasonable to expect that there would not be some impact on service delivery.[279]

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[277] Submission 65, AMA (NSW), p4

[278] Dr Anthony Llewellyn, Member of Health Services Union, Evidence, 23 March 2004, pp3-4

[279] Ms Collins, Evidence, 29 March 2004, p6

5.5 Like other health services across the State, Macarthur Health Service was hampered by a range of workforce problems, including:

> low nursing morale, varying skills and knowledge of CMOs [Career Medical Officers], a reduction in the number of medical officers choosing to specialise, a shortage of suitably qualified doctors and nurses and the increase in demand in emergency departments for medical conditions treatable by general practitioners.[280]

5.6 In addition, Macarthur had particular difficulty attracting specialist staff:

> The South Western Sydney Area Health Service has a half to a third of the number of staff specialists in corresponding area health services on the eastern seaboard, and to my mind that is nothing short of scandalous.[281]

5.7 Of particular concern was the absence of registrar cover out of business hours in several areas of specialist medicine.[282]

5.8 The Expert Review Team led by Professor Barraclough found that the paucity of clinical resources seriously undermined patient safety at Macarthur:

> In order for safe and effective patient care to be provided, sufficient numbers of appropriately qualified and skilled staff are required. The lack of adequate numbers of medical workforce with adequate skill and experience levels is perceived to be the greatest weakness in the delivery of care in some of the Departments of the [Macarthur] Health service.[283]

5.9 The final HCCC investigation of Macarthur Health Service found that many of the adverse incidents at Macarthur were linked to a lack of experienced staff, together with poor supervision of these staff. Of the 47 cases examined by the HCCC, 23 raised concerns about the availability of and supervision by senior staff.[284] The HCCC noted a 'vacuum of clinical leadership' due to the lack of VMOs and specialists.[285]

5.10 It is only since the problems at Macarthur were publicised in the media that Campbelltown Hospital has made significant inroads in addressing staff shortages, achieving a fully staffed Intensive Care Unit and a full complement of senior medical staff in the Emergency Department.[286] Campbelltown Hospital has also attracted very senior nurse consultants and general physicians from the major teaching hospitals. This includes Professor Reginald Lord (former head of surgery at St Vincent's Hospital) as part-time director of surgery, who is

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280 HCCC, *Investigation Report, Campbelltown and Camden Hospitals, Macarthur Health Service*, December 2003, Part 5, p96

281 Professor Jeremy Wilson, Director of Medicine, Bankstown Hospital, Evidence, 30 April 2004, p81

282 Mr Malcolm Masso, former Director of Nursing and Health Services, Macarthur Health Service, Evidence, 19 March 2004, p48

283 Barraclough B, Baker K, Burrell T, Wallace M, *Working Papers of the Review of Standards of Patient Care and Services at Macarthur Health Service* (henceforth referred to as the Barraclough Review), 16 October 2003, p30

284 HCCC (2003), Part 5, p14

285 HCCC (2003), Part 5, p16

286 Associate Professor Debora Picone, Administrator SWSAHS, Evidence, 21 May 2004, p13

'making a significant change in the way the surgical activities of that hospital work, particularly around quality and other issues.'[287] This shows the difference that highly skilled people make to the culture and practices of an organisation, and the advantage that hospitals in more established areas operate under in terms of being able to attract the best and brightest to work in their hospitals.

5.11 In the case of Macarthur Health Service, the level of resources did not keep pace with the rapidly increasing population and demand for services. This was a fundamental failure to match resources with need.[288] NSW Health uses the Resource Distribution Formula (RDF) to allocate funds to Area Health Services. The RDF reflects the size of an Area's population as well as a Health Need Index, which is derived from socio-economic variables used by the Australian Bureau of Statistics.[289] This following table shows the shortfall between the targeted and actual amount of funding allocated under the Resource Distribution Formula (RDF), which narrowed from a shortfall of –17.9% in the mid-1990s:[290]

Table 5.1 Resource distribution formula SWSAHS

1995-96		1998-99		2002-03	
Distance From Target $'000	Distance From Target %	Distance From Target $'000	Distance From Target %	Distance From Target $'000	Distance From Target %
63,246	**-17.9**	**15,449**	**-3.5**	**14,016**	**-2.7**

5.12 NSW Health now aims to ensure that no Area Health Service is more than 2% under their RDF target.[291]

5.13 The Committee asked Mr Robert McGregor whether the resources allocated to SWSAHS in 2002-03 included an allocation for the obstetrics contract at Camden Hospital. In response, the Committee was told that funding of the obstetrics contract would 'be from within the total allocation provided to South Western Sydney Area Health Service.'[292] The Committee believes that this would have exacerbated the existing tight budget.

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[287] Associate Professor Picone, Evidence, 21 May 2004, p13

[288] Barraclough Review, op cit, p15

[289] Correspondence from Ms Robyn Kruk, Director General NSW Health, to Chair, Tab B, 29 April 2004. For further information on the RDF, see NSW Legislative Council, General Purpose Standing Committee No. 2, Report 13, *Quality of Care for Public Patients and Value for Money in Major Non-metropolitan Hospitals in NSW*, March 2002

[290] Correspondence from Dr Tamsin Waterhouse, A/ Director, Structural Reform Branch, to Director, 24 May 2004, in response to a question taken on notice on 30 April 2004

[291] Correspondence from Ms Robyn Kruk, Director General NSW Health, to Chair, Tab B, 29 April 2004

[292] Correspondence from Dr Tamsin Waterhouse, A/ Director, Structural Reform Branch, to Director, 24 May 2004, in response to a question taken on notice on 30 April 2004

Tension between resources and safety at Macarthur

5.14 One of the nurse informants provided the Committee with a good example of the tension between inadequate clinical resources and safety. Ms Valerie Owen, formerly Clinical Nurse Specialist at Campbelltown Hospital operating theatres, described a policy requiring certain patients to be accompanied to theatre by a nurse who would do a hand-over of care. Ms Owen gave evidence that this policy was not always followed, in part due to staff shortages:

> … the staff on the ward were stressed, they didn't have the personnel to come down and I was being obstructive by not accepting the patient ... I would not accept the patient and they would wait until somebody came down from the ward and made the hand-over.[293]

5.15 Ms Owen believes failure to follow protocol had tragic consequences, citing the case of a patient who was not accompanied to theatre and subsequently had a wrong-side procedure:

> The patient came for a mastectomy, she had the wrong breast removed and it was only when her daughter visited that evening and noticed that the patient had the bandage on the wrong side. The patient was taken to theatre that night and she had to have the other breast removed.[294]

5.16 Similarly, the reluctance of some staff at Macarthur to call the Medical Emergency Team (MET) may, in part, be related to staff shortages. The MET system uses certain criteria to trigger early intervention in critical situations.[295] In evidence, Ms Sheree Martin made serious allegations that she was physically obstructed from triggering the MET alarm. [296] The HCCC found that staff may have been reluctant to call a MET as it removes MET staff from the care of their own patients,[297] which in an under-resourced hospital increases the burden on all staff members.

5.17 In Macarthur Health Service, inadequate resources meant a lack of funding for safety and quality processes. This included the Critical Care Committee, the prime vehicle to analyse adverse events and implement system improvements, which until December 2002 had 'no dedicated resources.'[298] As identified in evidence by Ms Jennifer Collins, 'all but one of the cases [investigated by the HCCC] were reviewed prior to these allegations being received.'[299] However, Macarthur's Critical Care Committee proved ineffective in reviewing these cases and did not put in place measures to address underlying problems. As identified by the HCCC: 'the ineffectiveness of the Committee may be explained by the volume of cases, the lack of resources and the lack of adequate medical input.'[300]

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293 Ms Owen, Evidence, 12 March 2004, p10

294 Ms Owen, Evidence, 12 March 2004, p10

295 HCCC (2003), op cit, Part 5, p42

296 Ms Martin, Evidence, 12 March 2004, pp14-16

297 HCCC (2003), op cit, Part 5, p43

298 HCCC (2003), op cit, Part 5, p89

299 Ms Collins, Evidence, 29 March 2004, p2

300 HCCC (2003), op cit, Part 5, p90

Limited resources require 'smart' spending

5.18 The perennial problems of inadequate health budgets and the respective roles of State and Federal governments in health care were referred to by several witnesses during the inquiry.[301] The problems with clinical and other resources experienced by Campbelltown and Camden Hospitals are illustrative of the difficulties being experienced across the health system, particularly in outer metropolitan and rural hospitals.[302] Workforce constraints are one of the major limiting factors in the health system today, and will continue to be so in the future. Such limiting factors require the health system to work more efficiently and effectively, to ensure that while every service cannot be provided in every location everyone has access to the services they need. As Professor Bruce Barraclough stated, there will never be enough money to meet increasing community expectations, and ' … it is how you spend the money, not the total amount of money.'[303]

5.19 According to Mr Allen Thomas of the AMA (NSW), safety and quality is all about recognising that 'prevention is better than cure' and that committing resources to patient safety leads to long-term savings.[304] The community needs to be educated about the importance of safety and quality initiatives, and the need to set aside money for quality processes rather than just frontline service delivery:

> There is an inordinate pressure on the system to provide more and more services for less and less overall outlay … as the demand for services grows, it is the service delivery (patient waiting list) area that receives primary focus, rather than at least the quarantining of dedicated funds to encourage and ensure more active incident reporting …[305]

5.20 The Committee hopes that the announcement of the new Clinical Excellence Commission will increase public awareness of the importance of quality processes, and their potential to prevent adverse events and therefore prevent waste of resources.

5.21 The next part of the chapter examines how realistic role delineation, strong clinical networking and effective transfer protocols may overcome some of the limitations and risks posed by inadequate resourcing. We also examine the standard of medical record keeping, and the need to invest resources now to save money later through improved safety and quality of care.

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[301] Mr Brett Holmes, General Secretary, NSW Nurses Association, Evidence, 12 March 2004, p32

[302] See Associate Professor Brad Frankum, Director of Medicine, Macarthur Health Service, Evidence, 30 April 2004, p83; Ms Kruk, Evidence, 19 March 2004, p9; and Ms Collins, Evidence, 29 March 2004, p24

[303] Professor Barraclough, Chair, ICE, Evidence, 19 March 2004, p43

[304] Mr Thomas, Director of Medico-Legal Strategic Policy and Training, AMA (NSW), Evidence, 24 March 2004, p9

[305] Submission 65, Australian Medical Association (NSW), p3

Role delineation[306]

5.22 Resource limitations require community acceptance that not all services will be available in all hospitals:

> We need to educate the community about the complexity of the health system and why sometimes the level of care needed cannot be delivered at any hospital anywhere; it is just too expensive for our community.[307]

5.23 Clear and realistic role delineation is vital to ensuring that all citizens can access the health services they need. Role delineation is about demarcating which services will be available at which health services, including hospitals, and allocating resources to support the safe delivery of these services. In addition to developing a clear role delineation for all health services, NSW Health needs to promote community understanding of the role delineations of their local health services.

5.24 Clearer role delineation does not necessarily involve reducing services such as obstetrics in rural and regional areas, but requires clear protocols to manage risk:

> If you have got an area in the country where you have no obstetricians and you have GP obstetrics and that is the only service you have got for that area, then I do not see anything wrong with that as long as you work within the confines of that area. If you have a high-risk patient, you transfer them out. You are aware of your limitations and what you can do, or you have a flying service backup or you use your perinatal emergency transfer team to do that. You have to be realistic about what you are doing, you know.[308]

Clinical networking

5.25 Role delineation cannot work without plans to network services within an area to ensure seamless delivery of services (known as clinical networking). The lack of clinical networking was identified as a major deficiency in SWSAHS:

> There is no seamless service for patients across South Western Sydney Area Health Service which enables patients to easily access appropriate and effective care where it is to be provided. The facilities and staff required may not be able to provided at all facilities all the time, but a much greater level of connectedness with appropriate "streaming" or networking would promote good care.[309]

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306 The role delineation of a service indicates the complexity of clinical activity undertaken by that service. Role delineation determines the support services, staff profile, minimum safety standards and other requirements needed to ensure that clinical services are provided safely and are appropriately supported.

307 Associate Professor Merrilyn Walton, Ethical Practice, Department of Medical Education, University of Sydney, Evidence, 29 March 2004, p61

308 Dr Mary Prendergast, VMO, SWSAHS, Evidence, 30 April 2004, p90

309 Barraclough Review, op cit, p7

5.26 The need for clinical networking was also recognised by the Review of Maternal and Perinatal Services in SWSAHS led by Professor David Henderson-Smart:

> Maternal and perinatal services provided in SWSAHS are currently working as independent units. It is the key recommendation of the Review Team that SWSAHS establish an Area-wide Maternal and Perinatal Service.[310]

5.27 NSW Health has recognised the need to strongly network clinical services across areas, but needs to ensure that networking plans are developed and implemented in each area, as well as developing links between areas for highly specialised services. In addition, the community needs to be educated about the importance of clinical networking.

Transfer protocols

5.28 Role delineation requires a realistic definition of the limitations of a health service, together with protocols and risk management to support the health service when a patient's needs reach the limit of the services that can be delivered safely.

5.29 This is especially important when planning for new services, when it is vital to ensure that appropriate support systems are in place. This requires a very clear understanding of the role delineation of the service, and protocols to ensure that patients requiring more complex care are transferred quickly to an appropriate service within the clinical network. The difficulty of doing this was outlined by Professor Katherine McGrath, Deputy Director General NSW Health, and former CEO of the Hunter Area Health Service:

> … Our experience in the Hunter has shown that people make these changes to services, often without thinking through the systems and protocols that have to be in place to make it a safe and sustainable service … it becomes a very, very big exercise to ensure that those systems are in place and working well and keep them working well. In the past, Health has frequently underestimated the size of that task.[311]

5.30 In evidence the nurse informants have commented on the difficulties in transferring patients out of smaller hospitals when their condition deteriorated because the larger hospitals were already full.[312] Similar problems in Campbelltown and Camden Hospitals have led to the development of the 'golden phone' concept:

> By the golden phone concept we mean that if a patient is acutely ill, either mentally or physically, there will be somebody at the other end of the phone, somewhat like an air traffic controller, who will take responsibility for that patient and if they cannot find a bed in the area for that patient to be looked after with an adequate level of care, the patient will be transferred out of the area. It will be the responsibility of a senior person – a professor, a senior nurse – to direct operations with respect to the transfer of that patient.[313]

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[310] Henderson-Smart, D, Ellwood D, Allan S, Kent-Biggs J, Milne P, *Report on Review of Maternal and Perinatal Services in South Western Sydney Area Health Service*, March 2004, p2

[311] Professor McGrath, Evidence, 29 March 2004, p40

[312] Ms Giselle Simmons, formerly Acting Nursing Unit Manager Fairfield Hospital, Evidence, 23 March 2004, p3

[313] Professor Wilson, Evidence, 30 April 2004, p81

5.31 In order for such transfer protocols to work, doctors, nurses and managers, as well as the local community, need to clearly understand the hospital's role delineation and the need to transfer patients to larger tertiary centres when urgent, unforseen clinical situations arrive.

Emergency Department code red

5.32 The Emergency Departments at Campbelltown and Camden Hospitals, like many hospitals across metropolitan Sydney, are often overwhelmed by patient demand, and frequently request code red status. According to Mr Greg Rochford, CEO NSW Ambulance Service, code red is a part of the Emergency Department Network Access system, which 'is a way of indicating to ambulance officers the status of the hospital and where might be the most appropriate destination for a patient.'[314] In short, code red indicates to the ambulance service that a hospital feels unable to cope with demand, and is a request that ambulances do not deliver any more patients, except in life-threatening situations.

5.33 In evidence Dr David Hugelmeyer, Director of Emergency Medicine at Macarthur, described a memo he wrote to Ms Jennifer Collins on behalf of the Emergency Department Executive Committee in September 2002. The memo raised a concern about a number of situations where senior managers in the Emergency Department requested a code red designation, but the on-call administrator denied the request.[315] Dr Hugelmeyer provided a copy of a *Code Red Log – Campbelltown Emergency Department* to substantiate his claim that a number of people had refused requests for code red status.[316]

5.34 Dr Hugelmeyer's memo to Ms Collins was leaked to the media, however Dr Hugelmeyer denied responsibility for the leak.[317] Dr Hugelmeyer was subsequently called to see Ms Collins, who refuted the claim that as the on-call administrator she had ever refused a request for code red status.[318] Dr Hugelmeyer described Ms Collins' response to his memo to be:

> an irrational and punitive and intimidating affront to the fact that I was trying to, as director of the emergency department, express … in a confidential memo, some genuine concerns ...[319]

5.35 Ms Collins, however, has a different version of events:

> On Dr Hugelmeyer's return to work I and one other person met with him to discuss the leaking of the memo to the media and its tone. I reminded him of the media policy and how to construct a less offensive memo.[320]

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[314] Mr Rochford, Evidence, 30 April 2004, p18

[315] Dr Hugelmeyer, Evidence, 29 April 2004, p12

[316] *Code Red Log – Campbelltown Emergency Department*, July – October 2002, confidential document, tabled by Dr Hugelmeyer, 29 April 2004

[317] Dr Hugelmeyer, Evidence, 19 April 2004, p73

[318] Dr Hugelmeyer, Evidence, 29 April 2004, p12

[319] Dr Hugelmeyer, Evidence, 29 April 2004, p14

[320] Ms Collins evidence, 29 March, p5

5.36 Code red status at Campbelltown Hospital would have flow-on effects, as ambulances were redirected to Camden Hospital. This was problematic due to Camden Hospital's limited capacity, for example with at times only one CMO doctor on duty after 10pm on weekends and 6pm weekdays.[321] As a result of the Review led by Professor Barraclough, ambulances from the emergency network no longer bring patients to Camden Hospital.[322] It is a poor administration that would declare a major hospital to go code red with the flow-on effect that the ambulances go to a lesser resourced hospital within the same Area Health Service.

5.37 Current ambulance waiting times show that SWSAHS still has problems with the time taken for ambulance patients to be admitted. The following table shows off-stretcher times by area.[323]

Table 5.2 Off-stretcher times by area

Area Health Service	Off-Stretcher Time March 2004 Average (Minutes)
Central Sydney	28.7
Northern Sydney	24.9
South Eastern Sydney	26.4
Western Sydney	27.3
Wentworth	26.8
South Western Sydney	33.7

5.38 The Committee understands that it is a target of NSW Health to have a stretcher time of less than 30 minutes for each Area Health Service. The Committee notes that the NSW Audit Office recently examined the code red issue in detail and made a number of recommendations.[324]

Medical record keeping

5.39 Much evidence has been raised in this inquiry and at the Special Commission regarding inadequate, incomplete or illegible patient records. Commissioner Bret Walker, commenting on the standard of the medical records he had viewed in the course of his investigation of Campbelltown and Camden Hospitals, noted that:

> … the defects which have most hampered me are not sinister, but most commonly reflect an inability, or perhaps a refusal, of those working in hospitals, the two hospitals I have looked at, to follow the basic instruction that they should prepare

321 Mr Masso, Evidence, Friday 19 March 2003, p52

322 Associate Professor Picone, Evidence, 21 May 2004, p13

323 Correspondence from Mr Greg Rochford, CEO Ambulance Service of NSW, to Chair, 26 May 2004, providing an answer to a question taken on notice on 30 April 2004. Off stretcher time is the most useful measure of ambulance waiting times at hospitals. It is the time from arrival at hospital to the time the patient is handed over to Emergency Department staff.

324 The Audit Office of NSW, Report No. 120, *Code Red: Hospital Emergency Departments*, 15 December 2003

> their records legibly and clearly, making sure that they name, sign, date and time all entries.[325]

5.40 This view is supported by Dr David Hugelmeyer, who described his surprise on finding that medical charting at Camden Hospital was 'disorganised and records were all over the place and it was sometimes difficult to find documents or lab results …'[326]

5.41 Since early 2003, Associate Professor Brad Frankum has taken the following steps to improve the quality of medical records at Macarthur Health Service:

> firstly, that every patient consultation is recorded; secondly, that it is dated and timed and signed; and thirdly, that there is both an assessment and a management plan and an estimated date of discharge for each entry.[327]

5.42 Ms Beth Wilson, Health Services Commissioner, Victoria noted that the quality of medical record keeping is also a problem in Victoria.[328] According to the CEO of the Australian Council on Healthcare Standards, at a national level 'medical record note taking … is one area of concern to ACHS, and something that we are doing something about at the moment.'[329]

5.43 Professor Katherine McGrath supported the view that the quality of medical records needs to be improved, and suggested this be done through implementation of electronic records:

> We in the Hunter have become aware of systemic problems in medical record keeping and … there is a need to revisit those policies and modernise them, update them. We are moving towards more electronic-based record keeping, and that is the way we need to go. Now there is a need to review those policies as a matter of urgency and it will be very time-consuming because medical records are kept not only by doctors but also by a whole range of people. We have to get a process that is streamlined and efficient, that records essential data as well as fitting in with the modern health care delivery system. People are extremely busy, they change frequently, they change shifts, and personnel change, et cetera. It is a mammoth task but we have to do it.[330]

5.44 Dr Diana Horvath, CEO Central Sydney Area Health Service, states that this has already started to happen in Central Sydney:

> Since 1995 Central Sydney Area Health Service has progressively been replacing its paper-based medical records with an integrated electronic medical record … This has reduced the mislaying of results, the need to redo tests and unnecessary x-rays.[331]

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325 Mr Bret Walker, Evidence, Special Commission, 26 March 2004, p11

326 Dr Hugelmeyer, Evidence, 19 March, pp65-66

327 Associate Professor Brad Frankum, Evidence, Special Commission, 16 April 2004, p133

328 Ms Wilson, Evidence, 29 March 2004, p29

329 Mr Johnston, Evidence, 23 March 2004, p51

330 Professor McGrath, former CEO Hunter Area Health Service, Deputy Director General NSW Health, Evidence, 29 March 2004, p40

331 Dr Horvath, Evidence, 29 March 2004, p45

Case study: Ms Caroline Anderson

The case of Ms Caroline Anderson illustrates the importance of accurate, complete and transferable medical records in maximising patient safety. Ms Anderson, 37, from Warren, died in May 2001 from an infection caused by an epidural abscess, less than a month after giving birth to her third child.[332]

Handing down his findings in March 2004, the Deputy State Coroner noted that he was disturbed by the 'too regular incident of notes, either taken or purportedly taken, being lost.' Her anaesthetist admitted at the inquest to filling in her medical records four days after her death. After the inquest, Ms Anderson's husband commented that the 'lack of record-keeping was a thread which ran through her entire management.'[333]

5.45 NSW Health plans to implement an electronic health record system in pilot areas from August 2005, noting that it will provide a single point of access to view patient information, at the point of care, so that all treating clinicians have access to up to date patient information.[334] The Committee welcomes this development considering the importance of clear and complete medical records for safety and quality of care.

5.46 Clearly the issue of medical records is not solely about resources or improved systems for storing and accessing information, but is related strongly to the culture and practice of medicine. The Committee believes that in a patient-centred system, with clinicians focused on the well-being of the patient, inadequate, incomplete or illegible patient records should not be tolerated. Cultural issues are discussed in Chapter 3.

Resources and Camden maternity service

5.47 The opening of the 'low-risk' Camden maternity service[335] in February 2003 has been the subject of much evidence to the Committee in relation to resources (especially clinical workforce shortages), role delineation and transfer protocols, and the need for stronger clinical networking.

5.48 A central theme of the evidence has been that the service, which has strong community support,[336] was opened in response to political pressure, ignoring safety and resource concerns raised by staff. The obstetrics and gynaecology staff at Campbelltown Hospital in particular had strong objections to the opening of the service:

> … as an obstetrician gynaecologist – and my colleagues and I are in complete agreement on this – we felt that that was not the appropriate best use of resources for the Camden and Campbelltown area. All of us unanimously wanted the unit to stay at

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332 Wallace, N, 'Misdiagnosis that led to mother's death 'defies belief'', *Sydney Morning Herald*, 10 March 2004

333 Wallace, N, 'Misdiagnosis that led to mother's death 'defies belief'', *Sydney Morning Herald*, 10 March 2004

334 NSW Health, *NSW Health Information Privacy Code of Practice* Circular 99/18

335 Camden Hospital provides antenatal, birthing and postnatal services for women with essentially normal pregnancies. It is expected to cater for 600 births per year.

336 HCCC (2003), op cit, Part 7, 2003, pp42-43

> Campbelltown, to redevelop Campbelltown as a bigger unit with a completely midwifery-run section and everything on site.[337]

5.49 Evidence has shown that the maternity service experienced major problems from the beginning in attracting sufficient numbers of appropriately qualified staff. This is particularly true of anaesthetics and paediatrics, which are essential support services for a low-risk maternity unit.[338] In addition, there have been problems in relation to on-call arrangements for theatre nurses who are required to support emergency obstetric surgery, few of whom have training or experience in supporting emergency obstetric surgery.[339]

5.50 To address concerns about obstetric coverage the Macarthur Health Service recruited five specialist anaesthetists from overseas. Macarthur has also engaged a private consortium to provide obstetrics services at Camden Hospital. Although the details of the contract are commercial in confidence, it is believed the contract is worth in excess of $750,000.[340] The reputed high costs of the private consortium, together with the costs of the anaesthetists recruited for the Camden maternity service, have raised further concerns among staff about efficient use of resources.

5.51 In relation to safety concerns regarding the Camden maternity service, Dr James Parker, VMO, Macarthur Health Service, commented:

> I was on for obstetrics yesterday at Campbelltown Hospital. A patient was induced into labour at Camden the night before, failed to progress in labour and had to be transported by ambulance to Campbelltown Hospital for a caesarian section … We are totally opposed to any intrapartum transfer of someone in labour in an ambulance in a metropolitan suburb of Sydney.[341]

5.52 Dr Mary Prendergast, while noting that the Camden maternity service was not inadequate,[342] agreed with Dr Parker that there are difficulties inherent in such a service. These difficulties centre on the limited support services and the time delays involved in having specialists on call, as well as unforseen emergencies that may mean a patient's needs exceed the capacity of the service.[343]

5.53 Despite concerns regarding the safety of the service, the recent Review of Maternal and Perinatal Services in SWSAHS led by Professor David Henderson-Smart[344] recommended

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337 Dr Prendergast, Evidence, 30 April 2004, p85. See also Dr Prendergast, Evidence, 19 March 2004, p73

338 Dr Jim Parker, VMO SWSAHS, Evidence, 19 March 2004, p70

339 HCCC (2003), op cit, Part 7, p42

340 Dr Parker, Evidence, 19 March 2004, p68. Regarding the monetary value of the contract, Associate Professor Picone advised the Committee that any release of information relating to the contract must be with the consent of the Consortium providing the obstetric services. Associate Professor Picone advised that the Consortium have 'declined my request to release such information.' Correspondence from Associate Professor Picone, to the Director, 10 June 2004.

341 Dr Parker, Evidence, 19 March 2004, p70

342 Dr Prendergast, Evidence, 30 April 2004, p88

343 See Dr Prendergast, Evidence 19 March 2004, p72 and Evidence, 30 April 2004, p85

344 Professor Henderson-Smart is a neonatologist, Deputy Chair of the NSW Maternal and Perinatal Committee and Director of the NSW Pregnancy and Newborn Services Network

retaining the current maternity service at Camden Hospital as long as medical support is available at the required level, that is, continuing appropriate on-call anaesthetic cover and on-call paediatric support.[345]

5.54 A perception remains that the opening of the Camden maternity unit was politically motivated.[346] The service was opened with inadequate staffing levels to provide safe coverage. Dr Prendergast said concerns about staffing were ignored by management:

> I was on the committee for that as chairperson for the department of obstetrics and gynaecology and we stated to them that we needed extra specialist obstetrics and gynaecology people, how we could have a functional roster, and we felt that we would need at least 10 visiting medical officers to run a roster like that. Also, from past experience of working in Camden years before when it was run by a visiting medical office and a resident doctor with no specialist obstetrics and gynaecology qualifications, we were very adamant that we wanted obstetrics and gynaecology registrar, or junior staff present in the hospital just to run it in safely as we were told that that was not going to be a consideration.[347]

Conclusion

5.55 As with previous chapters, the focus of the evidence has been on SWSAHS but the problems discussed are likely to be found in every Area Health Service. Lack of resources is a significant factor in the occurrence of adverse events, and restricts opportunities to analyse them and implement systems improvements. The NSW Government has recently announced a range of initiatives to address some of these resource issues:

- $1.6 billion increase in health funding over the next four years[348]
- $55 million for the new Clinical Excellence Commission over the next four years[349]
- Health budget quarantined from cuts announced in the mini-budget.[350]

5.56 The interplay between resources, culture and systems is seen in the incidence, analysis and prevention of adverse events. This inquiry has sought to find ways to address the limitations posed by all three factors in order to develop a safe and open health care system. The final chapter discusses some of these issues, as well as the way ahead.

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345 *Report on Review of Maternal and Perinatal Services in South Western Sydney Area Health Service*, March 2004, p6

346 Totaro P & Pollard R, 'Doctors hit out: the system's rotten,' *Sydney Morning Herald*, 18 December 2003, www.smh.com.au/articles/2003/12/17/1071337032768.html (accessed 25 February 2004); Australian Medical Association (NSW), 'HCCC Review - Hospital Funding the Casualty,' *Media Release*, 11 December 2003

347 Dr Prendergast, Evidence, 19 March 2004, p69

348 Hon Morris Iemma MP, Minister for Health, 'Minister announces massive health funding increases,' *Media Release*, 6 April 2004

349 NSW Health, 'Premier Carr announces new $55 million Clinical Excellence Commission to improve health standards,' *Media Release*, 8 April 2004

350 Hon Morris Iemma MP, Minister for Health, '$50 million boost for NSW hospitals,' *Media Release*, 28 April 2004

Chapter 6 Conclusion

This chapter attempts to highlight the most important themes identified during the inquiry. These include finding ways to 'marry' a systemic approach to medical error with professional accountability and the need to encourage open disclosure at a practitioner level and systemic level. It also includes our tentative response to some of the recent reforms proposed by the NSW Government to improve complaints handling in the health care system. This report includes 19 recommendations. Some people may suggest that given the extent of the problems encountered during the inquiry it is a relatively small number. While numerically few, they are nonetheless fundamental recommendations, designed to facilitate a major shift in attitudes and practices on the part of individual clinicians, health service management and NSW Health.

Systemic vs individual accountability

6.1 One of the key issues examined by the Special Commission and our inquiry over the past several months is the relationship between systemic and individual accountability. Events at Macarthur Health Service have placed this issue centre stage, which may be a good thing given the medical profession's traditional resistance to external regulation:[351]

> There is always tension between what might be a more regulatory approach and encouraging a quality-improvement culture within an organisation. Clinical staff … tended not to be all that enthusiastic about regulation.[352]

6.2 While few people would suggest that a systemic approach to medical error precludes professional accountability, how this works in practice is another matter. During a recent hearing of the Special Commission, Commissioner Bret Walker SC asked the Director of Medical Services at Macarthur Health Service if he thought the focus of the HCCC on systems rather than cases during the Macarthur investigation was illogical. Associate Professor Frankum replied:

> If I'd known the legislation I think I would have found it illogical, but having done a significant amount of quality assurance activity myself, I did not find it particularly at odds. For example, if we have a root cause analysis…we will assemble a team of people to look at that case and there is an absolute necessity to not look exclusively at the actions of one person or an individual.[353]

6.3 Ms Merrilyn Walton, the former Health Care Complaints Commissioner suggests that confusion about the two concepts has contributed to the angst over recent controversy surrounding health complaints. Ms Walton told the Committee that there is a misconception that a no-blame culture negates the need for professional accountability.[354]

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[351] Thomas D, 'Introductory Overview,' in D Thomas (ed), *Medicine called to account: health complaints mechanisms in Australia*, School of Health Services Management, UNSW, Kensington, 2002, pp2-5

[352] Mr Brian Johnston, CEO Australian Council on Healthcare Standards, Evidence, 23 March 2004, p52

[353] Associate Professor Frankum, Evidence, Special Commission, 16 April 2004, p138

[354] Ms Walton, Evidence, 29 March 2004, p58

6.4 Much of the controversy surrounding these events stems from the assessment of the allegations raised by the nurse informants as being against the *health service* rather than *individual practitioners*. Under the *Health Care Complaints Act 1993*, complaints may be made against an individual practitioner or a health service.[355] If a complaint is against a practitioner, it must notify that person within fourteen days and provide them with an opportunity to make submissions about its proposed actions at the completion of its investigation.[356] Where the Commission investigates a health organisation who is not a 'natural' person, before making recommendations or comments, the Commission must inform the health organisation of the grounds for its proposed actions and give the organisation an opportunity to make submissions.[357]

6.5 In the case of Macarthur, the HCCC interpreted the complaint received by the Director General as being against Macarthur Health Service rather than individual doctors or nurses:

> Given the very serious public health and safety issues identified early in the investigation, the Commission's primary focus was on addressing the systemic issues … The investigation has, however, raised questions about the performance of individual registered health providers. The Commission is assessing these to determine if further action is warranted in the public interest.[358]

6.6 The nurse informants as a result, saw their concerns about individual incidents as being ignored, despite the seriousness of what they had reported. We can understand why they resented the HCCC for this and sought other avenues to pursue their complaints.

6.7 It is likely that things would have been very different if the HCCC had from the very beginning sought to identify the individual practitioners involved in the incidents. In his First Interim Report, the Special Commissioner argues that classifying the allegations by the nurse informants as *not* being complaints against doctors and nurses was indefensible and castigates the Commission for failing to comply with the 'straightforward requirements of the complaints system,' [359] particularly given that the final HCCC Report included an appendix in which numerous allegations regarding the quality of clinical care provided by individuals were found to be 'substantiated.'[360]

> I cannot read these entries as anything other than a finding to the effect that eg the particular medical practitioner's conduct demonstrated a lack of adequate knowledge, skill, judgement or care in the practice of medicine.[361]
>
> The very notion that a public regulator such as the HCCC could prepare a report which substantiates (to use the language of the Investigation report) allegations of

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355 *Health Care Complaints Act 1993* (HCCA), section 7

356 HCCA, sections 16 and 40,

357 HCCA, section 43

358 HCCC (2003), op cit, Part 3, pp4-5

359 Walker B, *Interim Report of the Special Commission of Inquiry into Campbelltown and Camden Hospitals*, 31 March 2004, p10

360 Walker B, *Interim Report*, op cit, p6

361 Walker B, *Interim Report*, op cit, p6

> inadequate care etc on the part of identifiable doctors, without regarding those allegations as a complaint against that doctor is offensive to a sense of fairness.[362]

6.8 He points out the serious implications of this misclassification for the individual practitioners who were denied the procedural fairness that would have been accorded by triggering section 16. As far as the public were concerned, it:

> … has been denied for more than a year the efficient administration of the assessment, investigation and decision by the HCCC of many complaints against a number of doctors and nurses.[363]

6.9 In subsequent public hearings following the release of the first Interim Report, Commissioner Walker appears to be more appreciative of the dilemma faced by Ms Adrian in analysing the 'formidable body' of complex material that accompanied the complaint from the Director General and which unarguably dealt with both systemic and individual matters.[364]

> The Health Care Complaints Commission was being asked to deal with the hospital complaints system as well as the complaints that the hospitals complaints system had been dealing with, so that there was, from the beginning, a complexity or level of complication with which I'm sympathetic… I'm even more sympathetic, having now done this process myself, to the sorting out process of those who are, as it were, simply unlucky enough to have been involved in the care and those who are directly implicated as people against whom allegations are made, the distinction being no means clear … [365]

6.10 We look forward to the recommendations of the Special Commission on how to resolve the tensions around systemic and individual accountability in the final report due on 31 July. In the meantime, it is important to raise our concerns regarding the government's proposals to improve the investigation of complaints involving individual practitioners and systems issues.

6.11 The government recently announced its intention to expand the role of the Institute of Clinical Excellence, to become the Clinical Excellence Commission. This would allow the Commission to take a more active role in identifying, assessing and improving systemic shortcomings in patient care practices. It has also proposed legislative change to enable the HCCC to more effectively investigate complaints about health services and prosecute complaints of serious misconduct against individual practitioners.

6.12 It is proposed that the Clinical Excellence Commission and HCCC, while complementing each other, will have quite distinct roles:

> While the HCCC will be responsible for investigating individual complaints about healthcare or patient treatment, the new CEC will ensure that any potential system-wide problems picked up by the HCCC are dealt with.[366]

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362 Walker B, *Interim Report*, op cit, p9. Emphasis as per original quotation.

363 Walker B, *Interim Report*, op cit, p10

364 Forum chaired by Mr Bret Walker SC, Special Commission, 24 May 2004, p7

365 Mr Walker, Evidence, Special Commission, 5 May 2004, p262

366 NSW Health, *Information Paper: Providing the Best Health Care*, April 2004, p6

6.13 One of the lessons from the Macarthur investigation is the difficulty of extricating systemic issues from those involving individual practitioners. In many cases, even if it can be established that an individual's performance is unprofessional, systems issues are also likely to be involved, and vice versa.

6.14 This inquiry and the Special Commission are part of a debate across the system about where the parameters are of blameworthy and blame free actions. While we welcome the Government's commitment to providing more resources to investigate systemic and individual complaints, we are concerned about the proposal for health care complaints to be received and assessed by two separate agencies and suggest such a decision be deferred, pending the completion of the Special Commission. The Committee will monitor these recommendations, and the implementation of the reforms to the quality agenda, via the budget estimates process. In addition, this Committee will institute a review of the recommendations made in this report in June 2005.

Recommendation 19

That the proposal to split responsibility for the investigation of systemic and individual complaints between the Clinical Excellence Commission and the Health Care Complaints Commission, be reassessed following the release of the final report of the Special Commission of Inquiry into Campbelltown and Camden Hospitals.

Moving the pendulum towards professional accountability

6.15 One of the many tasks for NSW Health arising from recent events in south west Sydney is to reassure the community that individual professionals will be held to account if they do not meet professional standards.

6.16 In Chapter 4 we discussed the alleged euthanasia of Mrs Daly-Hamilton at Liverpool Hospital. The doctor involved in this case as well as a further three deaths that have been referred to the Coroner, was referred by SWSAHS to the NSW Medical Board on 13 February 2004. This doctor is now practising in South Australia. The NSW Medical Board is responsible for referring such matters to registration boards in other states, however, as of 21 May 2004, the NSW Medical Board had still not contacted the South Australian Medical Board.[367] That is a delay of more than *four months*. This delay has only come to light because of questioning by the Committee. In the interest of professional accountability, NSW Health should have pursued this matter with both the medical boards.

6.17 The community is not satisfied with the apparent failure to pursue individual accountability in the Macarthur affair. In further developing and refining the regulatory system for health care complaints in New South Wales, we need to ensure the pendulum swings towards professional accountability, without which there will never be community acceptance of systemic approaches.

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[367] Correspondence from Associate Professor Picone, Administrator SWSAHS, to Chair, 21 May 2004

Open disclosure at an individual and systemic level

6.18 At the heart of the issues involving Camden and Campbelltown Hospitals is the routine non-disclosure of adverse events at an individual and systemic level, a phenomenon that is by no means limited to one Area Health Service. The only way we will avoid a repeat of the events in south west Sydney is for NSW Health and health professionals, including managers, to be more open about the reality of health care mistakes. Everyone makes mistakes, but no one benefits from keeping them hidden, least of all the consumers of health services in New South Wales.

6.19 NSW Health has a major role to play in promoting change and not just by designing more policies and guidelines. The Department also has to open up about medical error. Publishing comparative data on adverse events would be a good start and being frank with patients, families and the media when adverse events occur, would be another.

6.20 Area Health Boards are responsible for clinical governance. In other words, ensuring a safe and high quality health system is in place within their area. At the end of the day, it is the Boards that are responsible for complaint handling processes. They must ensure that the rhetoric around patient safety and quality, of which we have encountered a good deal, is matched with what happens day to day in their health services. During the inquiry, some commentators have called for a drastic reduction of senior health managers in order to divert resources to direct patient care. We received very little evidence on this issue but believe that if we are serious about making sure the system learns from its mistakes, we need committed and experienced managers with the time to do this. Restructuring health service management before we have an opportunity to assess the new changes would be unwise.

6.21 NSW Health cannot achieve cultural change without the assistance of senior clinicians and their professional associations, including medical indemnity organisations. We know that approximately 10 per cent of hospital admissions result in some form of adverse event, only a very small fraction of which are reported to health managers or the patients themselves. Some doctors are practising open disclosure to the benefit of their patients, peers and junior colleagues, however, they are the minority. While the profession publicly supports the principles of open disclosure, it is not doing enough to make sure this happens.

6.22 If, despite the efforts of NSW Health and Area Health Boards, some health professionals feel they need to go outside of the system to report their concerns, it is in no one's interests to treat whistleblowers in the way the nurse informants from south west Sydney have been dealt with. They have paid a high price for their actions. We hope they gain some consolation from the fact that their determined efforts have had a radical impact on the quality agenda in New South Wales.

Appendix 1 Submissions

The Committee called for submissions through advertisements in major metropolitan and regional newspapers in late December 2003 and late January 2004, and by writing to relevant individuals and organisations. The Committee received a total of 71 submissions.

No	Author
1	Partially Confidential – name withheld
2	Mr and Mrs Brian Lindbeck
3	Ms Jennie Burrows
4	Confidential
5	Mr Baljinder Singh – Partially Confidential
6	Partially Confidential – name withheld
7	Mr E Burrows
8	Mrs McCudden
9	Ms Rose Hylton
10	Mr Charles McCusker – Partially Confidential
11	Mr John Harrison
12	Ms Diana Panfili
13	Mr Andrew Schwartz (Australian Doctors Trained Overseas Assoc)
14	Mrs Josephine Ball
15	Mr Stewart Dean
16	Mr Peter Gaigals
17	Clr Betty Moore
18	Mr Neil Wilson
19	Clr John Bowell (Kempsey District Hospital Action Group)
20	Mr Austin Helman – Partially Confidential
21	Ms Sally Crossing (Cancer Voices NSW)
22	Confidential
23	Ms Nola Fraser
24	Ms Annie Pettitt (Public Interest Advocacy Centre)
25	Mr Jack Passaris (Ethnic Communities Council of NSW)
26	Ms Patricia Le Lievre
27	Ms J Bushell – Partially Confidential
28	Mr Thomas Faunce (Australian National University)
29	Mr Phillip French (People with Disability Australia)

No	Author
30	Ms Maureen Stephenson
31	Mr Gary Silis
32	Mrs Susan Byrne
33	Ms Annette Fordham
34	Ms Jan Roberts (The Official Visitors' Program)
35	Mr Gary Moore (Council of Social Service of NSW)
36	Miss Rita Cameron
37	Mrs Irene Kaposi
38	Mr Stephen Kilkeary – Partially Confidential
39	Mr Andrew Allan (Medical Consumers Association Inc)
40	Dr Yolande Lucire
41	Mrs Yvonne Quinn
42	Mr Ron Paterson (New Zealand Health and Disability Commission)
43	Ms Jenna Bateman (Mental Health Co-ordinating Council)
44	Prof Judy Lumby (The College of Nursing)
45	Mr Gerard Crewdson – Partially Confidential
46	Mr Brett Holmes (NSW Nurses' Association)
47	Ms Patricia Witts
48	Mr Adrian Piccoli MP
49	Confidential
50	Partially Confidential – name withheld
51	Ms Elizabeth Foley (Royal College of Nursing, Australia)
52	Ms Anna Kolbe (Royal Australasian College of Surgeons)
53	Mr Dennis Newman
54	Mr Ron Dwyer (Nurses Registration Board of NSW)
55	Ms Kathrine Grover – Partially Confidential
56	Mr George Michalik
57	Ms Fiona Tito-Wheatland (ANU Research School of Social Sciences)
58	Mr Bill Grant (Health Care Complaints Commission)
59	Mr Michael Williamson (Health Services Union)
60	Ms Lesley Killen
61	Mr Brian Johnston (Australian Council on Health Care Standards)
62	Partially Confidential – name withheld
63	Ms Lorraine Long (Medical Error Action Group)
64	Confidential

No	Author
65	Mr Allen Thomas (Australian Medical Assoc. (NSW) Limited)
66	Ms Robyn Kruk (NSW Health Department)
67	Mr John Lee
68	Confidential
69	Partially Confidential – name withheld
70	Confidential
71	Ms Lynn Tonkin

Appendix 2 Witness list

A total of eight public hearings were conducted at Parliament House involving 70 witnesses. A list of witnesses is provided below and transcripts of the hearings are on the Committee's website at www.parliament.nsw.gov.au.

Date	Name	Position and Organisation
Friday 12 March 2004	Ms Nola Fraser	Former After Hours Hospital Manager, Campbelltown and Camden Hospitals
	Ms Vanessa Bragg	Former Clinical Nurse Specialist, Intensive and Coronary Care, Campbelltown Hospital
	Ms Sheree Martin	Former Enrolled Nurse, Camden Hospital
	Ms Kathrine Grover	Former Senior Nurse Manager, After Hours, Liverpool Health Service
	Ms Yvonne Quinn	Former Clinical Nurse Specialist, Operating Theatres, Campbelltown Hospital
	Ms Valerie Owen	Former Clinical Nurse Specialist, Operating Theatres, Campbelltown Hospital
	Ms Sarah Flegg	Health complainant
	Mr Brett Holmes	General Secretary, NSW Nurses' Association
	Ms Jan Grieg	Organiser, NSW Nurses' Association
	Ms Katherine Sullivan	Community and Government Relations Officer, NSW Nurses' Association
	Ms Angela Garvey	Professional Officer, NSW Nurses' Association
	Ms Kate Dyer	Deputy Chair, Nurses Registration Board of NSW
	Mr Irving Wallach	Chairman, NSW Nurses Tribunal
	Professor Brian McCaughan	President, NSW Medical Board
	Ms Anne Scahill	Deputy Registrar, NSW Medical Board
Friday 19 March 2004	Ms Robyn Kruk	Director General, NSW Health Department
	Mr Robert McGregor	Deputy Director General, NSW Health Department
	Dr Greg Stewart	Deputy Director General, NSW Health Department
	Ms Liz Jakubowski	Director, Communications, NSW Health Department
	Ms Victoria Walker	Director, Audit, NSW Health Department
	Ms Deborah Green	CEO, South Eastern Sydney Area Health Service
	Ms Lorraine Long	Chief Executive, Medical Error Action Group
	Professor Bruce Barraclough	Chair, NSW Institute for Clinical Excellence
	Assoc Professor Debora	Administrator, SWSAHS

Date	Name	Position and Organisation
	Picone	
	Ms Clair Cameron	Manager, Public Affairs, SWSAHS
	Mr Greg Driver	Area Human Resources Manager, SWSAHS
	Ms Mary Dowling	Manager, Professional Practice Unit, SWSAHS
	Mr Raad Richards	Chief Executive Officer, Carrington Centennial Hospital
	Ms Susan Connelly	Public Affairs, SWSAHS
	Ms Lisa Kremmer	Nursing Unit Manager, Emergency Dept, Camden Hospital
	Ms Catherine O'Connor	Nursing Unit Manager, Intensive Care Unit, Campbelltown Hospital
	Mr Malcolm Masso	Senior Research Fellow, Centre for Health Services Development, University of Wollongong
	Mr David Hugelmeyer	Director of Emergency Medicine, Macarthur Health Service
	Dr Richard Cracknell	Director of Emergency Dept, Liverpool Hospital
	Dr James Parker	Visiting Medical Officer, SWSAHS
	Dr Eddie Lim	Visiting Medical Officer, SWSAHS
	Dr Mary Prendergast	Visiting Medical Officer, SWSAHS
Tuesday 23 March 2004	Mr Peter Mylan	Assistant Secretary, Health Services Union
	Dr Anthony Llewellyn	Member, Health Services Union
	Ms Pat McDermott	Heath of Dept of Public Relations and Fundraising, Northern Sydney Area Health Service
	Dr Stephen Christley	CEO, Northern Sydney Area Health Service
	Ms Fiona Tito-Wheatland	PhD Scholar, ANU Research School of Social Sciences
	Mr Bill Grant	A/Commissioner, Health Care Complaints Commission
	Mr Bruce Greetham	Former Manager, Partnerships & Quality, HCCC
	Mr Giles Yates	Investigation & Resolution Officer, HCCC
	Ms Susan Donnelly	Assistant Commissioner, HCCC
	Mr Brian McMahon	Manager, Patient Support Service, HCCC
	Mr Brian Johnston	CEO, Australian Council on Healthcare Standards
	Ms Heather McDonald	Executive Manager Customer Services, Australian Council on Healthcare Standards
	Mr Geoff Dulhunty	A/Executive Director, The College of Nursing
	Ms Leanne Lancaster	Educator, The College of Nursing
	Ms Giselle Simmons	Former A/Nursing Unit Manager, Fairfield Hospital

Date	Name	Position and Organisation
Wednesday 24 March 2004	Ms Wendy McCarthy	Chair, NSW Health Participation Council
	Mr Allen Thomas	Director, Medico-Legal Strategic Policy & Training, Australian Medical Assoc. (NSW) Limited
	Mr David Brown	General Manager, Legal Division, United Medical Protection
Monday 29 March 2004	Ms Jennifer Collins	Former General Manager, Macarthur Health Service
	Ms Beth Wilson	Commissioner, Office of the Health Services Commissioner, Victoria
	Prof Katherine McGrath	Deputy Director General, NSW Health Department;Former Chief Executive Officer, Hunter Area Health Service
	Dr Alan Spigelman	Director, Clinical Governance, Hunter Area Health Service
	Dr Diana Horvath	Chief Executive Officer, Central Sydney Area Health Service
	Mr Mike Wallace	Deputy Chief Executive Officer, Central Sydney Area Health Service
	Ms Merrilyn Walton	Associate Professor, Ethical Practice, Department of Medical Education, University of Sydney
	Ms Amanda Adrian	Former NSW Health Care Complaints Commissioner
Thursday 29 April 2004	Dr David Hugelmeyer	Director of Emergency Medicine, Macarthur Health Service
Friday 30 April 2004	Prof Stewart Dunn	Professor of Psychological Medicine, Department of Psychological Medicine, University of Sydney, and Director, ErroMed
	Associate Prof John Cartmill	Department of Surgery, University of Sydney, and Director, ErroMed
	Mr Greg Rochford	Chief Executive Officer, NSW Ambulance Service
	Ms Louise Ashelford	A/Manager, Professional Conduct and Standards Unit, NSW Ambulance Service
	Ms Robyn Kruk	Director General NSW Health Department
	Ms Liz Jakubowski	Director, Communications, NSW Health Department
	Mr Robert McGregor	Deputy Director General, NSW Health Department

Date	Name	Position and Organisation
		Department
	Mr Greg Driver	Area Human Resources Manager, SWSAHS
	Mr Raad Richards	Chief Executive Officer, Carrington Centennial Trust
	Ms Lisa Kremmer	Nursing Unit Manager, Emergency Dept, Camden Hospital
	Mr Malcolm Masso	Senior Research Fellow, Centre for Health Services Development, Wollongong University
	Ms Catherine O'Connor	Nursing Unit Manager, SWSAHS
	Assoc Professor Debora Picone	Administrator, SWSAHS
	Assoc Professor Brad Frankum	Director of Medicine, Macarthur Health Service
	Dr Stephen Della-Fiorentina	Director, Macarthur Cancer Therapy Centre
	Professor Jeremy Wilson	Director of Medicine, Bankstown Hospital
	Dr Amanda Walker	Director, Palliative Care Unit, Camden Hospital
	Dr Mary Prendergast	Visiting Medical Officer, SWSAHS
Friday 21 May 2004	Assoc Prof Debora Picone	Administrator, SWSAHS
	Ms Robyn Kruk	Director General NSW Health Department

Appendix 3 Recent Developments SWSAHS

Achievements from October to December 2003

October 2003

- Associate Professor Picone appointed as Acting CEO and in turn appointed a new management team including Mr Matthew Daly as Acting Deputy CEO
- Appointed acting General Manager, Ms JoAnne Fisher and Acting Director of Nursing, Ms Jenny Becker, at Campbelltown-Camden Hospitals

November 2003

- Campbelltown Hospital's Intensive Care Unit networked with Liverpool Hospital, making it fully functional under leading intensivist, Dr Gillian Bishop
- A/Prof Brad Frankum developed a proposal to strengthen medical services at Campbelltown Hospital. This involves additional physicians in the Department of Medicine and creating a Department of Cardiology with the appointment of an academic cardiologist.
- A/Prof Frankum also proposed establishing a Centre of Excellence for Heart Failure Treatment and Research at Campbelltown Hospital.
- The Clinical Strategy Group, comprising prominent clinicians from SWSAHS, established to develop an Area-wide Clinical Services Strategy for 2004-2007

December 2003

- A/Prof Picone appointed as Administrator of SWSAHS
- A CT scanning service commenced in December 2003 at Campbelltown Hospital enabling enables a 24-hour diagnostic service initially for scanning of patients' heads
- A new Professional Practice Unit with legal, clinical and mediation skills was set up to receive grievances and handle patient and next-of-kin complaints

Between 10 January 2004 and 31 May 2004 SWSAHS has achieved the following:

- Professor Reginald Lord appointed in January 2004 as part-time Director of Surgery at Campbelltown Hospital;
- A Clinical Fellow in Neurology commenced at Campbelltown Hospital at the end of January 2004;
- A cardiology specialist has commenced and two more cardiology specialists being recruited for

Campbelltown Hospital to form the basis of a centre of excellence in heart failure;

- A cardiology roster has been introduced at Campbelltown Hospital;
- The Area has completed and submitted to the Minister for Health its new health plan comprising 57 Clinical Strategies;
- The Area commissioned a review of its Human Resources Policies and Structure;
- The Area also commissioned a review of its staff grievance and patient complaint handling procedures;
- An expert review of the roles of Maternity and Perinatal services led by Dr David Henderson-Smart has been undertaken to ensure an Area-wide model effectively linking services across SWSAHS;
- The Area subsequently introduced an Area-wide Department of Maternal and Perinatal Services and appointed A/Area Directors of Feto-Maternal Medicine and Midwifery;
- A Renal Physician commenced at Campbelltown Hospital in January 2004;
- Campbelltown Hospital opened a six-bed Haemodialysis Unit as part of the Area Renal Service and commenced recruitment of expert renal nurses;
- Campbelltown Hospital also advertised in the national press and planned interviews for Directors of Medical Education and Physician Training;
- A network of four Medical Emergency Teams (METS) coordinators - a central co-ordinator at Liverpool Hospital and one based at each of Campbelltown, Camden and Fairfield Hospitals - commenced in February 2004, staffed by clinical nurse consultants/clinical nurse specialists;
- Campbelltown-Camden Hospitals implemented a continuing program of nurse education covering: communication; physical assessment of patients; care of critically ill patients; documentation; and team work;
- Campbelltown-Camden Hospitals also commenced a new program of performance management for all staff, including nursing staff, staffing with all 44 nurse unit managers;
- A Nursing Operations Manager was appointed at Campbelltown-Camden Hospitals in April 2004;
- A Nurse Manager in the Operating Theatres at Campbelltown-Camden Hospitals commenced in May 2004;
- A further 3.5 FTE registered and enrolled nurses commenced in the medical ward of Campbelltown Hospital in May 2004;
- SWSAHS finalised the asset procurement plan for $7.1m enhancement funds (see below), including a functional specification for the Medical Imaging Information System and Picture Archiving and Communication System (PACS); and

- SWSAHS announced the establishment in April 2004 of an Area coordinated, stand-alone Acute Care Response Unit (ACRU) to operate 24 hours/day, seven days/week, supporting all SWSAHS hospitals with a single 'phone call to be used where a clinician has concerns about a seriously ill or at risk patient.

Funding enhancements of $7.1m announced by the Minister for Health

The Minister for Health on 14 January 2004 announced an additional $7.1 million for SWSAHS as part of an overall package of $37.5 million for NSW public hospitals to provide essential medical equipment and urgent capital works. The $7.1 million for SWSAHS is primarily for new equipment, the majority of which will be introduced at Campbelltown Hospital to improve the quality of care. The list of projects includes:

Campbelltown Hospital

- $2 million to extend medical imaging links between Campbelltown and Liverpool Hospitals
- $1m to upgrade anaesthetic, surgical and sterilising equipment in operating theatres
- $250,000 to expand ultrasound services
- $250,000 to provide additional capacity for medical staff treating cancer patients
- $250,000 to upgrade intensive and coronary care equipment
- $250,000 to introduce an echocardiography service
- $70,000 for telemetry monitoring equipment

Liverpool and Camden Hospitals

- $2.8m to replace the Cardiac Catheter Laboratory at Liverpool Hospital; and
- $250,000 for an operating theatre camera system at Camden Hospital.

Other Funding Announcements

An additional $1.9 million in additional funding for 298 elective surgery procedures was allocated to South Western Sydney Area Health Service in February 2004. $525,000 in additional funding was also provided for aged care services.

$4.15 million funding boost for the South Western Sydney Area Health Service as a result of the State Government Mini-budget in April 2004.

South Western Sydney Health Network: The Way Forward 2004-08, was launched 17 June 2004. It was developed by clinicians and involved a further boosting of the clinical workforce and the medical and academic leadership in the Area.

Specifically, it delivers:

- An increase of over **$300 million** over four years, including **$26.2 million in 2004/05** to back the Health Plan, rising to **$112 million per annum by 2007/08**
- A clear four year plan for the delivery of over 60 clinical services, with priority enhancements to 17 services including intensive care, diabetes services, renal medicine, cardiology, mental health, neurology and emergency medicine.
- Improved clinical leadership with new senior academic appointments in a number of service areas including cancer, aged care, anaesthetics and pain, emergency and trauma, colorectal surgery, maternity and foetal medicine, paediatrics, rheumatology and general medicine.
- An increase in beds in specialised services, including:
  - 12 intensive care beds, with seven to be located at Campbelltown Hospital
  - Eight high dependency beds
  - Three ventilated neo-natal intensive care cots at Liverpool Hospital
  - Additional inpatient maternity beds for women with complicated pregnancies
- A bed management plan that will determine the number of additional general, surgical and transitional beds that will be required to meet the growth in demand.
- The appointment of medical staff across a number of hospitals so that care can be provided at the most appropriate site by the most appropriate clinical team.
- A strengthening of the partnership between hospitals and the community sector to ensure that patients receive ongoing care after leaving hospital, or an alternative to hospital care; and

An improved single phone call system for inter-hospital acute patient transfer.

Appendix 4 Minutes

Minutes No.6
Wednesday 29 October 2003
At Parliament House at 1.15pm, Room 1108

1. **Members present**
Revd Dr Gordon Moyes *(Chair)*
Mrs Patricia Forsythe (*Deputy Chair)*
Mr Tony Catanzariti
Dr Arthur Chesterfield-Evans
Ms Robyn Parker
Mr Peter Primrose (Tsang)
Ms Christine Robertson

2. **Participating member**
Ms Catherine Cusack

3. **Substitute arrangements**
The Chair note advice from the Government Whip that Mr Primrose would be substituting for Mr Tsang for the purposes of this deliberative meeting.

4. **Minutes**
Resolved, on the motion of Mr Catanzariti, that Minutes Nos 1, 2, 3, 4 and 5 be confirmed.

5. …

6. …

7. **Proposed self referral of inquiry into South Western Sydney Area Health Services**
The Committee deliberated on the letter signed by four committee members, which had been previously circulated by the Director, requesting consideration of an inquiry into the South Western Sydney Area Health Service.

Mrs Forsythe moved that the Committee adopt the suggested terms of reference for an inquiry into the South Western Sydney Area Health Services.

The Committee deliberated.

Ms Robertson tabled a letter to the Director General of NSW Health from the Institute for Clinical Excellence containing recommendations arising from their review of the systems of patient care in place at Macarthur Health Service.

Question put.

Ayes:
Mrs Forsythe
Dr Chesterfield-Evans
Ms Parker

Noes
Revd Dr Moyes
Mr Catanzariti
Mr Primrose
Ms Robertson.

The question was resolved in the negative.

Mr Primrose moved that the Committee conduct a full inquiry into South Western Sydney Area Health Services if the Committee is not satisfied with the final report of the Health Care Complaints Commission inquiry into complaints made regarding Camden and Campbelltown Hospitals.

The Committee deliberated.

Question put.

Ayes: Revd Dr Moyes
Mrs Forsythe
Mr Catanzariti
Ms Parker
Mr Primrose
Ms Robertson

Noes: Dr Chesterfield Evans

Question resolved in the affirmative.

8. Adjournment
The Committee adjourned at 2.15pm *sine die.*

Minutes No.12
Monday 15 December 2003
At Room 1153, Parliament House at 1:00 pm

1. Members Present
Revd Dr Moyes (Chair)
Dr Chesterfield-Evans
Mrs Forsythe
Ms Parker
Mr Primrose (Catanzariti)
Ms Fazio (Tsang)
Ms Robertson

2. Confirmation of minutes
Resolved, on the motion of Mrs Forsythe, that minutes no 11 be confirmed.

3. Proposed Self Reference into NSW Health
The Chair referred to the Committee's decision at its meeting on 29 October to consider an inquiry into the South West Sydney Area Health Service if it was not satisfied with the report of the Health Care Complaints Commission.

The Committee deliberated.

Resolved, on the motion of Mr Primrose, that the Committee adjourn until 2:25 pm to draft revised terms of reference.

The Committee adjourned from 2:15 until 2:25 pm.

The Committee deliberated.

Resolved, on the motion of Mr Primrose, that the Committee adopt the following terms of reference:

That General Purpose Standing Committee No. 2 inquire into and report upon the complaints handling procedures within NSW Health, and in particular:

- *the culture of learning and the willingness to share information about errors and the failure of systems, and*
- *an assessment of whether the system encourages open and active discussion and improvement in clinical care.*

Resolved, on the motion of Mr Primrose, that the Chair and secretariat be empowered to make grammatical or technical amendments to the wording prior to making it public, such changes to be circulated to the other Committee members.

Resolved, on the motion of Ms Fazio, that the closing date for submissions be 28 February 2004, and that a preliminary advertisement be placed in this Saturday's *Sydney Morning Herald* followed by more extensive advertising in late January 2004.

Resolved, on the motion of Mr Primrose, that the reporting date be 31 May 2003.

4. Adjournment
The Committee adjourned at 2:45 pm *sine die*

Minutes No 13
Thursday 12 February 2004
At Room 1136, Parliament House at 3:00 pm

1. Members Present
Revd Dr Moyes (Chair)
Dr Chesterfield-Evans
Mrs Forsythe
Ms Parker
Mr Primrose (Catanzariti)
Ms Fazio (Tsang)
Ms Robertson

2. Confirmation of minutes
Resolved, on the motion of Ms Fazio, that minutes no 12 be confirmed.

3. Substitute arrangements
The Chair advised that for the duration of the inquiry into complaint handling by NSW Health, Mr Primrose will be substituting for Mr Catanzariti and Ms Fazio will be substituting for Mr Tsang.

4. **Correspondence**
The Chair noted the following items of correspondence:

Correspondence sen*t*
- Letter to the Minister for Health seeking a submission from the Department to the inquiry (24 December 2003)
- Letter to the Minister for Health seeking his cooperation in ensuring Departmental and Area Health Service employees are able to freely provide submissions or evidence to the inquiry (24 December 2003). See item 4.4
- Letters to various individuals and agencies inviting submissions to the committee's inquiry (5 February 2004)

Correspondence received
- Letter from the Hon Patricia Forsythe to Revd Gordon Moyes regarding the protection of NSW Health employees who wish to give evidence or make a submission to the inquiry (17 December 2003)
- Letter from the Acting Minister for Health to Revd Gordon Moyes advising that NSW Health would make a submission to the inquiry before the closing date and including the name of a contact person within NSW Health (received 30 January 2004)
- Letter from Mr Charles P McCusker to the Director, GPSCs, regarding the status of submissions to the inquiry
-

5. **Inquiry into complaint handling in NSW Health**

Progress report
The Committee Clerk advised members of the Committee that the inquiry terms of reference were advertised in the print media on 15 December 2003 and again on 31 January 2004.

Adverse comment
Mr Primrose raised concerns about the way the Committee intends to deal with witnesses who make adverse comments about the behaviour of particular healthcare workers.

The Chair advised his intention to deal with such situations in the following way:
An introductory statement would be prepared to be read at the beginning of each hearing, which would include the following points:
- That the inquiry is primarily concerned with systemic issues relating to health complaints.
- While individual cases may help to illustrate systemic issues, it should not be necessary to name individual healthcare workers.
- That Parliamentary privilege is not intended to provide a forum for people to make adverse reflections about others
- That parties adversely named in evidence may be given an opportunity to respond to the allegations made about them.

If a witness begins to make such allegations, the Chair will stop the witness to ascertain whether the evidence is relevant to the inquiry. If it is, the Committee should consider if it should go *in camera* to determine whether the witness should be allowed to continue to give their evidence in public.

In the witness is allowed to proceed, and the Committee determines that there has been an adverse reflection on a third party, it may offer the party an opportunity to reply to the allegations.

Mr Primrose noted that at a meeting of GPSC 1 earlier in the day, the committee resolved that the Clerk of the Committee should seek advice from the Clerk of the Parliament by Monday 16 February 2004 in relation to adverse comment and the right of reply, in order to provide consistency across committees.

Protection of public sector employees who participate in the in the inquiry
Concerns were raised by Committee members about ways to ensure public sector employees are afforded adequate protection is they wish to give evidence or a submission to the inquiry.

The Committee deliberated

Resolved on the motion of Mrs Forsythe that the Committee seek advice from the Clerk of the Parliament regarding (a) what powers a committee has to protect witnesses to ensure that witnesses appearing before it are not disadvantaged as a result of appearing before the committee, and (b) the powers of a committee to compel a witness to answer a question.

Witnesses and hearings
The Committee agreed to the following dates on which to hold public hearings and/deliberative meetings:

- **March**: 12, 19, 23, 24, 25, 26, (29 deliberative)
- **April** 30 (Reserve)

6. **Adjournment**
The Committee adjourned at 4.00 pm *sine die*

Minutes No 14
Thursday 26 February 2004
At Room 1136, Parliament House at 9:00 am

1. **Members Present**
Revd Dr Moyes (Chair)

Dr Chesterfield-Evans
Mrs Forsythe
Ms Parker
Mr Primrose (Catanzariti)

2. **Confirmation of minutes**
Resolved, on the motion of Mrs Forsythe, that minutes no 13 be confirmed.

3. **Correspondence**
The Chair noted the following items of correspondence:

Correspondence received

- Letter from the President of the Royal Australasian College of Surgeons, Ms Anne Kolbe to the Revd Gordon Moyes noting the intention of the College to make a submission after she has an opportunity to consult with various surgeons (9 February 2004)
- Letter from the editor of the Medical Journal of Australia, Mr Martin Van Der Weyden to the Revd Gordon Moyes declining an invitation to make a submission to the inquiry into complaint handling in NSW (16 February 2004)
- Letter from the NSW Ombudsman, Mr Bruce Barbour to the Revd Gordon Moyes declining an invitation to make a submission to the inquiry into complaint handling in NSW (18 February 2004)
- Letter from the Federal Secretary of the Australian Nursing Federation, Ms Jill Iliffe, to the Revd Gordon Moyes noting that correspondence in relation to the complaint handling inquiry had been sent to the NSW Nurses Association (20 February 2004)
- Letter from the Registrar, Nurses Registration Board, NSW, Mr RK Dwyer, to the Revd Gordon Moyes, noting that the Board will consider the invitation to make a submission at its next meeting to be held on 4 March 2004 (20 February 2004)
-

4. **Inquiry into complaint handling in NSW Health**

Hearing dates
The Committee considered the hearing schedule agree to at its previous meeting. Because of conflicting commitments it was decided to proceed with the half day hearing scheduled for 24 March, but to cancel the hearing scheduled for Thursday 25 March. This hearing will be rescheduled for Monday 29 March 2004.

Additional suggested witnesses
In addition to witnesses proposed by the secretariat, the Committee considered the following witnesses proposed by Mrs Forsythe and Dr Chesterfield-Evans:

Ministerial
Hon Craig Knowles MP – Minister for Infrastructure and Planning, and Minister for Natural Resources, former Minister for Health
Paul Levins – Chief of Staff to Hon Craig Knowles MP

NSW Health Department of Health
Robyn Kruk – Director General
Robert McGregor – Deputy Director General (Health System Support)
Dr Greg Stewart – Chief Health Officer, Deputy Director General (Population Health)
Liz Jakubowski – Director, Communications
Victoria Walker – Director, Audit

South Western Sydney Area Health Service
Associate Professor Deborah Picone – Administrator
Clair Cameron – Public Relations Officer
Susan Connelly – Public Relations Officer
Greg Driver – Human Resource Manager
Malcolm Masso – Director of Nursing, Macarthur Health Service
Lisa Cremmer – Nursing Unit Manager, Camden Hospital
Mary Dowling
Cathy Connor
Raad Richards – Chief Executive Officer, Carrington Hospital (aged care facility under SWSAHS)
Dr David Hugelmeyer – Director of Emergency Medicine, Macarthur Health Service
Manager of Emergency Department, Liverpool Hospital*

Central Sydney Area Health Service
Diana Horvath – Chief Executive Officer
Mike Wallace – Deputy Chief Executive Officer

North Sydney Area Health Service
Pat McDermot – Director, Communications

Nurses from South Western Sydney Area Health Service
Nola Fraser
Vanessa Bragg
Sheree Martin
Valerie Owen
Yvonne Quinn

Liverpool Hospital
Kathrine Grover.
Giselle Simmons

Consumer complainants from Campbelltown Hospital
Sarah Flegg
Peter Bentley

Other
Les Apolony – Chief Executive Officer, College of Presidents of Medical Colleges (CPMC) (CEO Australia and New Zealand College of Radiologists)*
Ian Badham – Director, NRMA CareFlight*
Association of Resident Medical Officers and Registrars

The Committee discussed a proposal that the former Minister for Health, The Hon Craig Knowles and his Chief of Staff, Mr Paul Levins, be invited to appear before the Committee as witnesses, and the powers of the committee to do so.

The Committee deliberated

Resolved on the motion of Mrs Forsythe that the Committee extend an invitation to the former Minister for Health, The Hon Craig Knowles and his Chief of Staff, Mr Paul Levins, to provide evidence to the inquiry into complaints handling.

The Committee deliberated.

Resolved, on the motion of Mr Primrose, that written advice be provided from the Clerks regarding the procedures and protocols relevant to witnesses who are subpoenaed to appear before a parliamentary committee, in particular, what should happen if a witness refuses to be sworn in or affirmed.

The Committee agreed that in addition to the list provided by Mrs Forsythe and Dr Chesterfield –Evans the Secretariat should contact the following people to give evidence to the Committee:

- Ms Amanda Adrian, former Health Care Complaints Commissioner
- Ms Jennifer Collins, former General Manager, Macarthur Health Service
- Mr Bruce Greathem and Mr Giles Yates, Health Care Complaints Commission
- Dr Jim Parker, Medical Staff Council, Campbelltown Hospital

5. **Adjournment**
The Committee adjourned at 9.40am *sine die*

Minutes No 15
Thursday 11 March 2004
At Room 1153, Parliament House at 10:00 am

1. **Members Present**
Revd Dr Moyes (Chair)
Dr Chesterfield-Evans
Mrs Forsythe
Ms Parker
Ms Robertson
Mr Primrose (Catanzariti)
Ms Fazio (Tsang)

2. **Confirmation of minutes**
Resolved, on the motion of Dr Chesterfield-Evans, that minutes no 14 be confirmed.

3. **Correspondence**
The Chair noted the following items of correspondence:

Correspondence received
Letter from Professor Bruce Barraclough, providing background information for his forthcoming appearance before the Committee (4 March 2004)

Correspondence sent
- Letter to Ms Robyn Kruk, Director General of NSW Health, inviting Ms Kruk and several officers or employees from NSW Health and various Health Services to appear as witnesses before the Committee (27 February 2004)
- Letter to Ms Robyn Kruk, asking her to forward a letter from the Committee to Ms Jennifer Collins, regarding an invitation to Ms Collins to appear as a witness to the Committee's inquiry (27 February 2004)
- Letter to Ms Amanda Adrian, former Health Care Complaints Commissioner, inviting Ms Adrian to appear as a witness before the Committee (2 March 2004)
- Letter to the Hon Craig Knowles MP, Minister for Infrastructure and Planning and Minister for Natural Resources, inviting Mr Knowles and his Chief of Staff Mr Paul Levins to appear as witnesses before the Committee (4 March 2004)
- Letter to Mr Bill Grant, Acting Commissioner, Health Care Complaints Commission, inviting Mr Grant and two other officers to appear as witnesses before the Committee (4 March 2004)

- Letter to Ms Robyn Kruk, regarding the rescheduling of the appearance of witnesses from Central Sydney Area Health Service (8 March 2004)
- Letter to the Hon Morris Iemma MP, Minister for Health, advising him of the appearance of departmental and AHS employees at forthcoming committee hearings (8 March 2004)

4. Inquiry into complaint handling in NSW Health

Meeting between the Chair and Ms Robyn Kruk, 9 March

Revd Moyes reported on his recent meeting with the Director General of NSW Health, Ms Robyn Kruk, to discuss the forthcoming public hearings, including concerns regarding patient confidentiality, the sub judice rule and dealing with adverse comments.

Staff briefing with witnesses

The Secretariat advised that they had held briefings with three of the nurse complainants and also with staff from SWSAHS to provide information on the inquiry process.

Request to provide in camera evidence

The secretariat advised that two nurse complainants, Ms Valerie Owens and Ms Yvonne Quinn had requested to give their evidence to the Committee in camera, but were willing for the transcript of their evidence to be made public.

The Committee deliberated

Resolved, on the motion of Ms Robertson, that evidence to be provided by Ms Owens and Ms Quinn on Friday 12 March, be taken in camera and subsequently published.

Additional suggested witnesses and scheduling of current witnesses

Dr Chesterfield-Evans tabled a list of additional prospective witnesses for forthcoming committee hearings

SWSAHS
Dr Mary Pendergast
Dr Eddie Lim
Dr Richard Cracknell

NSW Nurses Association
Ms Jan Grieg
Ms Kath Sullivan

NSW College of Nursing
Ms Leanne Lancaster

NSW Ambulance Service
…

The Committee deliberated

Resolved, on the motion of Mrs Forsythe, that the Committee invite the additional witnesses suggested by Dr Arthur Chesterfield-Evans to provide evidence to the inquiry into complaints handling procedures in NSW Health.

Dr Arthur Chesterfield Evans requested that the doctors from SWSAHS scheduled to appear on 19 March 2004 should appear at the same time, rather than in two separate groups, as indicated in the draft schedule.

The Committee deliberated.

Resolved, on the motion of Dr Chesterfield-Evans, that the doctors from SWSAHS who are scheduled to appear on 19 March 2004, appear as a group at 3.30pm.

Submissions received
The Committee Director advised members of the Committee that a CD Rom of submissions 1-51 and 55 has been distributed. He tabled a list of submissions the secretariat considers should remain fully or partly confidential, due to concerns about patient confidentiality and adverse comments.

The Committee deliberated

Resolved, on a motion of Ms Robertson that:

- the Committee publish the following submissions in full: 2,3,7-9,11-19,21,23-26,28-37,39-44,46-48,and 51-54
- the Committee publish the following submissions in part:1,5,6,10,20,27,38,45,50, and 55
- the Committee keep the following submissions confidential: 4,22,49, and 49a.

5. Adjournment
The Committee adjourned at 10.10am *sine die*

Minutes No 16
Friday 12 March 2004
At the Jubilee Room, Parliament House at 9:30 am

1. **Members Present**
Revd Dr Moyes (Chair)
Dr Chesterfield-Evans
Mrs Forsythe
Ms Parker
Ms Robertson
Mr Primrose (Catanzariti)
Ms Fazio (Tsang)

2. **Public Hearing – Inquiry into Complaints Handling Procedures in NSW Health**

Witnesses, the public and media were admitted

The Chairman made an opening statement regarding adverse comments, sub judice issues, patient confidentiality and the broadcasting of proceedings.

The following witnesses were sworn and examined:
- Ms Nola Fraser
- Ms Vanessa Bragg
- Ms Katherine Grover
- Ms Sheree Martin

The evidence was concluded and the witnesses withdrew.

The public and the media withdrew.

The Committee proceeded to take in camera evidence, as per Committee resolution of 11 March 2004.

The following witnesses were sworn and examined:

- Ms Valerie Owens
- Ms Yvonne Quinn

[Persons present other than the Committee: Mr Steven Reynolds, Ms Beverly Duffy, Ms Madeleine Foley, Ms Ashley Toms, Mr Warren Cahill and CAT reporters]

The evidence was concluded and the witnesses withdrew

The in camera evidence concluded and the media and the public were re-admitted.

The Committee resumed taking evidence in public.

The following witness continued to give her evidence having been previously sworn and examined

- Ms Vanessa Bragg

The following witness was sworn and examined:

- Ms Sara Flegg

The evidence was concluded and the witnesses withdrew

The following witnesses were sworn and examined:

- Mr Brett Holmes General Secretary, NSW Nurses' Association
- Ms Jan Grief Organiser, NSW Nurses' Association
- Ms Katherine Sullivan Community and Government Relations Officer, NSW Nurses' Association
- Ms Angela Garvey Professional Officer, NSW Nurses' Association.

The evidence was concluded and the witnesses withdrew

The following witnesses were sworn and examined:

- Ms Kate Dyer Deputy Chair, Nurses Registration Board of NSW
- Mr Irving Wallach Chairman, NSW Nurses Tribunal

The evidence was concluded and the witnesses withdrew

The following witnesses were sworn and examined:

- Professor Brian McCaughan, President, NSW Medical Board
- Ms Anne Scahill Deputy Registrar, NSW Medical Board

The evidence was concluded and the witnesses withdrew.

The public hearing was concluded and the media and public withdrew.

3. Deliberative meeting – Inquiry into Complaints Handling Procedures in NSW Health

Publication of in camera evidence
Resolved, on the motion of Mr Primrose, that the evidence provided by Ms Yvonne Quinn and Ms Valerie Owens, be published.

4. Adjournment
The Committee adjourned at 4.30pm until 9.30am on Friday 19 March 2004

Minutes No 17
Friday 19 March 2004
At the Jubilee Room, Parliament House at 9:30 am

1. Members Present
Revd Dr Moyes (Chair)
Dr Chesterfield-Evans
Mrs Forsythe
Ms Parker
Ms Robertson
Mr Primrose (Catanzariti)
Ms Fazio (Tsang)

2. Public Hearing – Inquiry into Complaints Handling Procedures in NSW Health

Witnesses, the public and media were admitted

The Chairman made an opening statement regarding adverse comments, sub judice issues, patient confidentiality and the broadcasting of proceedings.

The following witnesses were sworn and examined:

- Ms Robyn Kruk, Director General, NSW Heath Department
- Mr Robert McGregor, Deputy Director General, NSW Heath Department
- Dr Greg Stewart, Deputy Director General, NSW Heath Department
- Ms Liz Jakubowski, Director, Communications, NSW Heath Department
- Ms Victoria Walker, Director, Audit, NSW Heath Department
- Ms Deborah Green, CEO, South Eastern Sydney Area Health Service

Ms Kruk tendered correspondence containing her referral to the HCCC and the ICAC of matters raised by the complainant nurses; and correspondence with Ms Yvonne Quinn regarding referral of matters to the HCCC and the ICAC.

The evidence was concluded and the witnesses withdrew.

The following witness was sworn and examined:

- Ms Lorraine Long, Chief Executive, Medical Error Action Group

The evidence was concluded and the witness withdrew

3. Deliberative - Inquiry into Complaints Handling Procedures in NSW Health
12.15pm-12.25 pm

Confirmation of Minutes 15 and 16

Resolved, on the motion of Ms Fazio, that minutes no 15 and 16 be confirmed.

Transcript of previous health estimates hearings

Ms Robertson requested that the transcript of previous estimates committee hearings examining the health portfolio be available to participants in the Committee's inquiry into complaints handling.

The Committee deliberated

Resolved, on the motion of Dr Chesterfield-Evans, that copies of the transcript of two previous hearings of the estimates committee examining the health portfolio (25 November and 1 December 2003) be included with the transcripts of the Committee's current inquiry into complaint handling currently available on the Parliamentary website.

Publication of submissions
The Committee Director advised that an updated CD Rom of submissions has been circulated, which includes the submissions received since 11 March 2004

Resolved, on the motion of Ms Fazio that submissions 56-61, 63, 65 and 66 be published and 62 be published with the authors name withheld.

Publication of tendered documents
Resolved, on the motion of Ms Fazio, that correspondence tendered by Ms Kruk be published.

Request to give evidence in camera
Resolved, on the motion of Dr Chesterfield-Evans, that Ms Giselle Simmons be permitted to give evidence in camera on 23 March 2004, as per her request.

Witnesses, the public and media were admitted

The following witness was sworn and examined:

- Professor Bruce Barraclough, Chairman, NSW Institute of Clinical Excellence.

The evidence was concluded and the witness withdrew

The following witnesses were sworn and examined:
- Assoc. Prof Deborah Picone, Administrator, South Western Sydney Area Health Service (SWSAHS)
- Ms Clair Cameron, Public Relations, SWSAHS
- Mr Greg Driver, Area Human Resources Manager, SWSAHS
- Ms Mary Dowling, Manager, Professional Practice Unit, SWSAHS
- Dr Raad Richards, Chief Executive Officer, Carrington Centennial Hospital
- Ms Susan Connelly, Public Relations, SWSAHS
- Ms Lisa Kremmer, Nursing Unit Manager, Emergency Dept, Camden Hospital
- Ms Catherine O'Connor, Nursing Unit Manager, Intensive Care Unit, Campbelltown Hospital
- Mr Malcolm Masso, Senior Research Fellow, Centre for Health Services Development, University of Wollongong

The evidence was concluded and the witnesses withdrew

The following witnesses were sworn and examined:

- Dr David Hugelmeyer, Director of Emergency Dept, Campbelltown Hospital
- Dr Richard Cracknell, Director of Emergency Dept, Liverpool Hospital
- Dr James Parker, Medical Staff Council, SWSAHS
- Dr Eddie Lim, VMO, SWSAHS
- Dr Mary Prendergast, VMO, SWSAHS

The evidence was concluded and the witnesses withdrew.

The public hearing was concluded and the media and public withdrew.

4. **Adjournment**
The Committee adjourned at 4.30pm until 9.30am on Tuesday 23 March 2004

Minutes No 18
Tuesday 23 March 2004
At the Jubilee Room, Parliament House at 9:30 am

1. **Members Present**
Revd Dr Moyes (Chair)
Dr Chesterfield-Evans
Mrs Forsythe
Ms Parker
Ms Robertson
Mr Catanzariti
Ms Fazio (Tsang)

2. **Public Hearing – Inquiry into Complaints Handling Procedures in NSW Health**

Witnesses, the public and media were admitted

The Chairman made an opening statement regarding adverse comments, sub judice issues, patient confidentiality and the broadcasting of proceedings.

The following witnesses were sworn and examined:

- Mr Peter Mylan, Assistant Secretary, Health Services Union
- Dr Anthony Llewellyn, Member, Health Services Union

The evidence was concluded and the witnesses withdrew.

The following witnesses were sworn and examined:

- Ms Pat McDermott, Head of Public Relations and Fundraising, North Sydney Area Health Service
- Dr Stephen Christley, CEO, Northern Sydney Area Health Service

The evidence was concluded and the witnesses withdrew

The following witness was sworn and examined:

- Ms Fiona Tito-Wheatland, Phd Scholar, ANU Research School of Social Sciences

The evidence was concluded and the witness withdrew

The public and the media withdrew

3. Deliberative meeting - **Inquiry into Complaints Handling Procedures in NSW Health, 12.20pm -12.30 pm**

Recall of witnesses
Resolved, on the motion of Mrs Forsythe, that the following doctors be requested to reappear before the Committee:
- Dr Mary Prendergast
- Dr David Hugelmeyer
- Dr James Parker

The Committee discussed the most appropriate hearing date for the reappearance of the doctors from SWSAHS.

Mrs Forsythe moved that the doctors be requested to appear before the Committee on the 24 March 2004.

Question put.

Ayes: Ms Forsythe
Ms Parker

Noes: Ms Robertson
Ms Fazio
Mr Catanzariti
Dr Chesterfield-Evans
Revd Dr Moyes

Question resolved in the negative.

Dr Chesterfield-Evans moved that the three doctors from SWSAHS who previously appeared before the Committee on 19 March 2004, be requested to appear before the Committee on the 30 April 2004.

Question put.

Ayes: Ms Robertson
Ms Fazio
Mr Catanzariti
Dr Chesterfield-Evans
Revd Dr Moyes

Noes: Ms Forsythe
Ms Parker

Letter from Ms Victoria Walker
The Chair circulated a letter from Ms Victoria Walker, Director of Audit, NSW Health, dated 23 March 2004 to the Committee Chair, correcting her statements regarding receipt of an email from a nurse complainant made in evidence on 19 March 2004.

The Committee deliberated

Resolved, on the motion of, Mrs Forsythe, that the letter from Ms Victoria Walker, dated 23 March 2004, be published.

Witnesses, the public and media were admitted

The following witnesses were sworn and examined:

- Mr Bill Grant, A/Commissioner, Health Care Complaints Commission (HCCC)
- Mr Bruce Greetham, Former Manager, Partnerships & Quality, HCCC
- Mr Giles Yates, Investigation & Resolution Officer, HCCC
- Ms Susan Donnelly, Assistant Commissioner, HCCC
- Mr Brian McMahon, Manager, Patient Support Service, HCCC

The evidence was concluded and the witnesses withdrew.

The following witnesses were sworn and examined:

- Mr Brian Johnston, CEO, Australian Council on Health Care Standards
- Ms Heather McDonald, Executive Manager Customer Services, Australian Council on Health Care Standards

The evidence was concluded and the witnesses withdrew.

The following witnesses were sworn and examined:

- Mr Geoff Dulhunty, A/ Executive Director, The College of Nursing
- Ms Leanne Lancaster, Educator, The College of Nursing

The evidence was concluded and the witnesses withdrew.

The public and media withdrew

The Committee proceeded to take in camera evidence, as resolved at meeting no.17.

The following witness was sworn and examined

- Ms Giselle Simmons

[Persons present other than the Committee: Mr Steven Reynolds, Ms Beverly Duffy, Ms Madeleine Foley, and Hansard Reporters]

The evidence was concluded and the witness withdrew.

Resolved, on the motion of Mrs Forsythe, that the evidence provided by Ms Giselle Simmons be published.

4. **Adjournment**
   The Committee adjourned at 5.15pm until 9.30am on Wednesday 24 March 2004

Minutes No 19
Wednesday 24 March 2004
At the Jubilee Room, Parliament House at 9:30 am

1. **Members Present**
   Revd Dr Moyes (Chair)
   Mrs Forsythe
   Ms Robertson
   Mr Primrose (Catanzariti)
   Ms Fazio (Tsang)

2. **Apologies**
   Ms Parker; Dr Chesterfield-Evans

3. **Public Hearing – Inquiry into Complaints Handling Procedures in NSW Health**

   Witnesses, the public and media were admitted

   The Chairman made a brief opening statement.

   The following witness was sworn and examined:

   - Ms Wendy McCarthy, Chair, NSW Health Participation Council

   The evidence was concluded and the witness withdrew.

   The following witness was sworn and examined:

- Mr Allen Thomas, Director, Medico-Legal, Strategic Policy & Training, Australian Medical Assoc. (NSW) Limited

The evidence was concluded and the witness withdrew

The following witness was sworn and examined:

- Mr David Brown, General Manager, Legal Division, United Medical Protection

The evidence was concluded and the witness withdrew

The public hearing was concluded and the media and public withdrew

4. Adjournment
The Committee adjourned at 11.30am until 9.30am on Monday 29 March 2004

Minutes No 20
Monday 29 March 2004
Meeting room 814/815, Parliament House at 9.30am

1. Members Present
Revd Dr Moyes (Chair)
Mrs Forsythe
Ms Robertson
Mr Primrose (Catanzariti)
Ms Fazio (Tsang)
Ms Parker
Dr Chesterfield-Evans

2. Public Hearing – Inquiry into Complaints Handling within NSW Health
Witnesses, the public and media were admitted

The Chairman made an opening statement regarding adverse comments, sub judice issues, patient confidentiality and the broadcasting of proceedings.

Ms Jennifer Collins, former General Manager, Macarthur Health Service was sworn in and examined.

The evidence was concluded and the witness withdrew.

Ms Beth Wilson, Health Services Commissioner, Victoria was sworn in and examined.

The evidence was concluded and the witness withdrew

Dr Katherine McGrath, Deputy Director General, Health System Performance, and Dr Alan Spigelman, Director, Clinical Governance, Hunter Area Health Service were sworn in and examined.

The evidence was concluded and the witnesses withdrew

Dr Diana Horvath, Chief Executive Officer, and Mr Mike Wallace, Deputy CEO, Central Sydney Area Health Service were sworn in and examined.

The evidence was concluded and the witnesses withdrew

Ms Merrilyn Walton, Associate Professor, Ethical Practice, University of Sydney was sworn in and examined.

The evidence was concluded and the witness withdrew

Ms Amanda Adrian, former Commissioner, NSW Health Care Complaints Commission was sworn in and examined.

Ms Adrian tendered a full version of her opening statement to the Committee

The public hearing was concluded and the media and public withdrew

3. Deliberative meeting – Inquiry into Complaints Handling Procedures in NSW Health

Confirmation of Minutes
Resolved, on the motion of Ms Fazio, that minutes 17, 18 and 19 be confirmed.

Correspondence
Correspondence received

- Letter from Catherine Follent, solicitor to Special Commission of Inquiry into Campbelltown and Camden Hospitals to secretariat providing copy of advertised hearing (15 March 2004)
- Letter from Ms Robyn Kruk, Director-General, NSW Health to Committee Chair regarding the attendance of Dr Stephen Christley at the hearing (16 March 2004)
- Email from Ms Yvonne Quinn to secretariat responding to evidence by Brett Holmes, Kathryn Sullivan and Robyn Kruk (20 March, previously circulated)
- Email from Dr Chesterfield-Evans to secretariat enclosing his submission to the Walker Inquiry (10 March 2004, attached)
- Email from Dr Hugelmeyer regarding his inability to attend the Committee hearing scheduled for 30 April, and suggesting several other alternative dates (29 March 2004)

Correspondence sent
- Letter to Ms Sara Flegg from secretariat regarding question taken on notice during hearing (24 March 2004)
- Letter to Ms Nola Fraser from secretariat regarding question taken on notice during the hearing (24 March 2004)
- Letter to Ms Kate Dyer, Deputy Chair, Nurses Registration Board, from secretariat regarding question taken on notice (24 March 2004).

Public hearing 30 April
Resolved, on the motion of Ms Robertson, that the witnesses from SWSAHS scheduled to give evidence on 30 April, appear in two groups.

Resolved on the motion of Mr Primrose that the Committee invite the following witnesses to give evidence on 30 April 2004:
- CEO, NSW Ambulance Service
- Ambulance officer from SWSAHS, identified by Dr Chesterfield –Evans.

Additional hearing, 29 April
The Committee noted Dr Hugelmeyer's unavailability to attend the hearing on 30 April.

The Committee deliberated.

Resolved, on the motion of Mrs Forsythe, that Dr Hugelmeyer be invited to appear before the Committee on Tuesday 29 April 2004, at 5pm.

Request for documents
Resolved, on the motion of Ms Robertson, that the Committee request the following documents referred to in evidence, from the relevant agencies:

- NSW Health Care Complaints Commission
    - Interim report in relation to the disciplinary action taken against the nurse informants provided to South Western Sydney Area Health Service in January 2003
    - Information on all the clinical incidents at Camden and Campbelltown Hospitals provided to South Western Sydney Area Health Service in June 2003
    - Preliminary investigation report provided to South Western Sydney Area Health Service in August 2003.

- NSW Health
    - Evaluation report prepared by the Australian Council on Healthcare Standards on Macarthur Health Service
    - Report prepared by Ms Jan Stow on the operating theatres at Campbelltown Hospitals
    - Report of the Expert Clinical Review Team led by Professor Bruce Barraclough on Macarthur Health Service
    - Report prepared by the South Western Sydney Area Health Service audit team regarding medical records following the break-ins at Camden and Campbelltown Hospitals.

Request for documents from Ms Kruk, regarding Ms Yvonne Quinn's alleged concerns
Resolved, on the motion of Mr Primrose, that the Committee request Ms Kruk to provide a letter referred to in her evidence, relating to Ms Yvonne Quinn's alleged concerns about clinical issues at Camden/Campbelltown hospitals.

Submissions and tendered documents
Resolved, on the motion of Mr Primrose that submissions no 64 and 68 remain confidential and that submission no 67 and the opening statement tendered by Ms Adrian, be made public.

4. **Adjournment**
The Committee adjourned at 5.25pm until 5.00pm, Thursday 29 April 2004

Minutes No. 21
Thursday 29 April 2004
Jubilee Room, Parliament House at 4.45pm

1. **Members Present**
Dr Chesterfield-Evans
Ms Fazio (Tsang)
Ms Parker
Mr Primrose (Catanzariti)
Ms Robertson
Mr Ryan (Forsythe)

2. **Apologies**
Dr Moyes

3. Substitute arrangements

The Chair advised that Mr Ryan would be representing Mrs Forsythe

4. Deliberative meeting - inquiry into complaints handling within NSW Health

The Director announced that, as the Chair and Deputy Chair were unable to attend today's proceedings, it was necessary to select a member to be chair before the committee proceeded to the despatch of business.

The Director called for nominations for the Office of Chair.

Ms Parker proposed to the Committee and moved that, Dr Arthur Chesterfield-Evans do take the Chair of this Committee.

Debate ensued.

Ms Fazio proposed to the Committee and moved that, Ms Robertson do take the Chair of this Committee.

Debate ensued.

The Director informed the Committee that there being two nominations, a ballot would be held.

Ballot papers were distributed by the Director and members lodged their votes.

The Director announced the result of the ballot as follows:

Dr Arthur Chesterfield-Evans – 3 votes
Ms Robertson – 3 votes

There being no member with a majority of votes, the Director proposed to repeat the ballot.

Resolved, on the motion of the Mr Primrose, that for the purposes of the present meeting, that the Director should draw by lot the name of the Chair.

The Director drew the name of Ms Robertson. Ms Christine Robertson was therefore elected Chair of the Committee for the purposes of the present meeting.

Ms Robertson took the Chair.
Confirmation of Minutes 20
Resolved, on the motion of Ms Fazio, that Minutes No. 20 be confirmed.

Correspondence

Correspondence received
- Letter from Mr RK Dwyer, Registrar, Nurses Registration Board to the Chair, providing answers to questions taken on notice by Ms Kate Dyer during the public hearing on 12 March 2004. (19 April 2004)
- Fax from Ms Lorraine Long, Founder, Medical Error Action Group to the Director, providing answers to questions taken on notice during the public hearing on 19 March 2004. (14 April 2004)
- Letter from Judge KV Taylor, Acting Commissioner, Health Care Complaints Commission to the Director, providing further information requested by the Committee in relation to Mr Bill Grant, former Acting Commissioner. (14 April 2004)
- Letter from Ms Robyn Kruk, Director-General, NSW Health to the Director, providing further information requested by the Committee in relation to Ms Quinn. (13 April 2004)
- Email from Ms Yvonne Quinn to the Chair, in response to evidence given by Ms Jennifer Collins at the public hearing on 29 March 2004. (7 April 2004)
- Letter from Judge KV Taylor, Acting Commissioner, Health Care Complaints Commission to the Director, in response to the Committees' request for documents relating to the Macarthur Health Service investigation. (7 April 2004)
- Letter from Mr Malcolm Masso, providing clarification to evidence he gave at the public hearing on 19 March 2004. (2 April 2004)
- Letter from Assoc Prof Deborah Picone, Administrator SWSAHS, providing further information requested by the Committee in relation to Ms Audrey Daly-Hamilton. (24 April 2004)
- Letter from Ms Leanne Wallace, NSW Health, providing answers to questions taken on notice. (27 April 2004)
- (Confidential) Letter from Ms Victoria Walker, Director, Audit, NSW Health, relating to her previous evidence to the Committee. (27 April 2004)

Resolved, on the motion of Mr Ryan, that correspondence from Ms Victoria Walker dated 27 April 2004 be made confidential.

Correspondence sent
- Letter to Ms Robyn Kruk, Director-General, NSW Health from the Director, requesting further information relating to evidence provided at the public hearing on 19 March 2004.
- Letter to Ms Lorraine Long, Founder, Medical Error Action Group from the Director, requesting answers to questions taken on notice at the public hearing on 19 March 2004.
- Letter to Assoc. Prof Deborah Picone, Administrator, South Western Sydney Area Health Service from the Director, requesting answers to questions taken on notice at the public hearing on 19 March 2004.

- Letter to Ms Wendy McCarthy, Chair, NSW Health Participation Council from the Director, requesting answers to questions taken on notice at the public hearing on 19 March 2004.
- Letter to Mr Bill Grant, former Acting Commissioner, Health Care Complaints Commission from the Director, requesting answers to questions taken on notice at the public hearing on 23 March 2004.
- Letter to Judge Kenneth Taylor, Acting Commissioner, Health Care Complaints Commission from the Director, requesting copies of a number of documents produced by the HCCC to assist the Committee with their inquiry.
- Letter to Ms Robyn Kruk, Director-General, NSW Health from the Director, requesting copies of a number of documents produced by NSW Health to assist the Committee with their inquiry.

Publication of submissions

Resolved, on the motion of the Mr Ryan, that submission No. 69 be partially confidential, submission No 70 remain confidential and submission No. 71 be made public.

4. Public Hearing - Inquiry into Complaints Handling within NSW Health

The witness, the public and media were admitted

The Chair made an opening statement.

The following witness was examined under his former oath:

Dr David Hugelmeyer, Director of Emergency Medicine, Macarthur Health Service

Dr Hugelmeyer tabled a draft letter of resignation drafted by Dr Hegelmeyer, but not tendered to Ms Jennifer Collins

Resolved, on the motion of Ms Fazio, that the committee accept the document.

Dr Hugelmeyer tabled a copy of an Emergency Department 'Code Red' Log.

Resolved, on the motion of the Mr Ryan, that the committee accept the document.

Dr Hugelmeyer tabled a document entitled News Release: Statement re Macarthur Health Service, 11 October 2002.

Resolved, on the motion of Ms Parker, that the committee accept the document.

Dr Hugelmeyer tabled a copy of a memo written by Dr Hugelmeyer to Ms Jennifer Collins, dated 25 September 2002.

Resolved, on the motion of the Ms Parker, that the committee accept the document.

The evidence was concluded and the witness withdrew.

The public hearing was concluded and the media and public withdrew.

5. Adjournment

The Committee adjourned at 6.45pm until 9.30 am Friday 30 April 2004.

Minutes No 22
Friday, 30 April 2004
Meeting room 814/815, Parliament House at 9.30am

1. Members Present
Mrs Forsythe (Deputy Chair)
Ms Robertson
Ms Fazio (Tsang)
Ms Parker
Dr Chesterfield-Evans

2. Apologies
Dr Moyes
Mr Primrose (Catanzariti)

3. Public Hearing – Inquiry into Complaints Handling within NSW Health
Witnesses, the public and media were admitted

The Deputy Chair made an opening statement regarding adverse comments, sub judice issues, patient confidentiality and the broadcasting of proceedings.

The following witnesses were sworn and examined:

Associate Professor John Cartmill, Department of Surgery, University of Sydney

Professor Stewart Dunn, Professor of Psychological Medicine, Department of Psychological Medicine

Associate Professor Cartmill tendered his opening statement and written answers to indicative questions, previously provided by the Committee.

Resolved, on the motion of Ms Parker, that the Committee accept the documents.

The evidence was concluded and the witnesses withdrew.

The following witnesses were sworn and examined:

- Mr Greg Rochford, Chief Executive Officer, NSW Ambulance Service.
- Ms Louise Ashelford, Acting Manager, Professional Conduct and Standards Unit, NSW Ambulance Service.

The evidence was concluded and the witnesses withdrew.

The following witnesses were examined under their former oaths:

- Ms Robyn Kruk, Director General, NSW Health
- Ms Liz Jakubowski, Director, Communications, NSW Health
- Mr Robert McGregor, Deputy Director General, NSW Health

Ms Kruk tabled copies of Memoranda from successive NSW Premier's relating to the provision of information and evidence to parliamentary committees.

Resolved, on the motion of Ms Robertson, that the Committee accept the documents.

The evidence was concluded and the witnesses withdrew.

The following witnesses were examined under their former oaths:

- Mr Greg Driver, Area Human Resources Manager, South Western Sydney Area Health Service
- Ms Lisa Kremmer, Nursing Unit Manager, Emergency Department, South Western Sydney Area Health Service
- Mr Raad Richards, Chief Executive Officer, Carrington Centennial Trust.

The Deputy Chair directed that the public record expunge the name of a staff member from SWSAHS whose name was mentioned in relation to a sexual assault complaint, and that the media be prohibited from broadcasting the person's name.

The evidence was concluded and the witnesses withdrew.

The following witnesses were examined under their former oaths:

- Ms Catherine O'Connor, Nursing Unit Manager, South Western Sydney Area Health Service
- Assoc Professor Deborah Piccone, Administrator, South Western Sydney Area Health Service
- Mr Malcolm Masso, Senior Research Fellow, Centre for Health Services Development, Wollongong University.

Ms Piccone tabled a folder of documents prepared by the Structural Reform Branch to inform SWSAHS employees about the operation of parliamentary committees; a Review of Maternal and Perinatal services in SWSAHS (the Henderson-Smart report) dated March 2004 and the second interim report on the Implementation of the Recommendations of the Barraclough Review Team, dated 9 April 2004.

Resolved, on the motion of Ms Fazio, that the Committee accept the documents and that the second interim report on the implementation of the Barraclough Review be made confidential.

The evidence was concluded and the witnesses withdrew.

The following witnesses were sworn and examined:

- Assoc Professor Brad Frankum, Director of Medicine, Macarthur Area Health Service
- Prof Jeremy Wilson, Director of Medicine, Bankstown Hospital
- Dr Stephen Della-Fiorentina, Director, Macarthur Cancer Therapy Centre
- Dr Amanda Walker, Director, Palliative Care Unit, Camden Hospital

The following witness was examined under her former oath:

Dr Mary Prendergast, Visiting Medical Officer, Macarthur Area Health Service

The evidence was concluded and the witnesses withdrew.

The public hearing was concluded and the media and public withdrew.

4. **Deliberative meeting – Inquiry into Complaints Handling Procedures in NSW Health**

Correspondence received

- Letter to the Chair from the former Minister for Health, the Hon Craig Knowles declining the Committee's invitation to provide evidence to the Health Complaints inquiry (30 April 2004).
- Letter from Ms Robyn Kruk responding to the Committee's request for certain documents relevant to the inquiry (29 April 2004).

Status of correspondence from Ms Kruk

The Director advised that Ms Kruk has requested that one of the documents provided on 29 April 2004 to the Committee, The Stowe Report, be kept confidential. The document and several other confidential documents are available for viewing by Members in the Office of the Clerk of the Parliaments.

Status of tendered documents

Ms Fazio moved that the 'code red' Log tendered by Dr Hugelmeyer on 29 April be not made public.

The Committee deliberated

The question was resolved in the negative.

Resolved, on the motion of Ms Fazio, that a decision regarding the publication of the memo tendered by Dr Hugelmeyer on 29 April be deferred pending confirmation by the secretariat of the status and origin of the document.

Additional public hearing

Resolved, on the motion of Ms Robertson, that Professor Deb Picone be invited to reappear before the Committee within the next two weeks.

Adverse mention

Resolved, on the motion of Ms Robertson, that the Chair write to Dr Helen Parsons, inviting her to provide a response in relation to the adverse mention against her made in evidence to the Committee on 29 April 2004.

Privacy issue

Resolved, on the motion of Ms Fazio, that in consultation with the committee clerk, the Chair confer with NSW Health regarding the inadvertent naming of an person identified as an employee of SWSAHS in relation to a sexual assault complaint, suggesting appropriate support be provided to the employee, if required.

5. **Adjournment**
The Committee adjourned at 5.40pm sine dine.

Minutes No 23
Friday, 21 May 2004
Meeting room 814/815, Parliament House at 9.30am

1. **Members Present**
Revd. Gordon Moyes
Mrs Forsythe
Ms Robertson
Ms Fazio (Tsang)
Ms Parker
Mr Primrose (Catanzariti)
Mr Gallacher (participating member)

2. **Apologies**
Dr Chesterfield-Evans

3. **Public Hearing – Inquiry into Complaints Handling within NSW Health**
Witnesses, the public and media were admitted

The Chair made an opening statement regarding adverse comments, sub judice issues, patient confidentiality and the broadcasting of proceedings.

The following witnesses were sworn and examined:

- Associate Professor Debora Picone, Administrator, South West Sydney Area Health Service
- Ms Robyn Kruk, Director General, NSW Health

The evidence was concluded and the witnesses withdrew.

The public hearing was concluded and the media and public withdrew.

4. Deliberative meeting – Inquiry into Complaints Handling Procedures in NSW Health

Confirmation of minutes

Resolved, on the motion of Ms Fazio, that minutes no 21 and 22 be published.

Publication of Submission

Resolved, on the motion of Ms Fazio, that the supplementary submission from NSW Health be published.

Correspondence received

- Letter from Assoc Professor Deborah Picone to the Chair informing the Committee that Dr Helen Parsons is employed at Macarthur Health Service, not Liverpool Health Service
- Letter from Ms Robyn Kruk, Director-General NSW Health, to the Chair requesting permission to appear as a witness on the same day as Assoc Professor Picone, and would use the opportunity to table a second submission
- Letter from Mr Chris Simmons to the Chair responding to the testimony of Ms Giselle Simmons at the hearing on 23 March 2004
- Fax from Ms Lorraine Long, Founder, Medical Error Action Group, to the Committee Director responding to the testimony of Dr Stephen Christley, CEO Northern Sydney AHS at the hearing on 23 March 2004

Correspondence sent

- Letter to Mr Chris Simmons from the Committee Director, providing Mr Simmons with an opportunity to correct alleged factual inaccuracies in the testimony of Ms Giselle Simmons of 23 March 2004 (20 April 2004)
- Letter to Dr Helen Parsons from the Chair providing Dr Parsons with an opportunity to respond to testimony at the hearings on Thursday 29 and Friday 30 April 2004 (4 May 2004)
- Letter to Mr Greg Rochford, CEO Ambulance Service of NSW, requesting an answer to a question taken on notice at the hearing on 30 April 2004 (5 May 2004)
- Letter to Mr Robert McGregor, Deputy Director-General NSW Health, requesting answers to questions taken on notice at the hearing on 30 April 2004 (5 May 2004)
- Letter to Ms Lisa Kremmer, Nursing Unit Manager SWSAHS, requesting an answer to a question taken on notice at the hearing on 30 April 2004 (5 May 2004)
- Letter to Ms Robyn Kruk, Director-General NSW Health, requesting an answer to a question taken on notice at the hearing on 30 April 2004 (5 May 2004)
- Letter to Assoc Professor Deborah Picone, Administrator SWSAHS, requesting answers to questions taken on notice at the hearing on 30 April 2004 (5 May 2004)

Inadvertent naming of a complainant regarding a sexual assault matter

The secretariat advised that, following the inadvertent naming of a person during the Committee's hearing on 30 April, steps had been taken by the secretariat to contact the person regarding any concerns, but that the two calls to the persons have not been returned. The secretariat further advised that the person is no longer an employee of NSW Health.

Response from Mr Chris Simmons to testimony of Ms Giselle Simmons

The Committee considered a draft letter as response.

Resolved, on the motion of Ms Fazio, that the response be sent to Mr Simmons.

Adverse mention

Resolved, on the motion of Ms Fazio, that the Committee write to Ms Lisa Kremmer and Dr Helen Parsons regarding the possible adverse mention during the hearing on 30 April 2004.

Tabling Date for Report

Resolved, on the motion of Mr Primrose, that the Committee table the report on 24 June, and meet to consider the Chair's draft on 17 June (10 until 4) and 22 June during the dinner break.

The secretariat indicated the Chair's draft would be delivered to the Committee by 8 June.

Request from Ms Lorraine Long to publish correspondence

Resolved, on the motion of Ms Robertson, that the letter from Ms Long be published.

5. Adjournment

The Committee adjourned at 12:20pm until 17 June 2004.

Minutes No 25
Thursday 17 June 2004
10:00 am in room 1108, Parliament House

1. **Members Present**
Revd. Dr Gordon Moyes (Chair)
Mrs Patricia Forsythe
Ms Christine Robertson
Ms Amanda Fazio (Tsang)
Mr Peter Primrose (Catanzariti)
Ms Robyn Parker
Dr Arthur Chesterfield-Evans

2. **Confirmation of Minutes**
Resolved, on the motion of Ms Robertson, that minutes nos 23 and 24 be confirmed.

3. **Correspondence**
Correspondence received
- Letter from RL Whyburn and Associates, solicitor for Lisa Kremmer seeking further detail of allegations made against her by Mrs Forsythe during hearing (8 June 2004,)
- Letter from A Professor Debora Picone responding to matters raised during her evidence to the Committee on 21 May 2004 (2 June 2004)
- Letter from Dr Helen Parsons, Medical Director, Macarthur Health Service, in response to the Committee's letter 4 May regarding possible adverse reflections (27 May 2004)
- Letter from A Professor Picone responding to questions taken on notice during the hearing on 30 April 2004 (21 May 2004)
- Letter from Greg Rochford, CEO Ambulance Service of NSW responding to questions on notice taken during the hearing on 21 May 2004 (26 May 2004)
- Letter from A Prof Picone clarifying aspects of her evidence provided on 21 May 2004 regarding referral of a doctor to the NSW Medical Board (21 May 2004)
- Letter from the Hon Patricia Forsythe, requesting a meeting to discuss a proposed self reference by the Committee (2 June 2004)

Correspondence sent
- Letter to Dr Helen Parson Medical Director, Macarthur Health Service regarding possible adverse reflections during hearing on 21 May 2004 (27 May 2004)
- Letter to Ms Lisa Kremmer, Nursing Unit Manager, SWSAHS, regarding possible adverse reflections during hearing on 21 May 2004, (27 May 2004)
- Letter to A Professor Picone regarding question taken on notice during the hearing on 21 May 2004 (26 May 2004)
- Letter to the Minister for Health regarding the review of rotary wing services in NSW (7 June 2004)

4. **Inquiry into Health Complaints Handling**

Request from Lisa Kremmer's solicitor for further details of allegations made
Resolved, on the motion of Ms Fazio, that Ms Kremmer or her solicitor be asked to make a response to the specific allegation made during the hearing only, which may be then attached to the website.

Response from Dr Helen Parsons re adverse mention
Resolved, on the motion of Ms Fazio, that Dr Parsons' response be published and appended on the website next to the transcript to which it refers.

Publication of answers to questions on notice from hearing of 21 May 2004
Resolved, on the motion of Ms Fazio, that the answers from NSW Health be published by the Committee.

Response by Jennifer Collins' solicitor re adverse mention
The Committee Clerk tabled correspondence dated 16 June 2004 received from the solicitor for Jennifer Collins regarding comments made by Dr Hugelmeyer at a public hearing.

Resolved, on the motion of Ms Fazio, that the letter be published and appended to the website next to the transcript to which it refers.

Consideration of Chair's Draft
The Committee considered the Chair's Draft report, which had been previously circulated.
The Chair indicated his preference to begin deliberations on Chapter Two, and tabled a revised Chapter One for consideration later in the meeting.

Chapter Two read.

Resolved, on the motion of Mrs Forsythe, that the definition of "health professionals" in paragraph 2.7 include "administrative, management and clinical staff, allied health professionals and ancillary staff"

Resolved, on the motion of Ms Fazio, that the following be added at the end of paragraph 2.12:

These changes are designed to include a systematic clinical process involving the entire health team, not individual professional groups. More recently, in 2002, the Department set up the Patient Safety Improvement Program.

Resolved, on the motion of Dr Arthur-Chesterfield Evans, that the following be added to the end of paragraph 2.16:

The whole hospital system or area health service must be more responsive to the community.

Mrs Forsythe moved that the following recommendation be added at the end of paragraph 2.16:

That Hospital Boards be re-established with the majority of positions being statutory filled

Question put.

Ayes: Mrs Forsythe
Ms Parker
Dr Chesterfield-Evans

Noes: Revd. Dr Moyes
Ms Fazio
Mr Primrose
Ms Robertson

Question resolved in the negative.

Resolved, on the motion of Ms Fazio, that paragraph 2.33 be amended to read:

A system of co-regulation exists in New South Wales whereby the HCCC and the relevant professional body representing doctors, nurses, dentists and other allied professionals such as the Medical Board or Nurses Registration Board jointly assess complaints against individual practitioners and decide on a course of action.

Chapter Three read.

Resolved, on the motion of Ms Parker, that the following be added after the third sentence of the introductory paragraph of Chapter Three:

A key barrier to effective complaints handling is health professionals' reluctance to report adverse incidents. The hierarchical structures within the health system and the general reluctance by health professionals to report adverse incidents must be overcome.

Resolved, on the motion of Ms Parker, that the following sentence be added to the final paragraph of the introduction:

The Committee believes that health managers should play a critical and proactive role in developing a culture of learning and implementing responsive practices.

Resolved, on the motion of Ms Fazio, that the following additional quote be added to paragraph 3.2:

"It is not always present at the hospitals. After that level, particularly at the regristrar level, that is, where career paths are most important, a culture of openness about the complaint process would lead to an improvement." (Dr Llewellyn, 23 March 2004, p3)

Resolved, on the motion of Ms Fazio, that paragraph 3.5 be amended to cross-reference to the later discussion of the role of the ACHS and the recommendations relating to it.

Resolved, on the motion of Ms Fazio, that a recommendation be inserted at the end of paragraph 3.5 in the following terms:

That the NSW Minister for Health raise with his counterparts on the Australian Health Ministers' Advisory Council whether the criteria used by the Australian Council on HealthCare Standards in its accreditation surveys of health services is an appropriate measure.

Resolved, on the motion of Ms Fazio, that the case study after 3.14 clearly identify that this occurred in a different state to NSW.

Resolved, on the motion of Mrs Forsythe, that the section from paragraph 3.20 be retitled : "Health managers' attitudes to complaints" and contain examples drawn from the Final HCCC report and from the nurse informants.

Resolved, on the motion of Ms Fazio, that the following paragraph be added after 3.38:

The Committee acknowledges the frictions between doctors, nurses, managers and other health professionals in reporting adverse incidents, and the role of NSW Health to encourage open cultures and working environments.

Resolved, on the motion of Ms Parker, that the text of paragraph 3.41 be deleted after the first sentence

Resolved, on the motion of Ms Parker, that former recommendation 1 be amended by deleting the words "existing or developing" and replacing it with the words:

as part of the registration process. That evidence of ongoing professional development in this area should be an essential requirement of registration.

Resolved, on the motion of Ms Fazio, that a new recommendation be added after the former recommendation 5, in the following terms:

That, as part of their performance agreement, all health managers in NSW undergo ongoing training in quality and safety principles, including the Open Disclosure Standard, and that this becomes an essential requirement for their continuing employment.

Resolved, on the motion of Ms Fazio, that paragraph 3.53 be amended by deleting "unless" and inserting "should be" and deleting all words after health care.

Resolved, on the motion of Ms Fazio, that the former recommendation 6 be amended by the insertion of the following words:

Simple steps to make health complaints; and realistic expectations of health care.

Resolved, on the motion of Ms Fazio, that the following quote from Professor Barraclough be added after the fourth sentence of paragraph 3.57:

"By virtue of this safety improvement program and the other programs of ICE, there has been a dramatic increase in the reporting of severe adverse events to the Department of Health and to individual health areas. This is what we aim to do: We aim for a dramatic increase in reporting so that we can know where problems exist and so that the vulnerabilities can be corrected" (19 March 2004, p38)

Ms Fazio moved that paragraphs 3.58 to 3.57, and former recommendation 7, be deleted.

Question put.

Ayes: Ms Fazio
Mr Primrose
Ms Robertson

Noes: Revd. Dr Moyes
Dr Chesterfield-Evans
Ms Parker
Mrs Forsythe

Question resolved in the negative.

Mr Primrose moved that paragraph 3.62 be deleted after the first sentence.
Question put

Ayes: Mrs Forsythe
Ms Parker
Revd Dr Moyes
Ms Fazio
Mr Primrose
Ms Robertson

Noes: Dr Chesterfield-Evans

Question resolved in the affirmative.

Resolved, on the motion of Ms Fazio, that the following quote be inserted at the end of paragraph 3.63:
"…to give people an understanding of how you look at health care systematically, how you can measure and how you can improve…try to look at it in a way of how to improve the process of the interaction between different parts of the health system rather than historically people living in silos of occasions and if anything went wrong it was somebody else's fault rather than something about the way the system was working systematically" (Dr Christley, 23 March 2004, p19)

Dr Chesterfield-Evans moved a motion that a recommendation be added after former recommendation 9 in the following terms:

That the New South Wales Government convene a summit on adverse events within the next 12 months.
Question put

Ayes: Mrs Forsythe
Ms Parker
Revd Dr Moyes
Dr Chesterfield-Evans

Noes: Ms Fazio
Mr Primrose
Ms Robertson

Question resolved in the affirmative.

Resolved, on the motion of Ms Robertson, that paragraph 3.66 be amended to refer to responses to accreditation reviews to also be published, and that former recommendation 9 also be amended to require publication of rectification reviews.

Resolved, on the motion of Ms Robertson, that the following be added to paragraph 3.66:

While the Committee did not canvas the views of NSW Health, it can see no reason why such rectification reviews relating to all health services should not be published.

Resolved, on the motion of Ms Fazio, that the last sentence of paragraph 3.70 be deleted.

Resolved, on the motion of Ms Robertson, that former recommendation 11 be amended to read:

That NSW Health implement a statewide protocol that the patient or next of kin of a patient whose treatment is the subject of a Root Cause Analysis is informed of the conduct and results of this analysis by a suitable clinician.

Dr Chesterfield-Evans moved a motion that former recommendation 12 be deleted.

Qestion put

Ayes: Dr Chesterfield-Evans

Noes: Ms Parker
Mrs Forsythe
Revd Dr Moyes
Ms Fazio
Mr Primrose
Ms Robertson

Question resolved in the negative.

Resolved, on the motion of Dr Chesterfield-Evans, that a new recommendation be added after former recommendation 12, in the following terms:

That NSW Health ensure that each clinical team in all area health services should have regular review meetings on a protocol set up by management and audited by the Clinical Excellence Commission.

Resolved, on the motion of Ms Fazio, that the following sentence be added after the first sentence of paragraph 3.82:

NSW Health should trial ways of breaking the hierarchical barriers that currently work against a culture of learning by such things as: the use of teams of professionals; ensuring that junior medical staff are aware of their role delineations; and safeguards to ensure that doctors take accountability for their actions.

Chapter Four read.

Resolved, on the motion of Ms Fazio, that following paragraph 4.5 the following sentence be added with the source footnoted:

In further evidence Dr Lim refuted this evidence.

Resolved, on the motion of Ms Fazio, that the first sentence of the Sarah Flegg case study be amended to read:

Ms Flegg presented to the Maternity Department of Campbelltown Hospital and was then transferred to the Intensive Care Unit (ICU) in June 1999.

Resolved, on the motion of Ms Fazio, that the following after the second sentence of paragraph 4.15:

Ms Collins claimed that she was a victim of the failure of the HCCC to investigate the matters fairly and accurately.

Resolved, on the motion of Ms Fazio, that the following sentence be added at the end of paragraph 4.15:

This is not easily reconciled with the investigation process outlined in the HCCC report of December 2003.

Resolved, on the motion of Ms Fazio, that the following be added at the end of paragraph 4.17:

Ms Collins disputed the findings of the HCCC that the investigation against the nurses, initiated by Ms Collins, was not fair, impartial or complete and that the nurses were denied procedural fairness. The Committee supports the recommendation of the HCCC that the Department of Health reviews the disciplinary action and processes taken by Macarthur Area Health Service against the four nurses who underwent formal disciplinary action as a matter of urgency.

Resolved, on the motion of Ms Fazio, that paragraph 4.18 be deleted apart from the final sentence, and replaced with the following:

Ms Collins' evidence in relation to the deeds of release was evasive at best. Ms Collins stated that in relation to the deeds of release that had been drawn up and offered to Ms Owen and Ms Quinn: "That person did not report to me. That was at the area structure. That is part of the are HR department. That was not part of Macarthur HR department. I was not involved in the deed of release…This particular deed of release I have never seen." Following further questioning by the Committee, Ms Collins advised: "I did not say the director of HR had not discussed the contents of the deed of release, but I never saw it…I have never eyeballed it "(29 March 2004p15)

Resolved, on the motion of Mrs Forsythe, that prior to the final sentence of former paragraph 4.18, the following be added:

The Committee is critical of former Macarthur Health Service General Manager Jennifer Collins and believes her management approach hindered efforts to bring forward complaints about health care. An example was the evidence of Director of Emergency Medicine, Dr Hugelmeyer: "To deny that I was "dressed down" or rebuked is a gross inaccuracy that I must strenuously refute. The encounter I experienced on 23 October 2002 with Ms Jennifer Collins and Ms Greer Jones, acting Director of Acute Services, in the general manager's office at Macarthur Health Service was so traumatic to me that it caused me to immediately elect to resign my position as director of emergency medicine. That decision was to take effect immediately, without notice, and would have resulted in my family returning to the United States within a week or so. Such plans were discussed with my wife and were in force. To move a family of five back 10,000 miles suggests the degree of discomfort I felt. It poisoned my relationship with management and I believe it was a clear insight – although just one example – into the management culture that existed at the hospital " (29 April 2004,p1)

Resolved, on the motion of Ms Fazio, that the last sentence of paragraph 4.20 be deleted and replaced with the following:

The apparently conflicting assessments of management at Macarthur as well as of complaints handling raise important issues about the appropriateness of comparing the conflicting methodologies used by the different agencies conducting reviews. In assessing the performance of a health service the focus should be on complaints rather than adverse events.

Resolved, on the motion of Ms Fazio, that the following paragraph be added after paragraph 4.22:

The NSW Nurses Association provided a supplementary submission on 26 March 2004, which indicated that at the time Ms Martin contacted the Association for assistance (14 June 2002) she was not a member of the Association and did not join the Association until 12 July 2002. Mr Holmes advised that assistance was being provided to all members in the Special Commission of Inquiry. Further, Mr Holmes stated that the Association had been hampered in providing assistance to some of the nurse informants as they engaged their own legal advisors. When they approached the Association again after dispensing with their private legal advice, the Association then provided assistance.

The Committee agreed to adjourn and reconvene on Monday 21 June.

5. Adjournment
Monday 21 June at 8:30 am in room 1153.

Meeting No 26
Monday 21 June 2004
8:50 am in room 1153, Parliament House

1. Members Present
Revd. Dr Gordon Moyes (Chair)
Mrs Patricia Forsythe
Ms Christine Robertson
Ms Amanda Fazio (Catanzariti)
Mr Henry Tsang
Ms Robyn Parker
Dr Arthur Chesterfield-Evans

2. Substitutions
The Chair noted that Mr Tsang, as a substantive member of the Committee, was replacing Mr Primrose for the meeting so that Ms Fazio became the substitute for Mr Catanzariti for this meeting.

3. Inquiry into Health Complaints Handling
The Committee resumed consideration of the Chair's draft report.

In the absence of some committee members the Committee began its deliberations at Chapter Five.

Chapter Five read.

Resolved, on the motion of Dr Chesterfield-Evans, that the following be added to paragraph 5.11:
The Committee asked Mr Robert McGregor whether the resources allocated to SWSAHS in 2002-03 included an allocation for the obstetrics contract at Camden Hospital. In response, the Committee was told that funding of the obstetrics contract would 'be from within the total allocation provided to South Western Sydney Area Health Service.'(Correspondence from Dr Tamsin Waterhouse, A/ Director, Structural Reform Branch, to Director, 24 May 2004, in response to a question taken on notice on 30 April 2004)

Dr Chesterfield-Evans moved that a final sentence be added to paragraph 5.11:
The Committee believes that this would have exacerbated the existing tight budget.

Mr Tsang moved that the motion be amended by replacing "would" with "could".

Amendment put.

Ayes: Mr Tsang

Noes: Mrs Forsythe (Acting Chair)
Dr Chesterfield-Evans

Question resolved in the negative.

Original question put.
Ayes: Mrs Forsythe
Dr Chesterfield-Evans

Noes: Mr Tsang

Question resolved in the affirmative.

Mr Tsang moved that paragraph 5.15 be amended by either the deletion of the third sentence or the insertion of a new fourth sentence as follows:

Ms Jennifer Collins advised "I have got no information, and no-one ever raised with me that anyone was physically assaulted from raising a MET call"(29 March 2004, p14)

Question put.

Ayes: Mr Tsang

Noes: Mrs Forsythe
Dr Chesterfield-Evans
Revd. Dr Moyes

Question resolved in the negative.

Ms Fazio moved for the deletion of paragraph 5.16.

Question put.

Ayes: Mr Tsang
Ms Fazio

Noes: Mrs Forsythe
Dr Chesterfield-Evans
Revd. Dr Moyes

Question resolved in the negative.

Ms Fazio moved for the deletion of paragraph 5.37 and the accompanying table.

Question put.

Ayes: Mr Tsang
Ms Fazio

Noes: Mrs Forsythe
Dr Chesterfield-Evans
Revd. Dr Moyes

Question resolved in the negative.

Resolved on the motion of Dr Chesterfield-Evans that the following sentence be added to the end of paragraph 5.33:
Dr Hugelmeyer provided a copy of a *Code Red Log – Campbelltown Emergency Department* to substantiate his claim that a number of people had refused requests for code red status.

Resolved, on the motion of Dr Chesterfield-Evans, that the following final sentence be added to paragraph 5.36:
It is a poor administration that would declare a major hospital to go code red with the flow on effect that ambulances go to a lesser resourced hospital within the same Area Health Service.

Resolved, on the motion of Dr Chesterfield-Evans, that the following final sentence be added to paragraph 5.37:
The Committee understands that it is a target of NSW Health to have a stretcher time of less than 30 minutes for each Area Health Service.

Ms Fazio moved that the Caroline Anderson case study be deleted.

Question put.

Ayes: Ms Robertson
Mr Tsang
Ms Fazio

Noes: Mrs Forsythe

Dr Chesterfield-Evans
Revd. Dr Moyes

Question resolved in the negative on the casting vote of the Chair.
Ms Fazio moved that paragraph 5.48 be deleted, or be added by a final sentence in the following terms:
Some of the opposition to the opening of the unit came from obstetricians who had put in an unsuccessful tender to provide specialist services at the unit.

Question put.

Ayes: Ms Robertson
Mr Tsang
Ms Fazio

Noes: Mrs Forsythe
Dr Chesterfield-Evans
Revd. Dr Moyes

Question resolved in the negative on the casting vote of the Chair.

Ms Fazio moved that paragraph 5.54 be deleted.

Question put.

Ayes: Revd. Dr Moyes
Ms Robertson
Mr Tsang
Ms Fazio

Noes: Mrs Forsythe
Dr Chesterfield-Evans

Question resolved in the affirmative.

Ms Fazio moved that paragraph 5.55 be deleted.

Question put.

Ayes: Ms Robertson
Mr Tsang
Ms Fazio

Noes: Mrs Forsythe
Dr Chesterfield-Evans
Revd. Dr Moyes

Question resolved in the negative on the casting vote of the Chair.

Mrs Forsythe moved that the following be added after paragraph 5.55:
The Committee concludes the maternity unit at Camden Hospital was re-opened for political motives prior to the 2003 State Election.

Question put.

Ayes: Mrs Forsythe
Ms Parker

Noes: Dr Chesterfield-Evans
Revd Dr Moyes
Ms Fazio
Ms Robertson

Question resolved in the negative.

Mrs Forsythe moved that the following be added after paragraph 5.55:
The service was opened with inadequate staffing levels to provide safe coverage. Dr Prendergast said concerns about staffing were ignored by management:

> I was on the committee for that as chairperson for the department of obstetrics and gynaecology and we stated to them that we needed extra specialist obstetrics and gynaecology people, how we could have a functional roster, and we felt that we would need at least 10 visiting medical officers to run a roster like that. Also, from past experience of working in Camden years before when it was run by a visiting medical office and a resident doctor with no specialist obstetrics and gynaecology qualifications, we were very adamant that we wanted obstetrics and gynaecology registrar, or junior staff present in the hospital just to run it in safely as we were told that that was not going to be a consideration. (Dr Prendergast, Evidence, 19 March 2004, p69)

Question put.

Ayes: Mrs Forsythe
Ms Parker
Dr Chesterfield-Evans
Revd Dr Moyes

Noes: Ms Fazio
Ms Robertson

Question resolved in the affirmative.

The committee resumed consideration of Chapter Four at paragraph 4.25.

Resolved, on the motion of Ms Robertson, that former recommendation 13 be amended by deleting "whistleblower protections" and insert "protected disclosure safeguards".

Ms Fazio moved for the deletion of paragraph 4:30.

Question put.

Ayes: Ms Robertson
Ms Fazio

Noes: Mrs Forsythe
Ms Parker
Dr Chesterfield-Evans
Revd. Dr Moyes

Question resolved in the negative.

Resolved, on the motion of Mrs Forsythe, that the following be added to the end of paragraph 4.33:
The Committee believes that the Health Care Complaints Commission failed in its statutory obligations to investigate the nurse whistleblowers' complaints against practitioners. Former Commissioner Merrilyn Walton confirmed this view:

> The reason we are in this mess is because there is a misunderstanding of the no-blame culture and professional responsibility. It is not one or the other … Quality and safety is the right way to approach it as a no-blame thing, but it does not mean that people do not have to be accountable. (Ms Walton, Evidence, 29 March 2004, p58)

Resolved, on the motion of Ms Fazio, that the following be inserted at the end of paragraph 4.34:
Ms Victoria Walker stated in evidence in regard to the statements of Ms Fraser:

> I read the transcript and I just thought it was completely muddled. It was completely false, from my point of view. I never had any view that any specific matters should go to the police. I deal with the police in another part of my administration. We deal with the police on criminal matters. They are busy people. You do not send them a bundle of emails or allegations until it has been assessed properly that they were criminal matters. No, when I read that in the transcript I was completely puzzled about it. It was not correct. (Ms Walker, Evidence, 19 March 2004, p15)

Resolved, on the motion of Dr Chesterfield-Evans, that the following be inserted at the end of paragraph 4.39:
The Committee believes that the communication from NSW Health to Ms Fraser was inadequate.

Mrs Forsythe moved that at the end of paragraph 4:40 the following be added:

However another nurse, Ms Giselle Simmons, told the Committee about her encounter with the former Minister, which occurred at least three months later than the November meeting. Ms Simmons told the Committee about her experience in raising a complaint with the Minister at a nurse practitioner workshop at UTS:

> I told him what was happening at Fairfield and that people were dying who should not be dying. He asked me for my name and where I worked and I am very proud of that. I am not going to hide that so I told him who I was and where I worked, quivering in my boots ... He just bullied me, he harassed me, he spoke over the top of me, he told that I did not know what I was talking about, and he was quite rude. (Ms Simmons, Evidence, 23 March 2004, p6)

Ms Simmons told the Committee that she was removed from a senior position at Fairfield Hospital shortly after speaking to the former Minister.

> The Director of Nursing also told me, "You don't say what you said to the Minister for Health and expect to have a job at the end of it." I knew. It was the area Director of Nursing that really put me in the picture. She told me that after that meeting, he then went to the people in the Department of Health that he needed to speak to. He then spoke to people from the South Western Sydney Area Health Service and he had me removed from my position. (Ms Simmons, Evidence, 23 March 2004, p7)

Question put.

Ayes: Mrs Forsythe
Ms Parker
Dr Chesterfield-Evans
Revd. Dr Moyes

Noes: Ms Fazio
Ms Robertson

Question resolved in the affirmative.

Mrs Forsythe moved that the following be added to the insertion at paragraph 4:40:

The Committee believes that the pattern of intimidating the whistleblower nurses extended to the former Minister for Health, Craig Knowles. The Committee believes the former Minister should be sacked.

Question put.

Ayes: Mrs Forsythe
Ms Parker

Noes: Dr Chesterfield-Evans
Revd Dr Moyes
Ms Fazio
Ms Robertson
Mr Tsang

Question resolved in the negative.

Dr Chesterfield-Evans moved that the following be added to the former paragraph 4.41:
The Committee is disappointed that the Minister took this decision as it represents some contempt for the accountability that parliamentary committees give to the people. Clearly he wished to avoid public questioning.

Question put.

Ayes: Mrs Forsythe
Dr Chesterfield-Evans
Revd Dr Moyes
Ms Parker

Noes: Ms Fazio
Mr Tsang
Ms Robertson

Question resolved in the affirmative.

Resolved, on the motion of Ms Fazio, that the quote in paragraph 4.42 be deleted and replaced with the following:

> Yes, I have seen some improvement, that is for sure, in it being almost an expectation now that we will proceed with a new era, if you will, and searching for new mechanisms. However, there are still what I consider to be remnants of the old that tend to stand in the way of the kind of reporting that from a personal point of view I think is needed to ensure that. (Dr Hugelmeyer, Evidence, 19 March 2004, p64)

Resolved, on the motion of Ms Fazio, that a new paragraph be added after paragraph 4.42 in the following terms:
The Committee heard that there have been improvements in recent times. Ms Lisa Kremmer stated: "Yes, there have been recent improvements and they may be in staff morale, which varies depending on what it is we are being scrutinised for or how we are being scrutinised at the time. Recently staff morale has been much improved." (19 March 2004, p56)

Mrs Forsythe moved a motion that a new paragraph be added after 4.45 in the following terms:
Associate Professor Picone misled the Committee over the progress of four complaints made by Dr Mary Prendergast. Firstly Professor Picone denied being aware of the complaints and on another occasion, told the Committee the four complaints were being investigated. Dr Prendergast, however, had a differing view:

> First of all, I heard in the press the next day that Professor Picone said that the new administration had heard nothing about these complaints, which was wrong because when the new administration came to Campbelltown Hospital my department, particularly the visiting medical officers in my department, requested a meeting with her to try to bring up some of these complaints to see why we could not get them answered. So that was done in December last year so they were presented to the administration.
>
> After that I got a letter from Professor Picone asking me to outline these complaints, and I sent her that letter in detail, even including one of the letters from my patient who wrote about her situation which I felt was heartfelt because it really distressed her. That was a case of a lady who had a miscarriage and was sent home from casualty to miscarry at home. She is still undergoing psychological treatment for the distress that that caused her. I have not heard. Professor Picone said that Dr Saxton, our medical director, has discussed them with me. I have not heard from him about any of these cases to date. (Dr Prendergast, Evidence, 30 April 2004, p84)

Question put.

Ayes: Mrs Forsythe
Ms Parker

Noes: Dr Chesterfield-Evans
Revd Dr Moyes
Ms Fazio
Mr Tsang
Ms Robertson

Question resolved in the negative.

Ms Fazio moved for the deletion of paragraphs 4.46 to 4.50.

Question put.

Ayes: Ms Robertson
Ms Fazio

Noes: Mrs Forsythe
Ms Parker
Dr Chesterfield-Evans
Revd. Dr Moyes

Question resolved in the negative.

Mrs Forsythe moved that a new paragraph be inserted after paragraph 4:50 in the following terms:
Throughout the inquiry Associate Professor Picone was evasive and demonstrated she is either unwilling or unable to promote a culture of learning in the health service. This was shown by her repeated reluctance to volunteer information to the Committee regarding the referrals of four deaths at Liverpool Hospital to the Coroner. The Committee is gravely concerned that Associate Professor Picone did not inform it of three additional referrals when she had appeared before the Committee on two separate occasions. It showed further evidence of a failure on the part of the area health service to be open about adverse events.

Question put.

Ayes: Mrs Forsythe
Ms Parker

Noes: Dr Chesterfield-Evans
Revd Dr Moyes
Ms Fazio
Mr Tsang
Ms Robertson

Question resolved in the negative.

Mrs Forsythe moved that the following paragraph be inserted after paragraph 4:50:
The Committee noted Associate Professor Picone's repeated obfuscation to answer questions over the investigation into the death of Ms Sarita Yakub. Associate Professor Picone was the main contact between Mr Yakub and the Health Department and in the Committee's opinion exercised poor judgement in not keep him fully informed.

Question put.

Ayes: Mrs Forsythe
Dr Chesterfield-Evans
Revd Dr Moyes
Ms Parker

Noes: Ms Fazio
Mr Tsang
Ms Robertson

Question resolved in the affirmative.

Mrs Forsythe moved that an additional paragraph then be added in the following terms:
Medical professionals at the frontline contradicted Associate Professor Picone's evidence to the Committee by saying there was little evidence of change at SWSAHS. This is a matter of concern as it shows poor communication between complainants and management continues.

> My experience is that there has not being a lot of change in that area. I think people are still putting forward clinical issues that they are concerned about an offer like the same sort of process of dealing with them is still going on. It is hard to get a response and I think it is difficult in the position that managers are in for them to make responses, make decisions and implement change. (Dr Parker, Evidence, 19 March 2004, p66)

Question put.

Ayes: Mrs Forsythe
Ms Parker

Noes: Dr Chesterfield-Evans
Revd Dr Moyes
Ms Fazio
Mr Tsang
Ms Robertson

Question resolved in the negative.

Resolved, on the motion of Ms Fazio, that the words "That the Minister for Health" be deleted from former recommendation 14 and the words "be asked to clarify" inserted after "Medical Board."

Mrs Forsythe moved that after former recommendation 14 the following recommendation be added:
That Associate Professor Picone be removed as administrator of South West Sydney Area Health Service.

Question put.

Ayes: Mrs Forsythe
Ms Parker

Noes: Dr Chesterfield-Evans
Revd Dr Moyes
Ms Fazio
Mr Tsang
Ms Robertson

Question resolved in the negative.

Mrs Forsythe moved that the following be inserted before the first sentence of paragraph 4:65:
The Committee is deeply concerned that Associate Professor Picone authorised a press release that may have prejudiced the inquiry into Ms Audrey Daley-Hamilton's death.

Question put.

Ayes: Mrs Forsythe
Dr Chesterfield-Evans
Revd Dr Moyes
Ms Parker

Noes: Ms Fazio
Mr Tsang
Ms Robertson

Question resolved in the affirmative.

Ms Fazio moved for the deletion of the first sentence of paragraph 4:65.

Question put.

Ayes: Ms Robertson
Mr Tsang
Ms Fazio

Noes: Mrs Forsythe
Ms Parker
Dr Chesterfield-Evans
Revd. Dr Moyes

Question resolved in the negative.

Ms Fazio moved for the deletion of paragraph 4:67.

Question put.

Ayes: Ms Robertson
Mr Tsang
Ms Fazio

Noes: Mrs Forsythe
Ms Parker

Dr Chesterfield-Evans
Revd. Dr Moyes

Question resolved in the negative.

Ms Robertson moved that a new sentence be added at the end of paragraph 4:67:
The Committee recognises that the HCCC investigation which utilised a systemic approach was outside of the HCCC's legislative role.

Question put.

Ayes: Ms Robertson
Mr Tsang
Ms Fazio
Revd. Dr Moyes

Noes: Mrs Forsythe
Ms Parker
Dr Chesterfield-Evans

Question resolved in the affirmative.

Resolved, on the motion of Dr Chesterfield-Evans, that the following be inserted at the end of paragraph 4:69:

The Committee hopes that as further evidence becomes available appropriate action will be taken in respect of individuals who are found to have transgressed.

Resolved, on the motion of Ms Robertson, that the words "Since this inquiry commenced" be added to the beginning of paragraph 4:70 and the word "while" be deleted.

Mrs Forsythe moved that at the end of paragraph 4:72 a new paragraph be added in the following terms:

NSW Health remains an organisation that is reactionary towards daily media events. Its first priority is to cover-up to avoid adverse publicity for the government, when the focus should be on patients and patient care. A thorough inquiry into systemic and cultural issues across all area health services is needed.

Question put.

Ayes: Mrs Forsythe
Ms Parker

Noes: Dr Chesterfield-Evans
Revd Dr Moyes
Ms Fazio
Mr Tsang
Ms Robertson

Question resolved in the negative.

Chapter Six read.

Resolved, on the motion of Dr Chesterfield-Evans, that the quote from Mr Masso at the beginning of the Chapter be deleted.

Resolved, on the motion of Ms Fazio, that paragraph 6:13 be deleted after the first sentence, and that the first and last sentence of paragraph 6:14 be deleted, with the insertion, subject to advice from the Clerks, of the following sentence at the end of paragraph 6:14:

The Committee will refer this report to the Special Commission of Inquiry for consideration.

Resolved, on the motion of Ms Fazio, that paragraphs 6:17 and 6:18 be deleted.

Ms Fazio moved that the word "scandal" be deleted from the beginning of paragraph 6:20 so that it be amended to read:

At the heart of the issues involving Camden and Campbelltown Hospitals is the routine non-disclosure of adverse events at an individual and systemic level, a phenomenon that is by no means limited to one Area Health Service.

Question put.

Ayes: Dr Chesterfield-Evans
Revd Dr Moyes
Ms Fazio
Mr Tsang
Ms Robertson

Noes: Mrs Forsythe
Ms Parker

Question resolved in the affirmative.

Resolved, on the motion of Dr Chesterfield-Evans, that the following words be added in Chapter Three between the former recommendation 12 and the new recommendation added at the last meeting:

The Committee notes that a top down approach may lead to a perception of an inquisitorial system. Clinicians actively engaged in patient care need to be involved in meetings which openly discuss patient outcomes and recommendations for system change.

The Committee agreed to adjourn and defer consideration of Chapter One for a further deliberative.

4. Adjournment
Tuesday 22 June in the dinner break, in room 1108.

Minutes No.27
Tuesday 22 June 2004
7:00 pm in room 1108, Parliament House

1. Members Present
Revd. Dr Gordon Moyes
Mrs Patricia Forsythe
Ms Robyn Parker
Dr Arthur Chesterfield-Evans
Ms Amanda Fazio (Tsang)
Ms Christine Robertson
Mr Peter Primrose (Catanzariti)

2. Confirmation of Minutes
Resolved, on the motion of Ms Robertson, that the amendment to paragraph 3.66 attributed to her in minutes 25 be amended to change "reports" to "rectification reviews" and the report also be amended accordingly.

Resolved, on the motion of Dr Chesterfield –Evans, that the motion for a recommendation for a summit in minutes 25 refer to "medical" adverse events, and the report be amended accordingly.

Resolved, on the motion of Ms Fazio, that the division on page 7 of minutes 26 be amended to record Mr Tsang as voting with other government members, as actually occurred.

Resolved, on the motion of Ms Fazio, that minutes 25 and 26 as amended be confirmed.

3. Inquiry into Health Complaints Handling
Consideration of Chair's Draft Report
The Chair sought any further amendments to chapters previously considered.

Resolved, on the motion of Dr Chesterfield-Evans, that the following paragraph be added in Chapter Three somewhere after the new paragraphs regarding health manager's attitudes to complaints:

The Committee believes that a compulsory standard and performance measure should be introduced for all health managers relating to open disclosure and the effects of their decisions on clinical outcomes. The Committee also believes that proof of implementation of this compulsory standard and performance measure form part of the annual performance review by the Director General.

Resolved, on the motion of Ms Fazio after advice from the committee clerk, that the insertion in paragraph 6:14 regarding referral to the Special Commission of Inquiry be deleted, but instead that the Committee agree to send a copy of its report to the Commission following its tabling in the House.

Chapter One read.

Resolved, on the motion of Dr Chesterfield-Evans, that the words "and the inappropriate response of certain managers when complaints were received" be inserted at the end of the second sentence of paragraph 1.4.

Resolved, on the motion of Ms Fazio, that a new sentence be added to the end of paragraph 1.11:

NSW Health has also indicated that communication is a key area in which improvements need to be made and are committed to this, which is acknowledged by the Committee.

Resolved, on the motion of Dr Chesterfield-Evans, that the sentence "A further key finding was that health managers need to respond appropriately when complaints are made" be inserted at an appropriate place in either paragraph 1.13 or 1.14.

Ms Fazio moved the deletion of paragraph 1.17.

Question put.

Ayes: Ms Fazio
Mr Primrose
Ms Robertson

Noes: Revd. Dr Moyes
Ms Parker
Mrs Forsythe
Dr Chesterfield-Evans

Question resolved in the negative.

Ms Fazio moved that paragraph 1.17 be amended to read:

There were undoubtably serious cultural and system related problems concerning complaint handling in south west Sydney. The Committee believes that complaints handling systems can be approved across the entire state and notes that the department has instituted a program to do this.

Question put.

Ayes: Ms Fazio
Mr Primrose
Ms Robertson

Noes: Revd. Dr Moyes
Ms Parker
Mrs Forsythe
Dr Chesterfield-Evans

Question resolved in the negative.

Resolved, on the motion of Ms Fazio, that a new paragraph be inserted after paragraph 1.17 to read:

The Committee noted that the vast bulk of clinicians and staff at SWSAHS are good at their jobs and that patient outcomes were generally also good. Issues particular to SWSAHS that required addressing included a combination of avoidable incidents, poor treatment of staff and no culture of open disclosure. Along with these particular issues goes the need to acknowledge that errors and adverse incidents will always occur within any health system.

Ms Fazio moved for the deletion of the last sentence of the former paragraph 1.19.

Question put.

Ayes: Ms Fazio
Mr Primrose
Ms Robertson

Noes: Revd. Dr Moyes
Ms Parker
Mrs Forsythe
Dr Chesterfield-Evans

Question resolved in the negative.

Resolved, on the motion of Ms Fazio, that the second sentence of former paragraph 1.20 be replaced with:

Restoring staff morale and public trust is a major challenge to be addressed by the new management team that has been put in place.

Resolved, on the motion of Mrs Forsythe, that an additional paragraph be added after former paragraph 1.20 in the following terms:

The various inquiries and reforms that have flowed into Campbelltown and Camden Hospitals over the past 12 months would not have occurred had it not been for the determination of the original nurse informants. The nurses came up against an ingrained culture of cover-up and denial in the health service. Had it not been for the nurse informants at Camden and Campbelltown Hospitals, the problems they exposed may still be continuing today.

Resolved, on the motion of Ms Robertson, that after the former paragraph 1.21 the following be added, together with a new appendix:

Since this inquiry commenced NSW Health has informed us that they have made a number of changes in South West Sydney Area Health Service. These are detailed at appendix three.

Ms Robertson tabled a document entitled "Recent Developments SWSAHS."

Resolved, on the motion of Ms Parker, that the document be included as an appendix.

Mrs Forsythe moved that a new recommendation be added to Chapter One in the following terms:
That the State Government establish a Royal Commission into the operation, structure and accountability of the NSW Health system to restore the confidence of the people of NSW in the public hospital system.

Question put.

Ayes: Mrs Forsythe
Ms Parker

Noes: Revd. Dr Moyes
Dr Chesterfield-Evans
Ms Fazio
Ms Robertson
Mr Primrose

Question resolved in the negative.

Resolved, on the motion of Mrs Forsythe, that the deleted final sentence of paragraph 6.14 be restored with the additional words:

In addition, this Committee will institute a review of the recommendations made in this report in June 2005.

Resolved, on the motion of Ms Parker, that subject to time constraints regarding tabling a table be prepared by the secretariat and inserted as table 1.3 listing clinical governance changes introduced since the inquiry began, as outlined in Ms Kruk's evidence.

The Chair informed members of the requirements of standing order 228 regarding dissenting statements, and advised members that all dissenting statements should be received by the secretariat by no later than 3 pm on Wednesday 23 June. He indicated he wished to table the report in the House on Thursday 24 June 2004.

Dr Chesterfield-Evans moved that the Committee hold further hearings to consider additional evidence on (1) ways in which grass roots quality assurance can be implemented; and (2) no fault medical indemnity.

Question put.

Ayes: Dr Chesterfield-Evans

Noes: Revd. Dr Moyes
Mrs Forsythe
Ms Parker
Ms Fazio
Ms Robertson
Mr Primrose

Question resolved in the negative

The Chair tabled his draft Chair's foreword for consideration by the Committee.

Adoption of Report
Resolved, on the motion of Mrs Forsythe, that the report as amended be adopted as the report of the Committee.

Tabling of Report
Resolved, on the motion of Ms Fazio, that transcripts of evidence, submissions, tabled documents, answers to questions taken on notice, correspondence and minutes (excepting confidential submissions, documents and answers to questions provided on a confidential basis and confidential correspondence) be tabled with the report and made public.

4. Adjournment
The Committee adjourned at 8:30 pm *sine die*.

Appendix 5 Dissenting Statements

STATEMENT OF DISSENT
GENERAL PURPOSE STANDING COMMITTEE NUMBER 2

The undersigned Committee members took a positive approach to the inquiry and proposed amendments with the intention of improving the complaints handling processes in NSW Health and engendering an open culture of learning within NSW Health, rather than political point scoring.

We do not believe that evidence was received to support the state-wide comparisons that are contained in the report and sought to delete these references. The Committee heard extensive evidence from staff/management at SWSAHS, some evidence about complaints handling mechanisms from senior management at CSAHS and limited evidence about innovations in the Hunter. In view of this, and taking into consideration the issues raised in submissions received, the assertions made throughout the report about the situation state-wide cannot be supported and should have been removed from the report if the report is to be seen as credible and evidence based.

Chapter 3
Paragraphs 3.65 to 3.69 and Recommendation 9 are strongly opposed.
There is no way of making the number of serious incidents, deaths etc comparable across the health system in NSW as no two hospitals/health facilities are the same. This recommendation could lead to a false impression about the standards of care available in respective health facilities and could skew demands for care in an unwarranted and unsubstantiated way. Facilities that do not have an open culture of disclosure, with low reporting rates, would automatically appear to be the best, thereby promoting false confidence by health consumers. Hospitals that were scrupulously honest about reporting could be perceived to be the worst, which would be a disincentive for an open culture of learning. Additionally should the number of incidents be the measure or is the appropriateness and timeliness of the response the critical issue.

Recommendation 10 is strongly opposed. The proposed benefits or outcomes of holding such a summit were not discussed and it was not supported by evidence received. A recommendation "That the NSW Minister for Health raise with his counterparts on the Australian Health Ministers' Advisory Council the concept of holding a national conference on clinical excellence" would have been more constructive.

Chapter 4
Paragraph 4.35 should be deleted as evidence was not received which would justify the assertion that has been made.

The comments of Giselle Simmons in paragraph 4.47 should be deleted. When compared to the in-camera evidence of Nurses Owen and Quinn, two of the nurse informants who took their concerns directly to the Minister, Ms Simmons's comments do not appear to be representative of the Minister's response. Table 1.2 shows that Minister Knowles referred the matters raised by the nurse informants to the Director-General the very same day he met with them, thereby triggering the investigation process by NSW Health and the HCCC. This demonstrates immediate, responsive action undertaken by the former Minister.

The comments in paragraph 4.60 relating to the regrettable death of Mrs Yakub should be removed as this section of the report deals with patient deaths at Liverpool Hospital and Mrs Yakub was not a patient at Liverpool Hospital. Further the comments in relation to Associate Professor Picone are not based in fact and are part of a politically motivated attack on a well-respected senior member of Health NSW. This also applies to the unwarranted comments about her in the first sentence of paragraph 4.75.

The report has not focussed enough attention on the many positive changes that have been implemented at SWSAHS under the administration of Associate Professor Picone which have lead to faster, more appropriate responses to adverse incidents and improvements in staff morale. These positive changes appear at Appendix 3. It should also be noted that Associate Professor Picone's establishment of the Professional Practise Unit at SWSAHS and its medico-legal-mediation model of grievance handling will be implemented across the state in all area health services.

Chapter 5
The evidence given by Ms Martin regarding METs calls did not go unchallenged. (Paragraph 5.16) Ms Collins on 29 March 2004 advised, " I have got no information, and no-one ever raised with me that anyone was physically assaulted from raising a METS call."

Paragraph 5.37 and the table which follows relate to ambulance "off stretcher times" which are not within the terms of reference and these matters should not have been included in the report.

The "Case Study" in respect of Ms Caroline Anderson should not be included in the report as the committee heard no evidence on this matter and the sole source of the case study is media reports from daily newspapers.

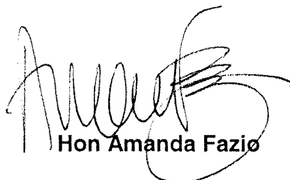
The discussion at paragraphs 5.47 to 5.54 of the Camden Maternity Service do not provide an accurate picture of the quality of the service offered and rely too heavily on the evidence of Dr Mary Prendergast who was a member of a consortium of specialists which unsuccessfully bid to provide services to the Camden Maternity Unit.

It is disappointing that the Committee has not given due recognition to the findings of the Henderson-Smart Review of Maternity and Peri-natal services in SWSAHS. The Review found that Camden Hospital was designed to provide antenatal, birthing and postnatal services for women with essentially normal pregnancies (level 3 and level 2 neonatal).

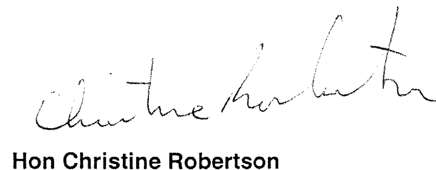
Camden Hospital has a level 3 maternity unit and a level 2 neonatal unit for normal pregnancies, with appropriate on-call anaesthetic cover and on-call paediatric support. The Review Team recommended:

- That this role delineation should continue as long as medical support is available at the required level.
- Units and hospitals know exactly what patients they are resourced and delineated to care for and when a patient needs to be transferred to a higher-level unit or hospital.
- Ensuring appropriate access to Area midwifery and neonatal clinical nurse consultants".

The findings of the Review support the decision to operate the service as a low risk service from the beginning. The Committee did not conclude that the maternity unit was re-opened for political motives based on the evidence before the inquiry. Rather this conclusion was politically motivated and not soundly based.


Hon Amanda Fazio

Hon Peter Primrose


Hon Christine Robertson

Dissenting Report
Arthur Chesterfield-Evans

I do not lightly write a dissenting report, as I would like to get the strength of a unified report, particularly in areas where I have tried very hard to achieve change.

As a surgical registrar in the UK during the late 1970s, I observed that the British National Health Service was poorly managed compared to NSW Health because of the remoteness of the bureaucracy. The increasing number of administrators without clinical contact makes the danger of this remoteness more real in NSW now.

The Committee process in NSW has the problem that it relies on a legal model. It does not set questions that need scientific research or experimentation. Assessing progress in quality control requires quantitative comparisons of past and current results. The Federal government's Professional Indemnity Review of 1994, chaired by Fiona Tito asked, 'How many adverse medical events are there in the Health system?' If the Committees cannot get a current answer to this question, then there must be a system that will. Policy must be based on hard data. This needs a more scientific approach, perhaps by changing the way Committees research or by creating long-term relationships with academic departments.

My principal reason for the dissenting report is that I believe that this committee has not addressed a number of questions. Some of these are:

- How can administrators be quality controlled? Currently they are responsible to the Health Department, which imposes resource constraints on them. This may result in their being in a conflict of interest position when asked both to cut budgets and provide necessary services. (The GPSC2 report on Dr Owen James brought this issue into the open some years ago, and the problem has clearly persisted). There is no administrative body analogous to the Medical or Nursing Boards, so external quality assessment is more difficult.
- How can medical services be more responsible to their communities? Hospital boards were abolished, and arguably were too hospital-focussed to the detriment of community health. However, with senior managers on contracts effectively at the behest of the Minister, and these people controlling the promotions in the middle level of the administration, there is danger of a culture that is very sensitive to political needs of its masters, but out of touch with its community.
- How can grass roots reporting be improved? The Health Care Complaints Commission (HCCC) in NSW is the only health care complaints body in Australia with a prosecutorial function. In other States, this is done by the Medical Boards. The reason for this is historical and dates from the Chelmsford Inquiry, relating to deaths in a private psychiatric hospital. The HCCC is a centralised complaints unit, that has an inquisitorial function, which may be difficult to reconcile with a more conciliatory role. The Clinical Excellence Commission (CEC) will be a travelling resource, but will only visit each institution occasionally. Cultural change necessary to achieve open discussion at the patient level requires trust by clinical staff. A top-down inquisitorial approach will not help this. This is why mandatory reporting, the ultimate external system is not likely to be helpful.
- What is the best way to deal with medical indemnity? The issue of medical indemnity is very close to quality control. This needs to be further investigated as it is the reason that some medical services such as obstetrics are hard to get in district hospitals like Camden. A possible solution to the problem of both medical indemnity and quality control which was not considered by the Committee has been implemented in Utah[i]. A group of hospitals offered to

> pay the Medical Indemnity insurance of all doctors on the condition that they reported all adverse incidents within 48 hours. This gave a great database of errors, which were then prioritised. The savings in reduced adverse incidents and better care paid for the premiums. Given that the NSW government covers most of hospital staff through the Treasury Managed Fund, the costs would be minimal for a big improvement in quality.

In some areas the Committee report is not strong enough. In evidence presented before the Committee the Nurses Association was of little help to the whistleblower nurses. It was difficult not to see union and political ties as over-riding the duty that the Association had to its members. Brent Holmes statement that the 'deed of release' was 'routine' was not backed up by evidence from the Department. The 'Deed of Release' looked very much like a deal between the unions and management that said in effect 'we will let you sack them, if you do not say that they are incompetent' (so that they cannot get another job). It may have also suited both unions and management to get rid of whistleblowers. This may be satisfactory to some hospitals, unions and some people, but is hardly helpful to the interests of health consumers in NSW.

The Australian Council on Healthcare Standards also needs to be looked at. The fact that it gave Campbelltown Hospital such a glowing report as all these problems existed and only months before the Barraclough investigation found so many problems really suggests that their methodology is flawed. Australia needs a credible certification system, and this situation throws grave doubts on the idea that it has one.

The final issue is that the whistleblower nurses, (or Nurse informants as some committee members preferred to call them) were clinical staff and were complaining. While a lot of emphasis was put on the cultural norms of clinical staff not reporting errors, the fact was that in the case of Macarthur AHS, clinical staff who did complain are now unemployed and arguably unemployable in NSW Health. A more transparent management culture is needed without political interference. What may need to be accepted is that a steady improvement in process and fall in error rates is the best we can realistically hope for, though excellence must always be striven for.

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[i] ABC Radio National Health Report 1/10/2001