REPORT ON PROCEEDINGS BEFORE

SELECT COMMITTEE ON OFF-PROTOCOL PRESCRIBING OF CHEMOTHERAPY IN NSW

OFF-PROTOCOL PRESCRIBING OF CHEMOTHERAPY IN NSW

At Jubilee Room, Parliament House, Sydney on Tuesday, 29 November 2016

The Committee met at 10:30 am

PRESENT

The Hon. Paul Green (Chair)

Mr J. Buckingham
The Hon. F. Farlow
The Hon. C. Houssos
The Hon. N. Maclaren-Jones
The Hon. G. Pearce
The Hon. W. Secord
The Hon. B. Taylor (Deputy Chair)

The CHAIR: Good morning, everyone. Welcome to the public hearing of the Select Committee Inquiry into Off-protocol Prescribing of Chemotherapy in NSW. Before I commence I would like to acknowledge the Gadigal people, who are the traditional custodians of our land. I would also like to pay my respect to the elders, past and present, of the Eora nation, and extend that respect to other Aboriginals.

The hearing today is the fourth hearing being held as part of this inquiry into off-protocol dosing of chemotherapy in New South Wales. Today we will hear, firstly, from the Chief Medical Officer of New South Wales, Dr Kerry Chant. Returning to give further evidence are leaders of the New South Wales Ministry of Health's departmental inquiry into off-protocol prescribing of chemotherapy, and senior staff from St Vincent's Hospital. Lastly, we will hear for the first time from the former Head of Medical Oncology at St Vincent's and the former Director of Clinical Governance and former Chief Medical Officer at St Vincent's Hospital.

I would like to make some brief comments about the procedures for today's hearing. Today's hearing is open to the public and is being broadcast live via the Parliament's website. A transcript of today's hearing will be placed on the Committee's website when it becomes available. In accordance with the broadcasting guidelines, while members of the media may film or record members and witnesses, people in the public gallery should not be the primary focus of any filming or photography. I remind members of the media that they are not authorised to film outside this hearing-room without permission. They may not film witnesses coming in and out of the hearing. I also remind media representatives that they must take responsibility for what they publish about the Committee's proceedings. The guidelines for broadcast of proceedings are available from the secretariat.

There may be some questions that a witness could answer if they had more time or with certain documents to hand. In these circumstances witnesses are advised that they can take questions on notice and provide an answer within 21 days. I ask witnesses to be careful when using individuals' names during the hearing in order to avoid unnecessary harm to people's reputations. Please ensure your comments are relevant to the terms of reference. I also remind participants to respect the privacy of individual patients. It is important to remember that Parliamentary privilege does not apply to what witnesses may say outside of their evidence at the hearing today, so I urge witnesses to be careful about any comments they may make to the media or to others after they complete their evidence, as such comments would not be protected by Parliamentary privilege if another person decided to take action for defamation. Witnesses are advised that any messages should be delivered to the Committee secretariat. I ask that everyone turns their mobile phones to silent or off for the duration of this hearing.

KERRY CHANT, Chief Health Officer, NSW Ministry of Health, affirmed and examined

The CHAIR: Do you have an opening statement that you would like to present?

Dr CHANT: I do. I would like to thank the Committee for the opportunity to present today. I will make a brief opening statement and then take questions.

I have held the position of Chief Health Officer since 2009. Prior to that I was the Deputy Chief Health Officer and prior to that I held the position of Director of South Western Sydney Area Health Service public health unit. I have had over 20 years of experience in public health and in managing public health and safety issues arising from infectious disease outbreaks and clinical incidents. This includes assessing the risk directly and managing or oversighting contact-tracing and notification processes, and ensuring that arrangements are in place to notify people and patients where there are serious safety risks affecting them, and ensuring people affected have access to appropriate information and any necessary follow-up or care.

These activities are reflected in the New South Wales Health policy framework for managing clinical incidents and public health risks. In my role as Chief Health Officer it is not unusual for chief executives, health service managers or senior clinicians in the health system to contact me for advice and support, or, in some cases, simply to advise me of potential community or media interest in matters relevant to my portfolio. When public health and safety issues are raised with me my standard approach is first to ascertain if immediate steps are needed to protect public health and safety. These steps might include the administration of specific medicines or vaccines, advice to cease using particular medical equipment, or warnings not to consume certain foods. Depending on the nature of the incident and the seriousness of the threat, I may also take a more active role in managing the response.

I recall receiving a phone call from Associate Professor Schembri in late 2015. I cannot recall the specific date, but I believe that it was in early November. Professor Schembri advised me that there was a potential for a media story in relation to concerns that had been raised about a St Vincent's doctor's prescribing of a chemotherapy drug. He also indicated that St Vincent's was going to engage an external clinician to review the issue. Whilst I do not have a strong recollection of the actual call—as I have already said it is not unusual for me to be contacted in this way—in any call, even where the purpose may be to advise me of a potential media story, my standard practice is to explore the issue to ascertain whether immediate steps are needed to protect public health and safety; whether individual patients are at risk, whether those patients at risk have been advised, and to satisfy myself whether appropriate action is in hand. In this case I was assured that St Vincent's had reviewed the matter and there was no issue of patient harm.

The fact that Professor Schembri indicated that St Vincent's Hospital was going to engage an external clinician in this matter was not unusual or at odds with the advice that there was no issue of patient harm. Drawing on external experts who have no management or clinical responsibility within the facility or the local health district is not unusual. This approach is often used in order to confirm and render more credible an internal clinical review. I therefore did not see this proposal, of itself, raising an issue of concern, particularly given the assurance that the internal review had concluded that patients were not negatively affected.

Based on the information I was provided by Professor Schembri, I ended the conversation confident there was no ongoing risk to patients requiring action by me. As a result, my impression was that the main purpose of the call was to give me a heads-up about a potential media story. I recall suggesting that Professor David Currow, as Chief Cancer Officer, may be able to provide useful suggestions on external experts. I then rang Professor Currow to advise him that Professor Schembri had rung me, outlined the situation as described by Professor Schembri and raised the possibility of a media story. I then followed up with Professor Schembri to let him know I had contacted Professor Currow, who was happy to assist in the identification of external experts. I ended the call with Professor Schembri with the clear impression that the matter was in hand, and that there was no significant public health or safety issue that warranted further action by me.

I did not advise any other senior Ministry of Health officers, given the nature and content of the call, and I received no further communication or information about this matter until February 2016.

The CHAIR: I can understand people in the health system touching base with you, given your role, but I cannot understand that you seemed to say in your opening statement that patients were not harmed, when you had not had the opportunity to investigate or understand the situation. How were you reassured that there was no harm to patients after that phone conversation, given that you had no evidence?

Dr CHANT: There has to be some reliance on the information provided to me by the chief executive. I have no reason to question the information gleaned by the chief executive. He had indicated that there had

been an internal investigation and that that was their conclusion. The fact that they were going to external review was something that I would have seen in a very positive light. I think it is very important that we use external experts, experts that cannot in any way be construed as having a conflict of interest. Drawing on experts remote from the facility is, I think, standard practice, particularly when you are dealing with concerns around a clinician that may have been raised by other clinicians. For me, that was the next reasonable step in terms of having an external review. That would have comforted me that the chief executive was taking this matter seriously. I then contacted Professor Currow and encouraged Associate Professor Schembri to make contact so that appropriate experts could be brought on board to look into the matter.

The CHAIR: Are you saying that it is not unusual practice when you get a phone call expressing concern at this level for you to trust the chief executive's input without testing it?

Dr CHANT: If there are any concerns that I had picked up in the conversation, and that would have brought into question the assertion from the chief executive [CE] in these circumstances, I certainly would have made further inquiries. The linking to Professor Currow was an additional mechanism of testing, given that my area of expertise is not cancer chemotherapy drugs and agents. I felt that action was prudent and appropriate to urge Associate Professor Schembri to make contact with Professor Currow. As I said, I would have seen the steps of engaging an external expert as a very positive step in getting to the bottom and confirming the internal investigation findings.

The Hon. WALT SECORD: Taking you back to the events of November 2015, do you in hindsight regret not giving them the attention they deserve?

Dr CHANT: I regret that the way in which patients heard about the situation was inappropriate.

The Hon. WALT SECORD: How so?

Dr CHANT: The fact that many patients heard about this for the first time in the media is just totally inappropriate. In all my endeavours in terms of looking back and contacts, I did my utmost to make sure that patients are told prior to the media and that the clinicians involved in the care or even the facility are advised prior to the media, so that there is a supportive environment for the patients receiving that information. The regret I have is that that was the way the information unfolded, and patients were presented with that and that there was not adequate support put in for patients in the disclosure process. I have gone through in my own mind the nature of the call and my response to that call, and I think, given the context of the call and what I was informed, the steps that I took were still appropriate.

The Hon. WALT SECORD: You characterised in your opening statement that it was a heads-up telephone call. Does Associate Professor Schembri make such calls? Do you know him well enough that he will call you and say, "Kerry, I have something happening at St Vincent's"?

Dr CHANT: I would get a number of calls; or when I am present in clinical meetings, or I am interacting with senior clinicians, or I would get specific calls from senior clinicians or CEs around issues. It is not uncommon that I would get calls. There are obviously different levels of calls—they may be just seeking advice, "Is this appropriate?" They may be all the way to saying, "This has happened to a patient; what do you think I should do? What are the mechanisms?" I get a varied range of calls, and it would not be unusual for me to get contact from chief executives.

The Hon. WALT SECORD: Did Associate Professor Schembri downplay the situation just to give you a heads-up? Did he say, "Kerry, we have this in hand, do not worry, this is what we are doing"?

Dr CHANT: The answer to this question relates to the fact that I have had the opportunity to read Professor Currow's reports, both the interim report and the final report. Then there have been interactions with Associate Professor Schembri since then, and the recall of my interactions with Associate Professor Schembri, even in the February when the formal notification to the ministry came and the issue emerged. I believe that St Vincent's did not understand the nature and seriousness of the issue, and therefore that factored into the way the incident was portrayed and the information provided. I think there was a fundamental failure to recognise that which then flowed through to all of the communication from that point.

The Hon. WALT SECORD: In her press conference in February and her subsequent press conference, the Minister said that she had felt that patients had been misled by St Vincent's. Do you feel that you have been misled by St Vincent's?

Dr CHANT: As I said, I think that St Vincent's did not understand the seriousness of the issue and did not act with sufficient urgency or put in place sufficient supports to ensure that accurate information was provided to patients in a timely, supported way. That is what I am left with the greatest concern about.

The Hon. WALT SECORD: Back to a comment you made earlier about notifying patients and the fact that patients found out from the media. Are you criticising the media for reporting or are you criticising St Vincent's for not telling them and their having to find out from the media?

Dr CHANT: I am saying that in all of my approaches to a variety of notifications of patients, my utmost attempts have always been the way I have approached it—which to be perfectly frank can sometimes call us into concerns from the media—and that is to make sure that patients have the information before hearing about it in the media. I think it is inappropriate that a number of patients did not hear about it in the media. I recall also concerns that perhaps there was not an adequate briefing of the staff within the St Vincent's facility, so that when patients were asking questions there was not a way of directing the patients to someone who could answer their questions. I recall some suggestions that I made around bringing the patients proactively in, not just waiting for the next visit for them to be reviewed. It was not ideal. I also think that the time line for the external review, from my reading of the report, was protracted.

The Hon. WALT SECORD: When did you think, "We have a big problem here at St Vincent's and I have to do something"? Was it when Matt Peacock called the Minister's office in February?

Dr CHANT: It would have been in the February, when the story and the brief came in from St Vincent's, that alerted me. Even at that point, I think that St Vincent's was still not fully recognising the extent of the issue.

The Hon. WALT SECORD: Okay, but when did you say, "This is a problem"?

Dr CHANT: Clearly I was then concerned by the patient impact of this and immediately worked with David Currow and Professor Schembri to have regular contact to ensure that patients were supported in the disclosure process—that the call centres were set up, that the rest of the staff were briefed, that patients were given written information. That was the process; that as soon as the magnitude of the issue and the patient impact—

The Hon. WALT SECORD: Okay. You mentioned it earlier in your opening statement. At any point did you say, "Is this doctor in question still treating patients?"

Dr CHANT: Those conversations were had, so I have got the minutes of the meetings that we held on 19 February where there were agreed actions.

The Hon. WALT SECORD: So you found out in November but did not ask until February if he was still treating patients?

Dr CHANT: Look, Mr Secord, I cannot recall the exact information that was relayed in that meeting but I would say that I would have been satisfied of what was relayed to me. I do not just receive these calls and ignore the information. I do have a discussion—

The Hon. WALT SECORD: We are talking about three months here, Dr Chant.

Dr CHANT: I would have been assured in November that there was no ongoing public health risk. That is my bread-and-butter approach. My principal position is: make sure that the controls are in place to prevent ongoing patient harm and I would have been convinced about the information that I was given in November that the steps that St Vincent's or Professor Schembri had relayed to me presented no issue or concern that patients could have been at ongoing harm; that the practice—that whatever was—as I said, I do not want to—there are many discussions that happened and I am very conscious of not misleading the Committee about my recollections about that specific date, noting that there have been many conversations and I have read many reviews. All I can assure the Committee is that the information given to me by Professor Schembri would have in no way—my standard of practice is to always make sure that patients could not have been ongoingly exposed to the underdosing.

The Hon. WALT SECORD: When did you tell the ministerial office?

Dr CHANT: The ministerial office, about? Could I just clarify?

The Hon. WALT SECORD: The St Vincent's chemotherapy underdosing, Dr Grygiel. When did you tell the ministerial office?

Dr CHANT: So if you are relating to the phone call in November, as I said in my opening statement, at that time in November there was no—I did not speak to the Minister's office or other senior executives at that time.

The Hon. WALT SECORD: But you did speak to Dr Currow?

Dr CHANT: Yes, I did speak to Professor Currow. So I spoke to Professor Currow and indicated and relayed the conversation I had had with Professor Schembri and said to him, "Are you able to help with getting external experts or providing assistance?" Professor Currow said, "Yes". I then re-contacted Professor Schembri and said, "Can you make contact with Professor Currow?" And I understand that that took place, yes.

The Hon. WALT SECORD: I would like to move to the section 122 inquiry that the Minister called?

Dr CHANT: Yes.

The Hon. WALT SECORD: Who suggested Dr Currow to conduct that inquiry? Did you suggest it? Who recommended to the Minister that Dr Currow do the section 122 inquiry?

Dr CHANT: The section 122 was initiated, as my understanding, by the Secretary.

The Hon. WALT SECORD: Did you provide any advice?

Dr CHANT: Around who?

The Hon. WALT SECORD: Who should do the section 122 inquiry because in November Dr Currow knew about this and then in February he is asked to do an inquiry into something you have known about for three months?

Dr CHANT: I think it is important to go back to the nature of the information transmitted in that November call and understand what was known at that time.

The Hon. WALT SECORD: You said that you have difficulty recalling these conversations?

Dr CHANT: I indicated the specifics of what was transmitted but in terms of the general issue that there was a doctor, there were issues of concern, there was clear no patient harm, the internal investigation had shown no patient harm and that they were going to external review. I am clear about that. The exact word for word dissertation of it, no, I am not.

The Hon. WALT SECORD: So if you were happy with the external review then why did you guys then do a section 122; if you were happy that St Vincent's, as you said, were doing an external review?

Dr CHANT: St Vincent's had then done the external review. I think that what then emerged were concerns about the adequacy and scope of the external review. The external review, as undertaken by St Vincent's, was getting an external expert to look at the records. I think, as you have seen from Professor Currow's more extensive report, a very broader investigation—this situation actually warranted a more holistic and in-depth investigation as undertaken by Professor Currow.

The CHAIR: Order! I will give Mr Jeremy Buckingham 15 minutes and we will go from there.

Mr JEREMY BUCKINGHAM: Dr Chant, can you guarantee this Committee and the people of New South Wales that St Vincent's has not acted to cover up a health scandal that may have led to the preventable death of some of its patients?

Dr CHANT: I think it is not in my remit to respond to that. All I can say is that in my reading of Professor Currow's report and my interactions with Professor Schembri the conclusion I have come to is that they totally did not understand the seriousness of the issue. They did not have the appropriate escalation processes and the systems in place.

Mr JEREMY BUCKINGHAM: I understand you are putting that point but can you rule out, are you satisfied, that St Vincent's have not acted to cover up in any way this scandal to put its public reputation before the interests of its patients?

Dr CHANT: I think that that is asking for me to form a view which can only be drawn from reading the report that Professor Currow led. I think that was a thorough report and so I would have to align with the conclusions drawn in Professor Currow's report about the system.

Mr JEREMY BUCKINGHAM: There has not been a cover up by St Vincent's?

Dr CHANT: I would say that St Vincent's failed to understand the seriousness of it; they failed to understand the need to progress things rapidly and to concurrently have good communication plans in place and they failed to organise systems to ensure that the patient disclosure process was done in a proper and appropriate way.

Mr JEREMY BUCKINGHAM: So the Chief Executive, Professor Schembri, contacted you in early November. How many phone calls did you have, or conversations? How much contact did you have with Professor Schembri from that point until the story became public?

Dr CHANT: About this issue, none.

Mr JEREMY BUCKINGHAM: None. You only had one phone conversation?

Dr CHANT: The phone call in November and then the issue emerged in the February and in the period between that and the issue emerging there were no phone calls relating to this issue until the February of 2016.

Mr JEREMY BUCKINGHAM: So you only had one phone conversation?

Dr CHANT: In November.

Mr JEREMY BUCKINGHAM: In November.

Dr CHANT: In November and then there was—

Mr JEREMY BUCKINGHAM: You were contacted by Professor Schembri?

Dr CHANT: I was contacted by Professor Schembri.

Mr JEREMY BUCKINGHAM: You then contacted Professor Currow?

Dr CHANT: And linked in Professor Currow with Professor Schembri and at that point I did not have any further contact from Professor Schembri until February 2016.

Mr JEREMY BUCKINGHAM: But that process of being contacted, contacting Professor Currow and then putting them back, there was only phone call?

Dr CHANT: The phone call from—

Mr JEREMY BUCKINGHAM: Professor Schembri?

Dr CHANT: —Professor Schembri to Professor Currow, and then I reconnected to Professor Schembri indicating that I had managed to contact Professor Currow, and he—

Mr JEREMY BUCKINGHAM: There were two telephone conversations?

Dr CHANT: Yes.

Mr JEREMY BUCKINGHAM: You just said in your evidence that at that time you did not contact the ministry—that is, in November.

Dr CHANT: I indicated that I did not speak to other senior executives within the ministry at that time.

Mr JEREMY BUCKINGHAM: In November?

Dr CHANT: Yes, in November.

Mr JEREMY BUCKINGHAM: Did you talk to anyone else in the Ministry of Health about this matter at any time between then and February?

Dr CHANT: No.

Mr JEREMY BUCKINGHAM: No-one?

Dr CHANT: Apart from Professor Currow. I did mention it, as is my usual practice, because I took the context of the call from Professor Schembri as alerting me to the potential for it to be a media issue. I could have raised it with the head of the media unit.

Mr JEREMY BUCKINGHAM: Really?

Dr CHANT: Yes.

Mr JEREMY BUCKINGHAM: So you did talk to someone in the department—the head of the media unit?

Dr CHANT: As is my usual practice.

Mr JEREMY BUCKINGHAM: You just said that you did not talk to anyone—

The Hon. NATASHA MACLAREN-JONES: Point of order—

Mr JEREMY BUCKINGHAM: I am trying to clarify the witness's evidence.

The Hon. WALT SECORD: This is an important point.

Mr JEREMY BUCKINGHAM: Yes, it is an important point. You just said that you did not contact anyone in the department between November and February. You have now gone further and said "other than the head of the media unit".

Dr CHANT: I want to clarify this. In my opening statement I was specific around members of the senior executive team. As I said, I do not have a clear recollection of informing the media unit. However, given that the context of the call was media related, I may well have spoken to the media unit.

Mr JEREMY BUCKINGHAM: Do you not think that it related to the health of the St Vincent's Hospital patients rather than a media story?

Dr CHANT: I clearly think this was fundamentally about the health of the patients. As I said, the information I received from Professor Schembri was that there was no patient harm, that they were going to undertake an external review, and that he was giving me the heads up about that. I believe I then took appropriate action in connecting him with Professor Currow to find and assist with potential external experts.

Mr JEREMY BUCKINGHAM: I understand that.

Dr CHANT: I do not want to mislead the Committee, but I have no specific recollection of notifying anyone else. However, it would not be unusual for me to have made a passing comment in that context.

Mr JEREMY BUCKINGHAM: A passing comment to whom? To the head of the media unit?

Dr CHANT: There may have been some exchange with the head of the media unit.

Mr JEREMY BUCKINGHAM: An email?

Dr CHANT: Just saying—

Mr JEREMY BUCKINGHAM: How would that passing comment have been made?

Dr CHANT: I do not have any recollection that I mentioned it to him. However, it would not have been unusual for me to have said, "Look, this issue has been raised. We might get queries about it given the context of the call from Professor Schembri." My recollection is that there may have been media interest in the issue.

Mr JEREMY BUCKINGHAM: Can you look into that further and report back to the Committee with regard to whether or not you did that?

Dr CHANT: I would be very happy to do that. I did not want any way—

Mr JEREMY BUCKINGHAM: What was the Minister's response to you when you told her that you had known about this matter since November?

Dr CHANT: As I said, it is important to go back to what was known in November. What was known in November is that there were concerns around the prescribing, but it was clearly relayed to me that there was no patient harm incurred by that practice. That was the basis of that information. I want to make it very clear that that was the information presented me at that time.

Mr JEREMY BUCKINGHAM: And that is what you told the Minister?

Dr CHANT: When this came to light in February—the seriousness and the scope of the issue—I raised it with members of the senior executive team. I informed them that there was this call back in November. However, I did not have any direct conversations with the Minister in relation to the November call.

Mr JEREMY BUCKINGHAM: You told the members of the senior executive team at that time—on 18 February or thereabouts—that you had known about it in November?

Dr CHANT: I said that I had received a heads-up call from St Vincent's Hospital in relation to Professor Schembri's call. I alerted members of the senior executive team that that had happened.

Mr JEREMY BUCKINGHAM: How did you do that?

Dr CHANT: I raised it.

Mr JEREMY BUCKINGHAM: In the form of an email?

Dr CHANT: No, I verbally told them that this had happened. It was in the general context of the discussion around St Vincent's Hospital's management. Obviously we were very concerned that things were put in place to support the response to the patients. There were many discussions going on around how the disclosure process could be supported for St Vincent's Hospital. I would also like to say that at that point in time

the focus quickly moved. My fundamental focus shifted to western New South Wales, where it became evident that he had been practising for a period of time.

Once that became evident, my major focus in western New South Wales was to work through the issues and to identify the patient impacts. Immediately that happened, we had a teleconference with the director of cancer services. In fact, we had weekly teleconferences; we had agreed action plans, and the minutes of those meetings were circulated. The 24 March teleconference was also attended by a number of oncologists from western New South Wales. Immediately after this, once the inquiry was established—it was announced by the former secretary on 19 February if I am not mistaken—Professor Currow, Paul Curtis from the Clinical Excellence Commission and, I think, Paul Gavel then took over the investigation. My focus was on supporting western New South Wales.

Mr JEREMY BUCKINGHAM: St Vincent's Hospital has provided the Committee with evidence that it did notify the Ministry of Health. Its initial RIB—the draft RIB that it never developed—indicates that it notified the Ministry of Health.

Dr CHANT: I have not seen that. What is the date of that?

Mr JEREMY BUCKINGHAM: The brief was provided on 18 February 2016, and it states in the key issues that "the Ministry of Health and the New South Wales Cancer Institute were notified". Do you think that a phone call to you acts as notification?

Dr CHANT: No, I do not. There is a bit of ambiguity in relation to that brief because Professor Schembri had called just prior to sending it in. I can double check my records, but I believe that Professor Schembri may well have rung me around that time just prior to sending in that brief.

The CHAIR: Mr Buckingham, can you clarify what is an RIB?

Mr JEREMY BUCKINGHAM: It is a "reportable incident brief". That statement disappears from a previous brief. When Professor Schembri contacted you, did he tell you who had done the internal review?

Dr CHANT: I cannot recall whether he specifically mentioned who had done the review.

Mr JEREMY BUCKINGHAM: So that internal review—you did not know who was doing it—was being escalated to an external review. Did you consider calling them back at any stage between then and February to find out what was going on? Did the fact that they saw fit to escalate it not ring alarm bells for you? They had done an internal review, they were getting in an external reviewer, and then there was nothing.

Dr CHANT: I am incredibly contactable—I carry my phone 24/7. I really would have expected that the CE, the fact that the issue was being raised with me by a chief executive of a network, that I should be able to rely on them re contacting me. My actions would have been very different if I had had an inkling of patient harm or the seriousness of it. So I think it is very important to understand the construct of the mindset that I had formed in that November 2015 conversation, which then really influenced my degree of follow-up. I certainly aggressively follow up anything where there is a concern about patient harm. It is not uncommon that I am dealing with many issues. I would not want to overstate the seriousness of all of them but there are a number of things that at one time I am following up and I think I should be able to rely on the chief executive of the local district, including the policies and procedures we have in place, including the role that the Clinical Governance Unit provides and others, in terms of managing these incidents.

As I said, the November call to me was very much a heads-up call: "Just letting you know this might turn out to be a potential media story. It's all in hand. No patient harm. We are going to get an external review", and I would have been very affirming of external reviews because in my practice I use external experts as an important component of adding transparency and veracity to internal findings.

The CHAIR: So you triaged that particular situation at a low level, given the information you were given?

Dr CHANT: With a sense that the CE was—

The CHAIR: You put a lot of faith in the CEO's ability?

Dr CHANT: That is right. My actions would have been different if I had have been, for instance, receiving a call from a clinician in an organisation around something. I would always make sure that I then had phoned the CE of that organisation to say I have had a call from a clincian, to make sure that the proper governance process is in place. If a clinician raises an issue I will always make sure that that is escalated or linked in to someone who has a governance role in the organisation.

The CHAIR: Where in your triage system do you start to think, "Hey, I need to call back. It is my responsibility to follow this up"?

Dr CHANT: If I had any inkling that the CE needed greater support. So in this circumstance I felt the referral to Professor Currow and linking those was appropriate and prudent—

The CHAIR: With all due respect, if you do not have an inkling you do not follow up.

Dr CHANT: No. If the issue relates at all to anything where there is a concern about patient harm or if I have a sense—I think that there were no warning bells ringing for me. I do not not prosecute the veracity of the information and there was nothing that alerted me to the fact that this was broader or the matter was not in hand. I was in no way not taking it seriously, but I would have expected that as information came to light that the formal processes that we have in place from a governance perspective, such as the involvement of the CEC, the IIMS, the reportable incidents, would have all been occurring and under the responsibility of the—

The CHAIR: Quite simply, would you agree with this comment, there was a failure in that system, that your inkling did not pay off, there was no return phone call because you have squared it away that everything is okay, it is in capable hands? Would you say there was a systemic failure in this matter?

Dr CHANT: I think there was a systemic failure by St Vincent's in relation to that—

The CHAIR: And was it from you or from St Vincent's?

Dr CHANT: I think St Vincent's had failed to have the systems in place and the proper governance arrangements and the proper mechanisms to identify the seriousness of the issue, and so the information conveyed did not trigger that concern. There was nothing about that. Having said that—

The Hon. WALT SECORD: Mr Chair, I am going to disagree with your characterisation. Dr Chant, do you not feel that you trusted St Vincent's and they downplayed this and you believed them? Is that a correct characterisation? They called you in November: "Kerry, we've got it in hand, don't worry", and you said, "Yes, Anthony", and you accepted that, because they downplayed it?

Dr CHANT: I accept that my actions were based on the nature and the context of the call that I had with Anthony and the information portrayed and characterised.

The Hon. WALT SECORD: So the answer is yes, that they downplayed it and you believed them?

Dr CHANT: As I have said, my reading of the report is very much that they did not appreciate the seriousness of it. So in terms of the information conveyed, yes it was downplayed. The seriousness of this issue was not conveyed in the November call.

Mr JEREMY BUCKINGHAM: Did Professor Currow ever contact you after you had asked him to contact Professor Schembri? Did you ever have any follow-up with him after you had asked him to contact—

Dr CHANT: I had asked Professor Schembri to make contact with Professor Currow, from my recollection.

Mr JEREMY BUCKINGHAM: But did you not have a conversation with Professor Currow as well?

Dr CHANT: Yes.

Mr JEREMY BUCKINGHAM: So you asked Professor Schembri to make contact with Professor Currow, you also contacted Professor Currow and asked him to contact Professor Schembri, putting everyone together—

Dr CHANT: Yes. To be clear, my recollection is Professor Schembri called me, I then called Professor Currow, then got back to Professor Schembri saying I had briefed Professor Currow and urged them to get together.

Mr JEREMY BUCKINGHAM: Did you ever, between then and February, talk to Professor Currow again about these matters?

Dr CHANT: No. Until it emerged in February, there were no follow-up discussions with Professor Currow in relation to this matter.

Mr JEREMY BUCKINGHAM: He never sent an email or reported back in any way to anyone in the ministry?

Dr CHANT: I know that you are speaking to Professor Currow, so, again, it would go to the characterisation of the conversation with Professor Currow, which I would not want to speculate on.

The CHAIR: We will move on to Government questions now.

The Hon. NATASHA MACLAREN-JONES: I have just got one question in relation to clarification of details. You received the call; at the time you said that you felt that there was no danger for patients, therefore you made connections with Professor Currow. In the event that you had concerns about patient safety, what steps would have been taken or are taken?

Dr CHANT: There would be many circumstances where I would get notifications where there were clear concerns around patient safety. In those events, the issue is I would always go to what would be the immediate steps to make sure we understood the risk fully. What would then be the case is to immediately understand what immediate things we needed to put into place—was there something that was time critical and in that circumstance how would we immediately find those groups that were impacted? I would be convening my emergency response group to urgently work up the action plan, we would be having a series of teleconferences to map out—and there would be a real sense of urgency in stopping any immediate harm, whether that be a media release, a media alert or whether it be direct phone calls to patients to alert them to a particular thing they should do to protect their health and safety; it may be even setting up an immunisation clinic or an immunoglobulin clinic to provide them with specific medication.

So those things would be my first priority, which would be quantifying the risk and identifying the steps that were needed to be taken. I would then look at—

The Hon. WALT SECORD: Point of order: I would like to make an observation here. This is a Dorothy Dixer.

The Hon. NATASHA MACLAREN-JONES: No, it is not. We have not had a chance to get to the details because—

The Hon. WALT SECORD: You are asking a hypothetical question. I want to get to the crux—it is a Dorothy Dixer taking up our time.

The CHAIR: Order! We have been very fair with the timing. The Government is entitled to ask some questions and I have allocated some time for that. We will come back to the crossbench and the Opposition shortly. Dr Chant, you can finish the answer or you can move on.

Dr CHANT: Basically just to assure you, we would rapidly identify what any risks to patients are, identify the issues that needed to be immediately taken, and then do a thorough investigation of how the issues emerged or what other steps needed to be taken to prevent a recurrence. Then, as usual practice, we have a debrief at the end of it to incorporate the lessons learned—and there are always lessons learned in terms of how we communicate or how we managed an incident. That is the cycle of my usual response.

The Hon. GREG PEARCE: During this hearing you have been led into considerable speculation about what might have happened; I am much more interested in the facts. You were asked about whether you had made contact with the head of media and there was a lot of speculation about that. I take it your recollection is that you cannot recollect making contact with the head of media in November?

Dr CHANT: I cannot recollect.

The Hon. GREG PEARCE: It would be helpful if you just gave us the facts; not speculation about what you might have done.

Dr CHANT: Yes. I cannot recollect but—

The Hon. GREG PEARCE: That is fine. We accept that.

The Hon. WALT SECORD: In an earlier question I asked you specifically when did you alert the ministerial office about the chemotherapy under dosing at St Vincent's?

Dr CHANT: When did I alert them?

The Hon. WALT SECORD: When did the Minister and the ministerial office find out about this? You found out in November—

The Hon. GREG PEARCE: They are two different questions.

The Hon. WALT SECORD: No, they are not.

Dr CHANT: I just want to be clear—

The Hon. GREG PEARCE: When did you inform the Minister's office is the question?

Dr CHANT: In terms of the Minister's office, the Minister's office was informed through the processes of the notification from St Vincent's.

The Hon. GREG PEARCE: Could you answer the question: When did you inform the Minister's office or did you not inform the Minister's office?

The Hon. WALT SECORD: Thank you, Mr Pearce.

Dr CHANT: I am just trying to say that there would have been—

The Hon. WALT SECORD: Dr Chant, did you tell the Minister—

The Hon. GREG PEARCE: What did you do is the question?

Dr CHANT: I cannot recall that I specifically was the first person to tell the Minister's office about this incident. There would have—

The Hon. WALT SECORD: How did the Minister's office find out about this?

Dr CHANT: Well that is a matter for you to direct to the Minister's office but there was a series of conversations. Obviously the Minister and the Minister's office was concerned about this issue. It was aired publically I believe on the 19th—

The Hon. WALT SECORD: Eighteen-nineteen?

Dr CHANT: There was an in brief around that time. That would have been in my recollection the time when the discussions with the Minister's office was happening but the focus of most of my conversations with the Minister's office was concern about making sure that the disclosure process was made robustly and there was a graphic decision made, given the concerns, to setup the inquiry. So I have got, for instance, notes of 19 February that we had a teleconference with the Chief Health Officer and Professor Currow where, "The CEC and the Cancer Institute will review the terms of reference and the report into the incident and associated findings. As well as providing an external oversight this will allow systems learning …"

The Hon. WALT SECORD: The question is very simple, and Mr Pearce has assisted me. When did the Minister's office find out? When were they told? Did they find out when the *7.30* report called or did they know prior to that?

Dr CHANT: That is something that I cannot answer, all I can answer is my own actions—

The Hon. WALT SECORD: This is a major issue; I would remember the details. Can I switch you to another—

Dr CHANT: Could I just be very clear about that? I cannot answer the question of when the Minister's office was notified because I am not privy to all of the communication sources and the various timings of the in briefs or other things that would have been transmitted from SRC as part of the usual process, particularly when the in brief was notified.

The Hon. WALT SECORD: You just told us that there was a teleconference on 19 February?

Dr CHANT: Yes.

The Hon. WALT SECORD: Where there was discussion of a section 122 inquiry?

Dr CHANT: No, I did not mention that. I said at that time given there were concerns about the robustness of the investigations that St Vincent's had done even emerging on the 19th—

The Hon. WALT SECORD: So, an inquiry?

Dr CHANT: But I believe that the Secretary that day had announced that that was the intent to move to that, but this teleconference was, as I understood it, earlier in the day. The particular issues we were trying to grapple with there was to also make sure that there were no issues outside the particular—whilst there had been a particular focus on the particular chemotherapy agents, carboplatin prescribing, at this meeting we wanted to also make sure that they had looked into other regimes, like widened the investigation to make sure it was very holistic.

The Hon. WALT SECORD: From your recollection was Professor Currow at these meetings?

Dr CHANT: At the meeting on the 19th, which was minuted and should be in the briefs that you have received, Professor Currow was at that meeting.

The Hon. WALT SECORD: At any point at those meetings did he disclose that he knew back in November with you about this?

Dr CHANT: The meeting was with—

The Hon. WALT SECORD: I will tell you what I am trying to get to, and I will make it quick because I am mindful of time. Did Professor Currow, when you and the Government decided to setup the section 122 inquiry that he carried out, tell anyone prior to that that he had known about this since November?

Dr CHANT: I cannot speculate, I cannot speak for—

The Hon. WALT SECORD: But you were at these meetings?

Dr CHANT: I was not—can I just be clear that the focus of this meeting that we had, the Chief Health Officer and Professor Currow and Anthony Schembri, was more focused not on the inquiry but on: Are there other things or other patients that might be affected? It was clear then that there were concerns emerging that there had not been an appropriate and thorough investigation of the issues. So the focus of this teleconference was basically saying that you need to work more quickly to get your patients contacted and offering support. You need to move quickly, we cannot have patients not being advised and told, informed. It was also around technical issues around making sure that the names were transmitted to the cancer registry so that we could do longer term follow-up. Also that St Vincent's noted they had commenced quality assurance in relation to the doctor's other prescribing because clearly when you do these investigations you look at the particular issues raised but then do a little bit of a broadening to make sure that there are not parallel issues that might emerge in other streams. So this was the focus of the conversation—

The Hon. COURTNEY HOUSSOS: Dr Chant, I am sorry to stop you there but we have very limited time. During this conversation between yourself, Professor Currow and Associate Professor Schembri, did any of you disclose that you had had a November discussion about this very issue?

Dr CHANT: Again, all of the parties would have been party to that discussion. As I said, the focus of the meetings on 19 February and the week after to be perfectly frank were patient-focused and understanding the extent and the scope of it—

The Hon. COURTNEY HOUSSOS: So you did not raise with Professor Schembri at any point in any of those meetings that he—

The Hon. GREG PEARCE: Can I just clarify, in earlier evidence Dr Chant said that she did disclose or mention the November discussions at this time in February.

Dr CHANT: With senior executive, but the focus of this meeting and to be perfectly frank the effort that was taken in the week following this was very much around the practicality of the issues of understanding the scope and the impact on patients.

The Hon. COURTNEY HOUSSOS: I appreciate that, Dr Chant. But I am trying to find out whether you raised with Associate Professor Schembri at that time that you were concerned that he had downplayed this very issue to you in November. Three months prior when he raised this issue with you, did alarm bells ring for you and say, "This is the issue that you downplayed to me only three months ago?"

Dr CHANT: I cannot recall the specifics of the nature of the conversation. All I can recall, I have the minutes from these meetings, is that they were more about the focus on patients and the way the disclosure was happening and patients being supported. Because at that time—

The Hon. COURTNEY HOUSSOS: I appreciate the patient focus at that point. But were alarm bells ringing for you that you had heard from Professor Schembri in November, three months prior, that an issue had been downplayed that was now clearly mishandled by St Vincent's Hospital?

Dr CHANT: I cannot recall the specific call or raising that with Dr Schembri. It would be speculation. I cannot recall the nature of the discussion.

The CHAIR: Order!

The Hon. WALT SECORD: I think we have the answer.

The CHAIR: The witness has answered.

Mr JEREMY BUCKINGHAM: Dr Chant, the secretary initiated the inquiry under section 122 of the Health Services Act 1997?

Dr CHANT: Yes.

Mr JEREMY BUCKINGHAM: Professor Currow was put in charge of that? In the timeline that he lists relating to the events he says on 31 August the Director Clinical Governance and Director of Cancer Services met Dr Grygiel and there is no contemporaneous written record. The next entry says that on 16 November, "Matter for information attaching final internal investigation was provided to St Vincent's Hospital executive". On 24 November it says, "Formal invitation issued to the first external reviewer who was approached". On 26 November it states, "The first external reviewer declines invitation".

Professor Currow has failed to mention in his report, under the Health Services Act 1997, that in the middle of that the chief executive of St Vincent's has contacted you and said, "We have a problem, but it is not a big one, I do not think. By the way you should probably call Professor Currow". And Professor Currow has had a conversation with Professor Schembri. Does this not mean that this report is not worth the paper it is written on and this is an action designed to downplay and cover up a scandal and to protect the reputation of St Vincent's and executives in NSW Health, rather than protect patient safety? How is it that does not appear?

The Hon. BRONNIE TAYLOR: You have asked your question.

Mr JEREMY BUCKINGHAM: The key question is: How is it that conversation between you and he and Professor Schembri does not appear in this report?

Dr CHANT: Professor Currow is attending the next session. I would again indicate the characterisation of that call basically said there was no patient harm, that they were going to external review, and the CE was managing it. For me that call was an informal heads up that this matter is in hand and there may be some media interest. That was motivating the heads up. It was informal in nature. The governance systems at St Vincent's should have been in place to have taken the appropriate escalations. As I said, I think it is appropriate that—I am very contactable and Professor Schembri could have made contact with me if there were any concerns.

Mr JEREMY BUCKINGHAM: That is not the point. The point is that it should have been included in this report that the first time it spilled outside St Vincent's into NSW Health is not listed.

The Hon. GREG PEARCE: Professor Currow is the next witness.

The CHAIR: We are out of time. As chief health officer, are you brought up to scratch with investigations with the Health Care Complaints Commission [HCCC] and the Australian Medical Association about any medical officers?

Dr CHANT: No, but as part of some of my actions, one of the things I may do if issues are raised or brought to my attention I may refer issues to the HCCC for investigation and have done so on many occasions.

The CHAIR: At any time prior to November were you aware of the alleged issues with Dr Grygiel at that time or Dr Phadke? Were issues with both of those doctors brought to your attention in any shape or form?

Dr CHANT: Apart from the November call I had no previous issues with Dr Grygiel. The name would not have rung any bells. I was a resident at St George Hospital and did a medical oncology term and Dr Phadke was my supervisor on the placement list a long time ago.

The Hon. COURTNEY HOUSSOS: You do not need to disclose dates.

Dr CHANT: In terms of the issue of Dr Phadke, I was in regular contact with the CE of the district in relation to the investigation of Dr Phadke. I was the contact person at the ministry for those investigations. Basically the role was to keep a watching brief and provide any assistance they may need as it was worked through. There were many conversations.

The CHAIR: How many chief executive officers are there across New South Wales under your care?

Dr CHANT: There are 17 if you take the speciality network and CEs of the health pathology.

The CHAIR: Any of them could call you 24/7?

Dr CHANT: Yes.

The CHAIR: And quite often do?

Dr CHANT: Quite often do and I have a lot of engagement with clinicians and attend a lot of meetings involving clinical issues.

The CHAIR: When you do get something from one of those 17 chief executive officers that you think needs to be forwarded what is your process? Do you write something down or make a phone call?

Dr CHANT: Where there is any need for me to follow up or where there is action I need to document we keep minutes of those meetings or I would routinely email and do documentation of the meeting, that is a standard practice. I can demonstrate that is my standard practice in a range of incidents.

The CHAIR: Zero patient harm. If there is anything involving patient harm you would put pen to paper?

Dr CHANT: And certainly more aggressively follow up in the investigation. That was clear. We kept a close monitoring brief on the Dr Phadke investigation as that rolled out. In that case the CE of the local health district led that and we were there in the event there needed to be extra expertise or support provided.

The CHAIR: Thank you for presenting this morning. Mr Buckingham has asked you some questions on notice. The committee may put further questions on notice. You have 21 days to answer and the secretariat will assist you with any issues.

(The witness withdrew)

DAVID CURROW, Chief Executive Officer, Cancer Institute NSW, on former oath

PAUL CURTIS, Director, Governance and Assurance, NSW Clinical Excellence Commission, on former oath

PAUL GAVEL, Director Workforce, HealthShareNSW, on former oath

TINA CHEN, Medical and Scientific Advisor, Cancer Institute NSW, affirmed and examined

The ACTING CHAIR (The Hon. Bronnie Taylor): I welcome the witnesses. I ask the witnesses to be careful when using individual's names during the hearing. In order to avoid unnecessary harm to people's reputations please ensure your comments are relevant to the terms of reference. I remind participants to respect the privacy of individual patients. It is important to remember that parliamentary privilege does not apply to what witnesses may say outside of their evidence at the hearing. I urge witnesses to be careful about any comments they make to the media or to others after they complete their evidence as such comments would not be protected by parliamentary privilege if another person decided to take an action for defamation.

The CHAIR: Would anyone like to make an opening statement?

Professor CURROW: The section 122 inquiry and this Select Committee have a common objective—of understanding the complexity of the issues at hand and putting forward recommendations that do justice to the people affected by this issue for patients past, present and future—but it would be remiss not to highlight to this Committee the insurmountable challenge faced by all of us around these tables, and indeed anyone tasked with investigating these complex issues. Evidence cannot be found if it does not exist. Conclusions cannot be drawn if there are no data. The evidence that will allow us to definitively and exactly say how many people were affected and what the outcome was or will be, does not exist. Given the absence of clinical records, this inquiry, the select Committee or anyone else tasked with investigating this issue may never know its full extent.

It is important to stress that this is not a short-coming of this inquiry, nor the work of this Select Committee. The contemporaneous evidence needed to draw certain conclusions simply does not exist. To make any meaningful determination in the face of such complexity a rigorous and systematic approach is needed, using the evidence that does exist. This is what the section 122 inquiry undertook. This includes full clinical record reviews and stratified random sampling, which is a well established, valid, scientific method to study or review populations accurately and rigorously. Assertions have been made in the media reporting of this Select Committee that palliative patients were ignored by this inquiry. Palliative patients were not ignored by this inquiry. In fact, they were identified. Given the differences in the evidence base between chemotherapy given for curative intent and chemotherapy given for palliative intent, no evidence exists that would allow this inquiry or any other to arrive at an evidence based conclusion about the care offered through administering chemotherapy with palliative intent. This is where evidence based practice meets clinical judgement.

If we let these unknowable unknowns obscure the task at hand we are doing an injustice to the legacy of those people whom we do know have been affected. The patients who spoke to this inquiry wished for one legacy—that this not happen again. That is, they wished for each patient to receive personalised treatment based on the most rigorous contemporary evidence; for each patient to take part in an informed decision-making process for consent and be involved in the decision-making that will affect their health and well-being; for patients to be treated in a health system that allows patients and clinicians to report concerns safely, and for the system to respond effectively and continuously learn from these concerns.

The section 122 inquiry found that in the case of the individual clinician, certain prescribing practices were not supported by peer-accepted evidence; nor were patients informed about alternative treatment options. That is, if these patients were seen by another clinician in New South Wales they would have—not "may have"—received a different, and personalised, dose. For St Vincent's Hospital and Western New South Wales Local Health District, the section 122 inquiry found issues of clinical governance, culture and systems. The conditions of these particular environments failed to recognise, escalate and address the prescribing issues identified.

The integrity of the section 122 inquiry stands. Full implementation of the inquiry's recommendations will help to achieve the legacy that affected patients wished for. In combination, these recommendations will strengthen systems and clinical governance across the State, and ensure any clinician who departs from the best available, peer reviewed evidence, will have his or her practice held to account.

The CHAIR: Thank you, Professor Currow. I put on the record that for this Select Committee on Off-protocol Prescribing of Chemotherapy in NSW the Chair is the media spokesman. As politicians, members are

entitled to put their own parties' views forward and make their own comments, but the formal media comments come through the Chair.

The Hon. WALT SECORD: Professor Currow, you indicated in your opening address that you are standing by your report and the integrity of your report. In summary, you are saying that we will never, ever know the number of patients affected in New South Wales. I also put to you that you did not interview at least three doctors and nurses and allow them to refuse to participate in the inquiry. I am going to disagree with you, today, and say that we cannot stand by your report. How can you sit here today and say that you did a thorough report when you did not interview junior doctors and senior doctors and nurses? You say that this report stands and then you say that we will never, ever know the number of people affected by this. How can you sit here today and say that and stand by that report?

Professor CURROW: Thank you for your questions. There are two issues that you raised, and I will take you to them in turn, if I may.

The Hon. WALT SECORD: Please.

Professor CURROW: Firstly, with regard to evidence that is not available, I draw your attention to the fact that medical record retention is very specific in the Acts that govern that in New South Wales. For retail pharmacy that is a minimum of two years, only. As we have seen, we have resources that take us back to 2010 from the third party retail pharmacy service that provided care in western New South Wales.

In category-A referral hospitals the retention of records is for 15 years; in category-B hospitals it is 10 years, and for out-patients it is seven years. So we have a challenge. You indicated, when we met with you last time, that you were concerned that this did not go back far enough, but the bottom line is that if those records no longer exist they no longer exist. So, in terms of our ability to understand the prescribing we have to rely on records. Those records include, fortunately, retail pharmacy records that go back far longer than they are required to. In that regard it is very clear that the inquiry has used all of the available clinical records that could be made available to it. As I have indicated in my opening statement, the challenge is, if the records no longer exist or were never created, this inquiry or this Committee is in the impossible position of—

The Hon. WALT SECORD: Professor Currow—

Professor CURROW: May I finish?

The Hon. BRONNIE TAYLOR: Allow Professor Currow to finish the question.

The Hon. WALT SECORD: I am referring to the interviewing of witnesses—doctors and nurses refusing to cooperate. I will take what you say about clinical records. That is fine; let us put that aside. We are talking about interviewing doctors and nurses who observed and were aware and refused to participate. Police investigations compel people to give evidence.

Professor CURROW: As we discussed when I last met with you on this Committee, Mr Secord, there were a small number of people who declined to engage with the inquiry. That is correct, and that is a matter of record in the report itself. We have been very open and clear about that, and there is no doubt that, however, as the report also says, we have not relied on a single source of information for any of the findings and hence any of the recommendations. What we have done is to ensure that we have corroborated the findings of the inquiry with as many sources of information as possible.

As you go to the report, you will see that in outlining our sources of information in the report we have been very explicit about the documents that are provided by St Vincent's, both the written questions to which both St Vincent's and Western New South Wales responded, the interviews that were conducted with key current and former staff members who were prepared to interact with the section 122 inquiry, with a detailed review of clinical records, with an expert panel from experts around Australia, from interviews with patients and families and, lastly, with submissions that were provided to the inquiry. As with any inquiry—and you use the example of a police inquiry—the role is to ensure that you are corroborating the evidence that is put before the section 122 inquiry, as you would with anything else.

The Hon. WALT SECORD: I take you back to your 31 October evidence. You said that one doctor offered to provide written answers, but you declined that. You said, "It was not felt that that would particularly aid the inquiry".

Professor CURROW: Yes.

The Hon. WALT SECORD: A doctor offered to provide written answers and you refused.

Professor CURROW: Again, let us go to the inquiry. The inquiry is very clear, and the findings of the inquiry stand and I do stand by those.

The Hon. WALT SECORD: How about—

Professor CURROW: Sorry, if I may finish. That there were serious problems in the culture of St Vincent's, that there were serious problems in the systems that support individual clinicians and that there were problems with clinical governance are findings with which I am prepared to stand. The fact that an individual clinician may have declined does not in any way detract.

The Hon. WALT SECORD: I disagree with you on that. Can we go back to November—

Professor CURROW: I would like to finish and say that such findings do not detract from the findings and recommendations, which, if implemented, will ensure that we are reducing the risk of this happening again for patients in New South Wales. That is the most important issue that we face this morning together.

The Hon. WALT SECORD: Professor Currow, let us go back to November, when you received a call alerting you to a matter at St Vincent's Hospital. Let us to a bit of a tick-tock, a time line. Who called you?

Professor CURROW: Dr Chant.

The Hon. WALT SECORD: Dr Chant's earlier evidence gave a picture of St Vincent's underplaying the matter. What was your advice at the time?

Professor CURROW: I believe people suggested to Dr Chant in the earlier evidence that it was underplayed. The conversation I had with Dr Chant was in the early hours of the morning. I was on leave; I was overseas, and Dr Chant indicated to me that I should have a conversation with Associate Professor Schembri.

The Hon. WALT SECORD: Do you know Associate Professor Schembri?

Professor CURROW: I know him as a professional colleague. I did not know him before he was appointed to St Vincent's. I had not come across him, and my only contact with him has ever been at a professional level, either in meetings between St Vincent's and the Cancer Institute or between St Vincent's and his role as a senior executive within Health NSW.

The Hon. WALT SECORD: Did Associate Professor Schembri call you?

Professor CURROW: No, I believe I actually called him. It was later in the day on the east coast of the US, which would have been the next morning in Australia. My call from Dr Chant was at about 3 a.m. my time. I was on leave; my phone was on and I called Associate Professor Schembri when I next could reasonably do so when we would both be awake.

The Hon. WALT SECORD: What happened after that? Did it not come up until February?

Professor CURROW: That is correct.

The Hon. WALT SECORD: Was that the end of the matter for you?

Professor CURROW: That is correct.

The Hon. WALT SECORD: What did you recommend that St Vincent's do?

Professor CURROW: I did not recommend anything. What was put to me was that this was a matter of information for me, that the issue was in hand, but if there were media inquiries it would be about St Vincent's.

The Hon. WALT SECORD: You are the second witness to talk about media inquiries, but at any point did you discuss the welfare of the patients?

Professor CURROW: Again, I stress what was conveyed to me was that this was an issue at St Vincent's and the issue was in hand. I was not made privy to the details at that time. That is not an unusual conversation, as I am sure you would have had in your professional roles.

The Hon. WALT SECORD: When it came to organising the section 122 inquiry, who suggested that you conduct the inquiry?

Professor CURROW: I do not know.

The Hon. WALT SECORD: I know how these inquiries work. You call up someone and say, "Would you be willing to conduct an inquiry?"

Professor CURROW: That is correct.

The Hon. WALT SECORD: Who called you?

Professor CURROW: The Deputy Secretary, Ms Karen Crawshaw.

The Hon. WALT SECORD: Did you accept immediately?

Professor CURROW: As has been indicated to this Committee already, I had been part of several phone calls that day and I indicated that I would be willing to do it.

The Hon. WALT SECORD: Did you disclose at any point that you had knowledge of this back in November and you had already advised St Vincent's on how to proceed?

Professor CURROW: As I just said to the Committee, I did not provide advice to St Vincent's on how to proceed. I have not said that, Mr Secord. I did not actually have enough details provided to me in November to connect the two incidents.

The Hon. WALT SECORD: Was your response related to the nature of how St Vincent's conveyed it to you?

Professor CURROW: Yes.

The Hon. WALT SECORD: Because they had underplayed it?

Professor CURROW: I have not used that word, you have, Mr Secord.

The Hon. WALT SECORD: Okay, how would you characterise it?

Professor CURROW: I would characterise it as a telephone call for information.

The Hon. WALT SECORD: For information?

Professor CURROW: Yes.

The Hon. WALT SECORD: You were told that there was a problem at St Vincent's, one of Australia's premier hospitals, and you just accepted it because it came from St Vincent's?

Professor CURROW: No, in fact what they told me was that they were investigating an issue. They did not describe it as problem—

The Hon. WALT SECORD: Dr Chant called you at three o'clock in the morning.

Professor CURROW: She did not know that. My phone was on. I have just told you I was on leave. She did not know that, so let us put that firmly aside.

The Hon. WALT SECORD: Okay, I will take that.

Professor CURROW: What was characterised to me was that there was a problem that was being investigated, but if there were media inquiries it was going to be about St Vincent's—end of conversation. I offered, if I could be of any help, I would be happy to do so.

The Hon. WALT SECORD: At any point during the meetings did you disclose that you had had a conversation with St Vincent's in November?

Professor CURROW: As I have just indicated to you, Mr Secord, I did not have enough information from that conversation in November to connect the two events.

The Hon. WALT SECORD: So you did not tell anyone that you had knowledge of it before?

Professor CURROW: That is correct, because I did not have knowledge of it.

The Hon. WALT SECORD: You had a telephone call from St Vincent's in November about a matter. You are the Chief Executive of the Cancer Institute New South Wales.

Professor CURROW: Yes. Can I make it clear again, Mr Secord, there was not enough detail in that conversation to characterise it and link it to future conversations.

The Hon. WALT SECORD: You still did not feel the need to tell anyone about the telephone call three months earlier when a section 122 inquiry was being established and you were going to head it?

Professor CURROW: I again stress that is part of the normal cut—

The Hon. WALT SECORD: Is that how you conduct your investigations? Do you conduct your investigations like this?

Professor CURROW: That is the normal cut and thrust of conversations between senior executives within Health. This inquiry—

The Hon. WALT SECORD: I think you should have disclosed that you had knowledge of this before.

Professor CURROW: Mr Secord, you asked me another question and I would like to finish it. The veracity of this inquiry still stands. Its findings are there because of the sources of information that this inquiry has meticulously and rigorously sought. The recommendations are recommendations which, if enacted, are going to ensure that we are continuing to improve the care of people across New South Wales.

The Hon. WALT SECORD: Professor Currow, I put to you that in November you had more knowledge. You were asked to recommend someone to conduct the review.

Professor CURROW: No, I was not and I have not said that. I said if they wanted help with that I would be happy to help and I was not contacted again.

The Hon. WALT SECORD: That was it.

Professor CURROW: That is correct.

The Hon. WALT SECORD: So when you get a call from an organisation, St Vincent's Hospital, that is it; it is done. A telephone call in November—

The Hon. GREG PEARCE: Just for clarity, your evidence was that you had a call from Dr Chant not from St Vincent's Hospital?

Professor CURROW: That is correct and I rang Professor Schembri.

The Hon. GREG PEARCE: And you made the call to Professor Schembri?

Professor CURROW: That is correct.

The CHAIR: We will move on to Mr Jeremy Buckingham.

Mr JEREMY BUCKINGHAM: So Dr Kerry Chant calls you at 3.00 a.m. and you are on leave in the United States. You have your mobile data pack where you can just get phone calls in the United States?

The Hon. WALT SECORD: It is called roaming.

The Hon. NATASHA MACLAREN-JONES: It is called technology, Jeremy.

Mr JEREMY BUCKINGHAM: It was on a mobile phone?

Professor CURROW: My phone was on, Mr Buckingham.

Mr JEREMY BUCKINGHAM: I am just getting the details. So your phone was on. She calls your mobile phone and you take the call at 3.00 a.m. You indicate to her that it is 3.00 a.m. and you are on leave wherever you are?

Professor CURROW: No.

Mr JEREMY BUCKINGHAM: No? You just take the call?

Professor CURROW: Yes.

Mr JEREMY BUCKINGHAM: She says to you, "Can you please call Dr Schembri because there's something happening at St Vincent's"?

Professor CURROW: That is correct.

Mr JEREMY BUCKINGHAM: What is your recollection of that conversation?

Professor CURROW: That is my recollection of the conversation.

Mr JEREMY BUCKINGHAM: She did not characterise what it is relating to, like chemotherapy?

Professor CURROW: It was in oncology and that was the characterisation of it.

Mr JEREMY BUCKINGHAM: How long do you reckon the conversation went for?

Professor CURROW: It was a very brief conversation.

Mr JEREMY BUCKINGHAM: You then contacted Professor Schembri the next day or thereabouts?

Professor CURROW: That is correct.

Mr JEREMY BUCKINGHAM: And you had another brief conversation with him?

Professor CURROW: That is correct.

Mr JEREMY BUCKINGHAM: How long do you think that conversation went for?

Professor CURROW: A few minutes.

Mr JEREMY BUCKINGHAM: You had no recourse; you did not contact anyone at NSW Health, in the Government, between that conversation and when the matters then emerged publicly in February?

Professor CURROW: That is correct, Mr Buckingham.

Mr JEREMY BUCKINGHAM: There was no conversation, no emails, nothing?

Professor CURROW: That is correct, Mr Buckingham.

Mr JEREMY BUCKINGHAM: That is why when the matter did arise in February you did not think the two were linked?

Professor CURROW: I did not have enough information from the first conversation to link them, that is correct.

Mr JEREMY BUCKINGHAM: In the first conversation you were not told it was about a possible underdosing?

Professor CURROW: No.

Mr JEREMY BUCKINGHAM: You were not told it was about underdosing. Were you told it was about chemotherapy?

Professor CURROW: Yes.

Mr JEREMY BUCKINGHAM: What about chemotherapy?

Professor CURROW: That was it. Can I just—

Mr JEREMY BUCKINGHAM: No, no. You were told that there was an issue with chemotherapy in our hospital?

Professor CURROW: So, if I can take—

Mr JEREMY BUCKINGHAM: Can you characterise what the issues were—

The Hon. BRONNIE TAYLOR: Let him answer and then you will find it out.

Mr JEREMY BUCKINGHAM: Say point of order if you have an issue.

The Hon. BRONNIE TAYLOR: I am trying to be fair, Jeremy.

Mr JEREMY BUCKINGHAM: What were the issues around chemotherapy that were raised with you at that time?

Professor CURROW: If I can take the Committee back to how this was characterised still at the time by St Vincent's, it was not an incident in their view. They had not had content expertise and so at that time they had had no medical oncology input into it.

Mr JEREMY BUCKINGHAM: They had had an internal review?

Professor CURROW: With no content expertise related to medical oncology. The inquiry report is very clear on that, Mr Buckingham. So at this time as they are talking about going to get an external opinion, that is an entirely appropriate step for them to take.

Mr JEREMY BUCKINGHAM: And you just took it at that and you did not—

Professor CURROW: This is a senior executive saying to me, "This issue is in hand. If there is media interest in this it would relate to St Vincent's" rather than going, "To which hospital in the State does this media interest—

Mr JEREMY BUCKINGHAM: Did you think they were not materially important facts? Why did you not include the first notification in your inquiry report? Why did you decide not to include that in the section 122 inquiry report?

Professor CURROW: Firstly, the time line that is included is actually the time line provided by St Vincent's and at no time did St Vincent's in any of their submissions to this inquiry actually identify those phone calls or that contact.

Mr JEREMY BUCKINGHAM: So the time line is not the time line of events as established by you; they are the time line of events asserted by St Vincent's?

Professor CURROW: And as I have said, we did not rely on a single source before accepting that. We ensured that that was triangulated in order to confirm that through the interviews, through the written questions and through the documents that were provided to this inquiry.

Mr JEREMY BUCKINGHAM: That is St Vincent's and others?

Dr CURTIS: Excuse me; I am sorry, could I correct Professor Currow there because you have taken him in a different direction. The time line in the report is the time line we established based on the documentation, interviews and so forth. That is our time line. St Vincent's provided us with a time line as part of their documentation to us and other documentation. In none of that documentation did they indicate they reported to Professor Currow or Dr Chant in November. That is what Dr Currow is saying.

Mr JEREMY BUCKINGHAM: Yes, but that defies common sense. You would think that you, as a participant in that conversation, would then put that in there—"I've got a phone call from the NSW Chief Health Officer that might be materially of interest in your own report"?

Professor CURROW: Dr Chant and I would talk several times a week in the normal course of business and again there was not sufficient detail in the November conversation, Mr Buckingham.

Mr JEREMY BUCKINGHAM: You never put the two together?

Professor CURROW: The two go together very clearly.

Mr JEREMY BUCKINGHAM: But you never did, and that is why you did not put it in there?

Professor CURROW: That is correct, Mr Buckingham.

Mr JEREMY BUCKINGHAM: Well, I do not accept that.

The Hon. COURTNEY HOUSSOS: When did you connect the two?

Professor CURROW: The two were connected in February.

The Hon. COURTNEY HOUSSOS: So you are saying—

Professor CURROW: But it is not material. This was not a notification of Health.

The Hon. COURTNEY HOUSSOS: Sorry, Professor Currow, let me just go back—we have very limited time today—you just said that the two were clearly connected but you said that you had not connected them to write it in the report but you had connected them in February. So at what point did you think that you should disclose that you knew about this in November?

Professor CURROW: Again, I need to make it clear that I did not know about off-protocol flat dose prescribing in November. What I knew was there was an area of interest for the media at St Vincent's Hospital, Darlinghurst, and we need to be really clear about the distinction between those two things, so in terms of—

The Hon. COURTNEY HOUSSOS: So would you say that you are generally part of the media management of issues for NSW Health?

Professor CURROW: If it relates to cancer, chances are that I will be brought into the loop at some stage.

The Hon. COURTNEY HOUSSOS: But you are saying now that you were not brought into the loop; you are saying that actually you indicated that there could be some media interest but not provided with any details?

Professor CURROW: That is correct. I want to reiterate—

The Hon. COURTNEY HOUSSOS: I repeat my first question: At what point did you connect the November phone call with the February notification?

Professor CURROW: I am saying that I did not have sufficient information in November to connect the two.

The Hon. COURTNEY HOUSSOS: I appreciate that, but at what point did you connect the two?

Professor CURROW: In February.

The Hon. COURTNEY HOUSSOS: When it was first announced on 18 or 19 February?

Professor CURROW: Yes.

The Hon. COURTNEY HOUSSOS: So well prior to you beginning your report?

Professor CURROW: That is correct.

The Hon. COURTNEY HOUSSOS: At what point did you decide not to include it in the report?

Professor CURROW: It was not an active decision. I did not have information in November and nor did Dr Chant that this was flat dose off-protocol prescribing of chemotherapy.

The Hon. COURTNEY HOUSSOS: And we have established that.

Professor CURROW: So it was not characterised that way. I need to be really clear about that.

The Hon. COURTNEY HOUSSOS: But you were charged with writing an independent review into this process. Ms Crawshaw from the NSW Ministry of Health called you and asked you to conduct an independent review. At any point did you say to her, "I was first advised that this may be an issue or that there maybe an issue" in November? Did you ever say that to Ms Crawshaw?

Professor CURROW: We had a discussion about my contact with St Vincent's and that included the fact that I meet with St Vincent's executive on an annual basis to look at their cancer performance, that I am on an advisory group across the campus, which was part of the normal business processes that would occur in interacting between an organisation such as the Cancer Institute NSW and local health districts right across the State.

The Hon. COURTNEY HOUSSOS: I bring you back to the question: Did you disclose to Ms Crawshaw on that first day, or at any point subsequently, that you had been informed an issue was emerging at St Vincent's Hospital?

Professor CURROW: No.

The CHAIR: From what I am hearing, it appears that you had no idea that it was to do with this issue in November. It could have related to five other issues.

Professor CURROW: That is correct.

The Hon. COURTNEY HOUSSOS: With respect, Dr Currow said that he did realise that in February.

The CHAIR: From what I understand, he made the link in February, but in November he had no idea that it related to this issue.

Professor CURROW: That is absolutely correct.

The Hon. COURTNEY HOUSSOS: I appreciate that. However, I am trying to establish at what point in February you realised there were warning signs that this problem was emerging.

Professor CURROW: I had no indication in February that there were warning signs that this problem was emerging because I did not have enough detail characterised in November that it was this problem.

The CHAIR: In light of your consultations with St Vincent's Hospital over the years, could there have been any amount of other issues that you could have believed were the topic of that November conversation?

Professor CURROW: It is fair to say that a number of issues would be the subject of ongoing conversations with St Vincent's Hospital.

The CHAIR: That phone call could have related to any of those instances?

Professor CURROW: That is right.

The CHAIR: Thank you.

Professor CURROW: Again, I make it very clear to the Committee that even in February the extent and the characterisation of this was not in place. If we look at 18 and 19 February in terms of the media statement made by St Vincent's Hospital and the knowledge of what was happening at that time, it was not until the section 122 inquiry got underway and we started to do detailed clinical reviews that the extent of this became apparent. It was not apparent on the night of 18 February; it was not apparent on 19 February. It was apparent when the section 122 inquiry started to do detailed clinical reviews of patient notes.

The Hon. GREG PEARCE: You had one phone call in November from Dr Chant, and you did what you were asked, which was to call Dr Schembri. It was all in the context of a potential media inquiry, but there was no inquiry.

Professor CURROW: Not to me or to my organisation.

The Hon. GREG PEARCE: No-one contacted you or asked you to do anything further?

Professor CURROW: That is correct.

The Hon. GREG PEARCE: No-one gave you any further information?

Professor CURROW: Or asked for further assistance.

The Hon. BRONNIE TAYLOR: I take you back to a comment you made earlier. As the chief cancer officer you regularly meet with health services across the State. I know that, but I want to make it clear for the record. Every year you have a detailed a meeting with chief executive officers of every health service to discuss how they are progressing with their cancer plans.

Professor CURROW: That is correct.

The Hon. BRONNIE TAYLOR: At any time during your annual meeting with St Vincent's Hospital—the annual meeting that you have with every health service—did it ever flag any concerns related to off-protocol chemotherapy dosing?

Professor CURROW: No.

The Hon. BRONNIE TAYLOR: That was never mentioned; you never had a heads up in those formal meetings. That would have been the ideal opportunity to raise concerns with you.

Professor CURROW: Absolutely. Those meetings are about their cancer performance and cancer outcomes. They are detailed meetings with clinicians and senior executives, and those issues were never raised.

The Hon. BRONNIE TAYLOR: I know and you know, but for the benefit of everyone else, they are detailed meetings and they involve detailed documents and data about progress and any concerns they have. They are also about benchmarking and establishing whether those benchmarks are being met across the State. Is that correct?

Professor CURROW: That is correct. This is about the spectrum of cancer control. Importantly, it includes local data that are adjusted for the population that is served. Each local health district or specialty health network gets that information weeks in advance to understand their performance in the context of what is happening across the State.

The Hon. BRONNIE TAYLOR: Would it be reasonable to expect that if there were concerns about what was happening St Vincent's Hospital they would be raised in that forum with you as the chief cancer officer and the director of cancer services at St Vincent's Hospital?

Professor CURROW: I think it is a perfect forum in which to raise issues of concern. I have been in those meetings, and I will be involved in further meetings with other local health districts, this week. We talk about a wide range of issues in medical, surgical, radiation oncology and supportive services. It is the environment in which to raise issues and to explore them.

The Hon. BRONNIE TAYLOR: And it was never raised.

Professor CURROW: No.

Mr JEREMY BUCKINGHAM: I put it to you that what is absent from your report, findings and recommendations is any mention of responsibility or accountability with regard to any individual. You have made recommendations and findings about clinical governance, better protocols and so on. Who is actually held to account? The key failing of your inquiry was the failure to interview Dr Stephen Cooper. It is not true that he offered to give evidence but that you refused to take it despite the fact that he is effectively the whistleblower? Why?

Professor CURROW: If I may correct the record, firstly, Dr Cooper declined to give evidence on legal advice.

Mr JEREMY BUCKINGHAM: But he did.

The Hon. NATASHA MACLAREN-JONES: Point of order: The witness is trying to answer the question. Mr Buckingham should be directed to allow the witness to answer.

Mr JEREMY BUCKINGHAM: To the point of order: He has answered the question and I have another one to ask him. Did Dr Cooper offer to provide written evidence?

Professor CURROW: I reiterate, on the suggestion of his legal advisers, Dr Cooper declined to be interviewed by this inquiry. That is very clear. Mr Buckingham, you have indicated that you believe Dr Cooper is the whistleblower. The inquiry's report is very clear in making it plan that there were several sources of information in the second quarter of 2015 that were raising the issue of Carboplatin prescribing.

Mr JEREMY BUCKINGHAM: But he was the key source. You previously stated, "One of the people offered to answer some of the written questions." That was Dr Cooper. You further stated, "It was not felt that that would particularly aid the inquiry." How is it that the written evidence of Dr Stephen Cooper would not aid the inquiry? Do you stand by that statement?

Professor CURROW: I absolutely stand by the statement because what you have in front of you in the section 122 findings is very clear: St Vincent's Hospital had major problems—

Mr JEREMY BUCKINGHAM: I do not want to talk about St Vincent's Hospital. I want to talk about why you decided not to interview Stephen Cooper. You made—

Professor CURROW: Please do not shout at me.

Mr JEREMY BUCKINGHAM: I will not be misled; I will not deal with obfuscations. I want to know why you decided not to—

The Hon. GREG PEARCE: Point of order: The member should behave civilly—even though it does not suit him.

Mr JEREMY BUCKINGHAM: He should treat the Committee with respect.

The CHAIR: Order! This is a parliamentary committee hearing.

Mr JEREMY BUCKINGHAM: To the point of order: The witness will treat the Committee with respect. We are not idiots.

The CHAIR: We should also treat witnesses with respect given our role in public office. The member has had an opportunity to ask a question, the witness has the right to answer it, and the member then he has the right follow on with a further question. Dr Currow has tried to answer the question. I have no problem with the fact that the member's questioning is vigorous, but Dr Currow should be allowed to defend himself in respect of why Dr Cooper was not involved in the inquiry.

Professor CURROW: As I indicated, Dr Cooper declined to be interviewed, on legal advice, by this inquiry. I want to reiterate—your face suggests you doubt that, Mr Buckingham.

Mr JEREMY BUCKINGHAM: He has given evidence to us. He says, "I extended a further invitation to appear at a later stage and provide written evidence". That is the case, is it not?

Professor CURROW: No, it is not. He did not ever offer to be interviewed by this inquiry.

Mr JEREMY BUCKINGHAM: He did not offer to give any evidence?

Professor CURROW: No. I said very clearly he did not offer to be interviewed—

Mr JEREMY BUCKINGHAM: Okay, so he did—

Professor CURROW: I am sorry, can I please answer the question? You have shouted at me so far this morning—

Mr JEREMY BUCKINGHAM: There were two parts to the question. The question was: Did he offer to provide evidence?

Professor CURROW: No, you said did he offer to—

The Hon. NATASHA MACLAREN-JONES: Point of order—

The Hon. WALT SECORD: I do share Jeremy's frustration with the witnesses.

Mr JEREMY BUCKINGHAM: The question is: Did he offer to provide evidence to the inquiry?

Professor CURROW: He offered to provide written answers to questions.

Mr JEREMY BUCKINGHAM: And why did you decline it?

Professor CURROW: If I may answer that question—

The Hon. NATASHA MACLAREN-JONES: Point of order—

Mr JEREMY BUCKINGHAM: I have asked the question three times.

The CHAIR: Order! You have asked the question three times and you will not get an answer if you do not let the witness answer. Let Dr Currow answer this because we are all interested in this key submission from Dr Cooper that he gave to this inquiry. We want an answer and we want a fair answer from Dr Currow, who is entitled to give the answer that he feels answers the question. Dr Currow?

Professor CURROW: Thank you for your question, Mr Buckingham. The inquiry was not in a position to interview Dr Cooper because he declined to be interviewed on legal advice. He offered to provide written answers to questions and, as the inquiry report has very clearly outlined—not to obfuscate, not to mislead you—we have not relied on a single source of information for any of our findings. So the omission of Dr Cooper does not change the findings that there were substantial problems—

Mr JEREMY BUCKINGHAM: With all respect, Professor, why did you decline the offer?

Professor CURROW: I do not actually have a written offer from Dr Cooper offering to answer written questions, Mr Buckingham, so if you have, please share it with us.

Mr JEREMY BUCKINGHAM: So are you saying that he never offered to provide written evidence or evidence in any way?

Professor CURROW: That is correct. On legal advice, the evidence we have is that he was not going to provide evidence.

Mr JEREMY BUCKINGHAM: But you have already told this inquiry—

The Hon. WALT SECORD: It is his own words.

Mr JEREMY BUCKINGHAM: Your own words are—

Professor CURROW: That there was a senior clinician. Did I mention Dr Cooper?

Mr JEREMY BUCKINGHAM: So you are saying that that evidence does not relate to Dr Cooper?

Professor CURROW: We identified that there were people who had declined and—

The Hon. WALT SECORD: Dr Currow, can you help us? How many people refused to participate in your inquiry, in total?

Professor CURROW: As we put in our written answers to you, Mr Secord, there was one person from Western NSW Local Health District—

The Hon. WALT SECORD: A nurse, yes.

Professor CURROW: And there were, in total, four people from St Vincent's.

The Hon. WALT SECORD: And of those, two were junior doctors, one was a senior clinician. Is that correct?

Professor CURROW: That is correct.

The Hon. WALT SECORD: And who was the fourth?

Professor CURROW: A junior doctor.

The Hon. WALT SECORD: So, in total, five clinicians refused to participate in your inquiry.

Professor CURROW: They declined to do so.

The Hon. COURTNEY HOUSSOS: Professor Currow, I am just going to stop you there because you have said that at St Vincent's there were three junior clinicians and one senior clinician.

Professor CURROW: Yes.

The Hon. COURTNEY HOUSSOS: In evidence that has been provided to this Committee, Dr Cooper has self-identified himself as saying that he offered to provide written answers to your inquiry. You say that one of the people offered—and this is your previous testimony, which Mr Jeremy Buckingham has said—to answer some written questions. Are you saying now that there was another senior clinician, other than Dr Cooper, at St Vincent's who was prepared to answer written questions? Is that your submission today?

Professor CURROW: We have three junior doctors who declined: a nurse from Western and certainly we had Dr Cooper. But what I am saying is I do not have an offer of written questions there.

The Hon. COURTNEY HOUSSOS: But you said that one of the people offered to answer some written questions. So you are saying that it was one of the three junior doctors who offered to answer written questions?

Professor CURROW: We had the offer from one of the potential interviewees to answer written questions, but—

Mr JEREMY BUCKINGHAM: Was it one of the junior doctors or was it the senior clinician? Was it one of the nurses or—

Professor CURROW: Mr Buckingham, importantly, it was not Dr Cooper.

The Hon. WALT SECORD: If someone said they would provide written answers and you are doing an investigation, why did you not then take them?

Professor CURROW: Because, Mr Secord, as I have been trying to convey to this Committee—

The Hon. WALT SECORD: You have given an impression about this inquiry and it seems that this inquiry that you conducted was not very thorough.

Professor CURROW: As I have tried to convey to this Select Committee, the findings of the section 122 inquiry have at no time relied on a single witness, a single document. They have triangulated to ensure that we have firm findings around the issues that this inquiry was asked to look at, and those issues are around St Vincent's, how it conducted its internal inquiry and how its clinical governance and processes were in place.

The Hon. COURTNEY HOUSSOS: Professor Currow, I put it to you that you do not know what you do not know, and when you have five outstanding witnesses who have evidence that could have been relevant to your inquiry you cannot rule out that there was something else that was not discovered by your inquiry.

Professor CURROW: You are correct. I cannot rule that out at all. But what we do have—

The Hon. COURTNEY HOUSSOS: That contradicts what you said earlier today in saying—

Professor CURROW: No, I am sorry, I do not believe it contradicts—

The Hon. WALT SECORD: How can you stand by this report? You did not interview five clinicians.

Professor CURROW: I do not believe that this contradicts in any way what I said earlier today. The findings of this report are not from a single person, are not from a single source. There are issues, and, importantly, we have both St Vincent's and NSW Health accepting the recommendations in their entirety across these programs. The findings of this inquiry stand.

The Hon. COURTNEY HOUSSOS: We are not disputing that, but we are saying that there is additional information that is out there that could have been provided to your inquiry by Dr Cooper, by other doctors, who clearly wanted to provide information from written evidence.

Professor CURROW: Perhaps Dr Curtis can take that.

Dr CURTIS: Can I make a comment?

The Hon. COURTNEY HOUSSOS: Can I just finish my question?

The CHAIR: Dr Curtis, we will allow the member to complete her question. I appreciate that you want to add some clarification.

The Hon. COURTNEY HOUSSOS: The point that you have made consistently, Professor Currow, is that you need more than one person to corroborate something. With at least five outstanding people who were not interviewed, surely then there could have been matters that were not pursued, and given that at least one, but now perhaps two—which is somewhat unclear—were prepared to answer written questions but you declined this offer, how can you then say that there are not outstanding matters that were not dealt with by your inquiry?

Professor CURROW: I have already agreed that there may be other issues. But what I am saying is that this inquiry has found very clearly that there are problems of culture, of systems, of clinical governance, that require remediation, and the recommendations, if enacted, are going to improve the health in this State as a direct consequence of the inquiry.

The CHAIR: Dr Curtis?

Dr CURTIS: Firstly, it is our report, not Dr Currow's report—with due respect to Dr Currow. But we have all worked very hard on this report. I think we ought to look at the other side. We have interviewed more than 30 people at length—usually an hour at least for each person—and we have reviewed—St Vincent's said they gave us 1,500 pieces of documentation; Western NSW gave us a large amount of documentation as well. We reviewed all of that documentation, took into account all of those interviews, to come up with the substantive issues of concern regarding the prescribing of off-protocol carboplatin. Even if there are other issues that people could raise, we have identified the substantive issues that will go to improving care for cancer patients in New South Wales. That is the most important thing. That was what we were charged to do. We were not charged to look at individuals; we were charged with making sure that, going forward, the care of cancer patients is improved not—

The Hon. GREG PEARCE: Was it open to individuals who have had an interest to actually make a submission to you or to provide you with information?

Professor CURROW: As outlined in the inquiry's report, several people made submissions spontaneously and—

The Hon. GREG PEARCE: These non-witnesses could have done the same?

Professor CURROW: That is correct.

Mr JEREMY BUCKINGHAM: As part of your written responses to the Committee, this question was put to you: "Did anyone other than Dr Grygiel give evidence to your inquiry that they had raised Dr Grygiel's practice of flat dosing with anyone other than Dr Grygiel before June 2015?" The answer was: "Yes." The next question was: "Who?" The answer was: "Two people indicated that a pharmacist had raised it." The next question was: "On how many occasions?" The inquiry was told of one occasion but the key thing here is: "Who was it raised with?" The answer was: "The two people indicated it had been raised with a senior clinician, the senior clinician concerned indicated that no-one had raised it with him/her." Can you tell us who that senior clinician was or is?

Professor CURROW: Again, in the light of the introductory remarks of the Chair I would need to take on notice whether we are going to name someone in that circumstance, given that they have denied the conversation has taken place and given that we undertook to all interviewees that their interviews were confidential.

Mr JEREMY BUCKINGHAM: You do not think it is materially significant that you have a senior clinician disputing this? Would you be prepared to provide the evidence of those people in camera to the Committee, on a confidential basis?

Professor CURROW: This inquiry is happy to provide anything in camera to this Committee, noting that as people were invited to be interviewed by the inquiry the letter that was sent to them offered them confidentiality. So this Committee would need to treat that very seriously.

The CHAIR: We understand the spirit of that.

The Hon. GREG PEARCE: You would need to get a release from them.

Professor CURROW: Yes.

The Hon. WALT SECORD: Dr Grygiel said in evidence that he was not the only doctor underdosing at St Vincent's. In your inquiry—and perhaps Dr Paul Curtis could enlighten us if Professor Currow does not know—did you discover that there were other doctors who were underdosing?

Professor CURROW: I believe that Dr Grygiel may have been referring to two patients in the case series that was developed at St Vincent's who were prescribed 100 milligrams of carboplatin. I would again draw the Select Committee's attention to my evidence last time that a personalised dose of carboplatin may include a dose of 100 milligrams for some patients.

The Hon. WALT SECORD: So Dr Grygiel is wrong, there was not another doctor underdosing?

Professor CURROW: I am sorry, if I may finish the explanation because this is very important; it is incredibly germane to the conversation today. There are people for whom 100 milligrams may be the personalised calculated dose for their particular cancer and there are other people for whom 100 milligrams given as a flat dose in a way that was not personalised is the subject of this inquiry. So, yes, there were two patients in—

The Hon. WALT SECORD: Who received 100 milligrams?

Dr CHEN: Could I please add to that?

The Hon. WALT SECORD: Yes.

Dr CHEN: As you could tell from the inquiry's final reports on St Vincent's Hospital that we conducted a thorough case note review based on the pharmacy records that St Vincent's had provided to us, which enabled us to look at all carboplatin and cisplatin prescribing for all prescribers. With regards to 100 milligrams carboplatin we actually reviewed patients who were prescribed that dose, not just by Dr Grygiel but also other consultants, and we could say with confidence that there was no other off-protocol flat dose at 100 milligrams. There may have been other patients who had received that dose but that just happened to be their personalised calculated dose.

The Hon. WALT SECORD: Can I take you to the brain cancer patients that came up in previous evidence. Materials that we received last night said there were 11 patients involved. Can you take me through what happened?

Dr CHEN: I believe how that issue came to light—

The Hon. WALT SECORD: Again, it was a whistleblower's family that came forward on this one.

Dr CHEN: So, as we have repeatedly emphasised, the inquiry has relied on multiple sources of information. In the course of talking to the staff at St Vincent's and also doing a detailed case note review, there was no indication that there was other off-protocol prescribing to a similar extent with the flat dose carboplatin. I believe the temozolomide issue came to us because St Vincent's had a 1800 phone number for any of their patients who might be concerned. I understand a patient or the patient's family rang and asked to be reviewed. In the course of that—I am not sure about the specific details of that case—it did appropriately prompt St Vincent's to look into all other temozolomide prescribing by Dr Grygiel. Temozolomide, very much like capecitabine, is an oral chemotherapy, which means that there would be information gaps in terms of the hospital's pharmacy records.

They did look and in their own system they could find 11 patients, and they very kindly provided that information to the inquiry. But I do have to highlight that the temozolomide issue only came to St Vincent's attention after the inquiry had already delivered our final report—so this was after 31 July. Based on the information that St Vincent's gave to us, and we were reassured that they involved medical oncology content expertise in a very timely way, and based on their own expert review, there was nothing to suggest to us that apart from the one person who happened to be very sick—again I have not seen the actual clinical notes—but there was no other indication that there were issues with temozolomide.

The CHAIR: In light of the self-preservation of the high reputation of St Vincent's Hospital, could it be likely that they did not fully disclose all information to you?

Dr CHEN: I cannot comment on what St Vincent's may or may not have done.

The CHAIR: You just said that you made a judgement on the stuff that you were given. My question is: Could there be stuff that you were not given?

Dr CHEN: I do not think I would be able to make a comment with regards to that but—

Professor CURROW: May I?

Dr CHEN: Sure.

Professor CURROW: Again back to Dr Curtis's point, the interviews that this inquiry undertook included the Executive, those charged with management particularly of clinical governance, the entire clinical governance team and clinicians at all levels within oncology services. If we are really saying that something has been deliberately withheld, we are talking about a very wide range of people who would need to be party to that. I do not believe that they have knowingly withheld information from this inquiry.

The Hon. WALT SECORD: Professor Currow, that is a big call.

The Hon. GREG PEARCE: That is his view.

Mr JEREMY BUCKINGHAM: I am interested in a couple of things. Earlier I raised the matter about the two people who indicated that it had been raised with a senior clinician. When was that raised with a senior clinician?

Professor CURROW: The indication was that was some years ago.

Mr JEREMY BUCKINGHAM: How long? Five years ago? Two years ago? Can you give a date?

Professor CURROW: No, I cannot give a date. This was someone who had been a junior member of staff on rotation who was reflecting that some years ago they had been told that a conversation occurred. I cannot give a date because a date was not given to the inquiry.

The Hon. GREG PEARCE: It is hearsay on hearsay.

Professor CURROW: It is hearsay on hearsay.

Mr JEREMY BUCKINGHAM: It is hearsay on hearsay but you did not think to say: "When did this happen?" Because when these matters began was important—

Professor CURROW: What was said was several years ago. I cannot get a witness to be more precise than that if that is what the witness is going to tell me.

Dr CURTIS: We did ask the question, "When?" They could not recall when but they could recall doing it. They did not remember the date. We did follow that up.

Mr JEREMY BUCKINGHAM: They would have known when they were working in that role, they should be able to pin it down to a couple of years?

Professor CURROW: As I say it was several years ago.

Dr CURTIS: Some of those pharmacists did multiple rotations through oncology. Even though you say they were working at a certain time they did have trouble pinning it down.

Mr JEREMY BUCKINGHAM: Fair enough. What was the sequence in terms of interviewing some of the senior clinicians? Did you interview Dr Grygiel after you had interviewed Dr Gardiner, Dr Gallagher and Dr Dalley?

Professor CURROW: The order was that Dr Grygiel was interviewed later. As you will recall from the interim report Dr Grygiel was overseas throughout that time and the inquiry, I believe, sought to meet with him on his return to Australia. My understanding, if I recall, Mr Buckingham, was that he met with the medical council immediately upon returning to Australia and we met with him within a couple days of his return to Australia.

Mr JEREMY BUCKINGHAM: His evidence contradicts the evidence of Dr Gallagher in particular?

Professor CURROW: Sorry, which particular evidence of Dr Gallagher?

Mr JEREMY BUCKINGHAM: About who knew what when. Whether or not Dr Gallagher knew. Dr Grygiel was saying that Dr Gallagher was aware of his protocol and practice for many years.

Professor CURROW: I think you will find that Dr Grygiel said that Dr Cooper knew for several years and Dr Dalley knew, I am not aware of Associate Professor Gallagher being identified by Dr Grygiel.

Mr JEREMY BUCKINGHAM: I made a mistake. It must be Dr Dalley. You did not follow that up with Dr Dalley? You did not reinvestigate that element, the contradictory evidence?

Professor CURROW: We interviewed several people twice.

Mr JEREMY BUCKINGHAM: Did you interview Dr Dalley twice?

Dr CURTIS: No, we only interviewed Dr Dalley once, but it was after the first interview with Dr Grygiel. Dr Dalley was overseas at the same time. We were not able to interview him before we interviewed Dr Grygiel. And, yes, we put the question to him and he denied it.

Mr JEREMY BUCKINGHAM: He did deny it?

Professor CURROW: Yes. You are seeing him this afternoon and there is opportunity to discuss that with him.

Mr JEREMY BUCKINGHAM: My last question relates to statistical analysis of cancer patients in NSW Health. It has been put to me that the methodology is not particularly reliable and that the random sampling is less than 1 per cent of cancer cases. Do you stand by the methodology and statistical analysis you

employed to assess the various types of cancer and whether or not this flat dosing is an issue amongst them? The fact that we have a random sample of 1,800 of up to 200,000 patients in these circumstances. Do you stand by the statistical methodology that you have employed?

Professor CURROW: Could I seek direction from the chair? It would seem that talking about the audit of cancer patients going forward is outside the remit of the section 122 inquiry.

The CHAIR: Professor Currow, you have every right to refuse to answer a question if it is outside your expertise or you feel you cannot answer it.

The Hon. GREG PEARCE: It is outside the terms of reference.

Mr JEREMY BUCKINGHAM: As the head of the Cancer Institute in this State what is your view on that?

Professor CURROW: That is a different question.

Mr JEREMY BUCKINGHAM: It is the same question to a different person apparently.

Professor CURROW: I am sorry you find cancer statistics amusing.

The Hon. GREG PEARCE: Fair call.

The CHAIR: Order!

The Hon. GREG PEARCE: Bit of a glass jaw, Mr Buckingham?

The CHAIR: We were aware that this inquiry would be sensitive and there are people out there dying of cancer. Members need to be compassionate with their questions and remember it goes far beyond this room.

Mr JEREMY BUCKINGHAM: One is my mother-in-law.

The CHAIR: I ask everybody to pull it in.

The Hon. WALT SECORD: I find myself in the unusual position of siding with Mr Buckingham on that one. That was an unfair comment from the witness.

The Hon. NATASHA MACLAREN-JONES: Point of order: We are running out of time.

The CHAIR: He may have exercised a little outside discretion and we will overlook it. I do understand the sentiment because it is a sensitive issue the Committee is dealing with. There are a lot of people suffering with cancer and members might bring it back into line.

The Hon. COURTNEY HOUSSOS: Can I place on the record, in light of his response to the question, that it was a flippant remark but for the witness to misinterpret the way we responded to Mr Buckingham's remark is deeply insulting.

The Hon. NATASHA MACLAREN-JONES: Further to the point of order—

The Hon. COURTNEY HOUSSOS: It does not convey the serious line of questioning proposed by the Committee. It would be unfair not to place that on the record.

The Hon. NATASHA MACLAREN-JONES: The members opposite have been badgering witnesses this morning. We are about to run out of time. If Mr Buckingham has a final question or further comments for the witness this might be an opportune time.

The CHAIR: In light of the point of order, I am aware there has been robust questioning this morning. If the member has a final question, he may ask it.

Mr JEREMY BUCKINGHAM: In terms of the section 122 inquiry, do you believe that the statistical analysis that the team has employed to analyse any potential off-protocol dosing of chemotherapy in a range of cancers is robust and you stand by it?

Professor CURROW: Yes, Mr Buckingham. Importantly, if we look at Western New South Wales almost 19 per cent of all patients seen have had their records reviewed as part of this process. We identified all of the people who have been prescribed carboplatin or cisplatin where those records are available. The inquiry has done everything it can to identify people who have been prescribed capecitabine despite the challenges in the medical records that are available. If we look at the sampling process within this inquiry, it has focused on areas where there have been identified challenges and simultaneously ensured that there was a broad cross section of practice that was reflected in the detailed clinical reviews that were undertaken.

The CHAIR: Time for questions has finished.

The Hon. GREG PEARCE: Could we thank the witnesses for their patience.

The CHAIR: You do have 21 days to answer any questions put on notice and given the evidence brought forward today Committee members may place further questions put on notice. Can I thank you for representing today because it is an important and sensitive issue. The questioning has been robust and there were some reasonable questions that needed to be answered and followed up.

(The witnesses withdrew)

(Luncheon adjournment)

TOBY HALL, Group Chief Executive Officer, St Vincent's Health Australia, on former oath

GABRIELLE PREST, Medicine Clinical Stream Manager, St Vincent's Health Network Sydney, on former oath

DAVID FAKTOR, Director of Media and Communications, St Vincent's Health Network Sydney, on former oath

RICHARD GALLAGHER, Director of Cancer Services, St Vincent's Health Network Sydney, on former oath

The CHAIR: Good afternoon. Thank you for appearing before our inquiry. I note that, given that you have already presented at this inquiry, you will not need to be sworn in. Does anyone wish to make an opening statement?

Mr HALL: I just wanted to make a brief statement with a view to assisting members in relation to some matters that have been raised during the inquiry. Questions have been asked about the participation of St Vincent's staff in the Professor Currow inquiry. I would like to clarify for the Committee that all current St Vincent's staff who were invited to participate in the inquiry did so, and they did so with the hospital's encouragement. We understand that a small number of ex-employees and staff of third party providers declined to participate. These staff are not employees of St Vincent's and not part of our organisational structure.

Secondly, there were also questions raised about whether other St Vincent's doctors may have been engaged in flat dosing. I can reassure the Committee that the section 122 inquiry has had full access to our records dating back to 2009 of any patients who were prescribed 100 milligrams of carboplatin, and have not identified any pattern of flat dosing of any other St Vincent's Hospital medical oncologists. Further, we now obviously have the electronic systems in place to detect and raise an alert if something similar was to happen.

Finally, I will address the overall management of the issue. There has been no evidence available to me, including from Profess Currow's inquiry, that the hospital intentionally misled the public, our patients or the Government about this matter. The hospital's mistake was that they clearly did not appreciate the seriousness of this issue. We have said before—we have said it publicly on a number of occasions—and acknowledge absolutely that this was a failure on our part. This affected, pretty much from day one, how we responded to the issue, including how it was investigated and how it was internally reported, and, in turn, how it was broadened to the Ministry.

We have publicly admitted these mistakes and apologised, and we are working to make sure that they never happen again. We have participated in a number of inquiries—hopefully, with total openness. We are also committed to implementing all of the changes and recommendations of the inquiry. A number of those have already been implemented. Again, I would like to offer my apologies to patients and their families who were affected by this incident.

The Hon. WALT SECORD: Associate Professor Richard Gallagher, I will take you to evidence that was provided by Dr John Grygiel. On 1 November, Dr John Grygiel said:

> I was made aware by a phone call from Richard Gallagher made at Sydney airport—I cannot tell you immediately, but it will be on my phone—that he wanted to talk to me about whether I would take early retirement …

John Grygiel has provided me—just in the last 90 minutes—with an email exchange from him. It was from Richard Gallagher to John Grygiel on 27 November 2015. It says, "John, have you considered what we discussed last Sunday? I arrive back on Sunday. If I don't hear from you I will contact on Monday." Is that in reference to the evidence that John Grygiel gave on 1 November? That email exchange is from your St Vincent's address.

Associate Professor GALLAGHER: I spoke to John Grygiel later in November. It was not on 1 November—it was later in November—prior to going overseas. As a colleague, I rang him off my own bat, because I had become aware that there was now some media interest in this, and I advised him as a colleague that, given that we were about to have a new head of medical oncology start work, that from the point of view of his reputation it would be in his best interests if he took his retirement earlier than he had planned, in February.

The CHAIR: Order! Just one moment. Professor, could you bring the microphone closer to you—around your paper—for the sake of the gallery.

The Hon. WALT SECORD: I note that yesterday, at 5.15, in the supplementary answers provided by you, you refer repeatedly to answer No. 14. That is where you were asked about this exchange that Dr Grygiel

referred to, on 1 November 2016, and the email exchange of 27 November 2015. Is this the situation where Dr John Grygiel was told by you that he should take an early retirement to avoid a so-called "shit storm" coming his way?

Associate Professor GALLAGHER: I had a conversation with Dr Grygiel where I recommended to him that he consider for his own reputation retiring early. It was only advice; I have no power to suggest otherwise. But I just suggested that to him for his reputation's sake.

The Hon. WALT SECORD: You do not deny the use of the phrase "shit storm"?

Associate Professor GALLAGHER: I advised him that he should consider retiring.

The Hon. WALT SECORD: Mr Hall, in your opening statement you said you had concerns about how St Vincent's reported the underdosing to the Minister. Can you elaborate on that?

Mr HALL: I do not recall using those exact words, but we reported to the ministry in November 2015 in an informal fashion. I understand that the discussion was then followed by a discussion with the head of the Cancer Institute, Professor David Currow, who carried out the report. The next major discussions with the ministry were in February this year.

The Hon. WALT SECORD: You expressed in your opening statement concern or regrets about how St Vincent's reported the incident. Only today we received evidence from Dr Kerry Chant, using my words, that it was characterised as an understatement of chemotherapy underdosing. Would you say that St Vincent's was telling the New South Wales Government that they understated it to the Chief Health Officer?

Mr HALL: I think St Vincent's has been very clear from very early on in this inquiry that we underestimated the seriousness of the situation that was facing us. That underestimation certainly continued into February, I think, when we receive the external report, which came in on 9 February. It is quite clear that it was a serious situation, but prior to that the organisation had clearly underestimated the seriousness. In terms of the reporting to myself and the ministry, I would expect, knowing what I know now, that it would have been different. But knowing what the team knew at the time, they did not realise it was as serious a situation as it was, and therefore they took all communications in that light. I think the ministry would have fallen into that situation as well.

The Hon. WALT SECORD: So it was not an understatement but an underestimation?

Mr HALL: I think we have been consistent in saying that we underestimated the seriousness of the situation and the reporting was done in that light.

The Hon. WALT SECORD: Professor Gallagher, earlier in answer to a question you said you were not in a position to make the offer to Dr Grygiel to take early retirement to avoid, in your words, "a shit storm". Were you not in fact his supervisor?

Associate Professor GALLAGHER: No, I am not his supervisor as such. This supervisor is the Director of Clinical Governance.

The Hon. WALT SECORD: Did he not report to you?

Associate Professor GALLAGHER: About some matters, but he did not report about all of his department's running or other issues to do with his department.

The Hon. WALT SECORD: Mr Hall, going through material we received yesterday in response to questions on notice—when was Dr Grygiel officially dismissed?

The Hon. COURTNEY HOUSSOS: August.

The Hon. WALT SECORD: You discovered in November 2015 that there were concerns, you had an external review and then it hit the fan, so to speak, in February, but you removed Dr Grygiel in August. Why did it take so long? What was happening behind the scenes?

Mr HALL: We felt that it was important for the Currow inquiry to fully investigate what had happened. The ministry announced that inquiry, Dr Grygiel essentially had retired from active practice at that point anyway and we said at the time that we would institute any review of staff involved once we had seen the finalised Currow inquiry. Once that finalised inquiry came in, the first step we took was obviously to talk to Dr Grygiel as to his employment with St Vincent's. We thought that was appropriate given the evidence from the inquiry, and particularly that some of the inquiry evidence did not align with internal informational that Dr Grygiel had provided to the organisation.

The Hon. WALT SECORD: What was your official rationale for removing him?

Mr HALL: A serious misconduct.

The Hon. WALT SECORD: As part of those arrangements ending his employment with St Vincent's, did he receive a farewell remuneration package?

Mr HALL: He did not receive a farewell remuneration package. As part of his retirement, he has a standard package that would have come with anyone else retiring, which are standard benefits that he was allowed to keep. In terms of the termination, there has been no payment of any kind and, barring any outcomes of legal action, St Vincent's will strenuously avoid making any additional payments to Dr Grygiel.

The Hon. WALT SECORD: Even though he had been found to have engaged in serious misconduct, he received all of his entitlements? He had been with St Vincent's for like 20 years?

Mr HALL: He had been with St Vincent's for 20 years, and those payments essentially were finalised in February of that year, and the ceasing of his employment accentuated a technical issue.

The Hon. WALT SECORD: So those payments were finalised in February but you did not get rid of him until August?

Mr HALL: He was technically on long service leave during that period of time.

The Hon. COURTNEY HOUSSOS: Professor Gallagher, I wanted to come back to you about the conversation that you had with Dr Grygiel while you were at Sydney Airport. I understand from the testimony that you were at Sydney Airport and you made a phone call. You went to great lengths to stress that it was a colleague phoning a colleague to give some friendly advice. Can you just explain what your professional relationship was to Dr Grygiel at that point?

Associate Professor GALLAGHER: He was a colleague.

The Hon. COURTNEY HOUSSOS: Previously you said there were some matters that he reported to you on but not all matters?

Associate Professor GALLAGHER: Yes, he was a colleague.

The Hon. COURTNEY HOUSSOS: So did he report to you or did not he report to you?

Associate Professor GALLAGHER: He reported to me about some matters to do with the department and desk space and office space and other things in the building where we are.

The Hon. COURTNEY HOUSSOS: I appreciate that I am not a doctor but can we characterise the relationship that you were in some ways then his boss, his supervisor?

Associate Professor GALLAGHER: In a small area, yes.

The Hon. COURTNEY HOUSSOS: So you as his supervisor, perhaps only on some matters, picked up the phone to him to say, "You should consider an early retirement"?

Associate Professor GALLAGHER: No, I did not pick it up as a supervisor; I picked it up as a colleague and suggested that he should consider it.

The Hon. COURTNEY HOUSSOS: In the course of this conversation did you say, "I am phoning you as a colleague not as your supervisor"?

Associate Professor GALLAGHER: Absolutely.

The Hon. COURTNEY HOUSSOS: Did you clarify the conversation with Dr Grygiel at the time?

Associate Professor GALLAGHER: Absolutely. I did. I rang him and I said, "As a colleague I am advising you that you should consider early retirement." I said, "The new head of department starts in two weeks time" and this was clearly going to be or it appeared to me that it was going to be a—something was going to happen, so I was suggesting to him that he should think about taking his retirement now. It would not have stopped anything from happening but it might have helped him with his reputation.

The Hon. COURTNEY HOUSSOS: So let us just go back to some of the questioning that we talked about the last time that you were here, which was, despite knowing that there were concerns as early as June in 2015, you continued to refer patients to see Dr Grygiel and your course of action in November, before notifying patients about these concerns, was actually to advise this colleague of yours to take an early retirement instead of raising the concerns with patients or those affected? You were more concerned about his reputation than about informing patients about potential problems?

Associate Professor GALLAGHER: Let me clarify for you that patients and their care are what I do every day. It was what I was doing until half an hour ago until I came here and that's what I do full time. I am a part-time cancer director. I only think about my patients actually, so I do not really quite understand your question but—

The Hon. WALT SECORD: Sorry to interrupt but those were your words. I wrote them down. You were more concerned about protecting his reputation. I am sorry, Dr Gallagher, those were your words. We are not misquoting you. You were more concerned about his reputation than patients.

Associate Professor GALLAGHER: I am not more concerned about someone's reputation than my patients.

The Hon. WALT SECORD: Those were your words.

The Hon. COURTNEY HOUSSOS: My point, Professor Gallagher, is that it was clear that there were some problems in St Vincent's. It was clear there was a problem with Dr Grygiel and his prescribing. These were highlighted by the multidisciplinary team as early as June 2015. We canvassed extensively the last time you were here the delays and the fact that you continued to refer patients to see Dr Grygiel despite these concerns being raised and now we have found out that instead of investigating or allowing an investigation to occur of these still unclear complaints, you were advising your colleague, some would say a person who reported to you, to instead seek an early retirement rather than investigating these claims?

Associate Professor GALLAGHER: I care for my patients. I do not know what you are alluding to.

The Hon. COURTNEY HOUSSOS: I am asking why your advice was not—

Associate Professor GALLAGHER: Well, let me clarify for you since you seem to be insisting about patient referrals. The way that patient referrals work are that head-neck patients are seen at our multidisciplinary clinic meeting and then they are sent down a pathway. If I look after them they will have surgery and then they will be referred to the radiation oncologist and he will have a discussion about the surgical pathology result and then he refers the patient on to see a medical oncologist for an opinion.

Mr HALL: Chair, can I just make a request in relation to the line of questioning?

The CHAIR: Yes.

Mr HALL: Dr Gallagher has got an excellent reputation as a clinician and I have never heard him say that he cares for a colleague more than a patient, which is what was just reiterated. Can you please make sure that the record confirms either Dr Gallagher said that or those statements are withdrawn because I have never heard him say that and that would be a significant thing for any clinician to say.

The CHAIR: The Hon. Walt Secord, can you just clarify where that quote was from?

The Hon. WALT SECORD: That was from earlier evidence from—

The Hon. NATASHA MACLAREN-JONES: Point of order: He is not quoting from *Hansard* directly. He has written down comments and there could be an error in how Mr Secord has actually heard or written down what was said earlier.

The Hon. WALT SECORD: Why do we not check?

Mr JEREMY BUCKINGHAM: To the point of order: That is not a point of order.

The CHAIR: Order! I am trying to break this down so I understand. We have heard the witnesses say that they want something withdrawn. I need to ascertain where the quote was from. Can you just clarify where the quote was from; what day, what time, was it *Hansard*?

The Hon. WALT SECORD: I am sorry, we are talking about proceedings that have just occurred. I was referring to the email exchange from Richard Gallagher to John Grygiel asking if he had considered what they had discussed on Saturday and then he said—I do not know why I am defending this here. The fact is that he made reference to the fact that he was more concerned about his colleague's reputation and I challenged him on that.

The Hon. BRONNIE TAYLOR: He actually did not.

The CHAIR: I am not at liberty, without *Hansard* being in front of me, to see what was taken on request.

The Hon. WALT SECORD: The proceedings are being recorded. We will see this evening.

The CHAIR: That is right so the best I can do is we will have to review *Hansard* in light of the evidence you gave and it will reflect what was said. We will continue.

The Hon. WALT SECORD: He was concerned about Dr Grygiel's reputation. He said that.

The Hon. BRONNIE TAYLOR: Yes, but not above his patients.

The Hon. SCOTT FARLOW: You are the one who added that in, Walt.

The Hon. WALT SECORD: I think it is implied.

The Hon. SCOTT FARLOW: Well, no. We have gone from you making a quote to now saying it is implied.

The CHAIR: Order!

The Hon. WALT SECORD: He was more concerned about Dr John Grygiel's reputation than he was patients.

The Hon. SCOTT FARLOW: This has now moved along. You are the one who is confecting this.

Mr JEREMY BUCKINGHAM: Mr Hall, you said in your evidence previously, and we will check the record, that you formally reported to the ministry in November 2015. Was that formal notification to the ministry when the Chief Executive, Anthony Schembri, picked up the phone to Kerry Chant?

Mr HALL: To be clear, my words were informally reported to the ministry in November and formally in February and, yes, the informal discussion was with the discussion with Kerry Chant in November.

Mr JEREMY BUCKINGHAM: The informal one?

Mr HALL: Yes.

Mr JEREMY BUCKINGHAM: So you informally notified the ministry. You then said the next major discussion—they were the words you used—was in February. Do you maintain that there was no contact between anyone at St Vincent's or NSW Health in relation to these matters between that phone call between Anthony Schembri and Kerry Chant and then that period on or about 18 or 19 February?

Mr HALL: That is my understanding but I am happy to take it on notice and confirm that that was the case.

Mr JEREMY BUCKINGHAM: There has been a lot of water under the bridge between now and then. You cannot confirm that that is the case?

Mr HALL: I would have to take it on notice because any discussion between St Vincent's and the hospital—it may have been something which came up in discussion informally. I would have to take it on notice but we would have records of the conversations and I am happy to take that on notice.

Mr JEREMY BUCKINGHAM: It was put to us earlier today by both Dr Kerry Chant and Professor Currow that this was been dealt with as a media issue. Mr Faktor, because you were brought in very early, did you at any time contact anyone in NSW Health in that period to talk to them about these matters?

Mr FAKTOR: I do not believe I did.

Mr JEREMY BUCKINGHAM: You were not contacted by anyone from NSW Health, the Cancer Institute or anyone else?

Mr FAKTOR: No, I was not contacted by anyone.

Mr JEREMY BUCKINGHAM: Did you contact anyone? Did you have any discussions with anyone at NSW Health or any other agency about these matters?

Mr FAKTOR: Prior to which date?

Mr JEREMY BUCKINGHAM: Prior to February 2016.

Mr FAKTOR: I do not believe I did.

Mr JEREMY BUCKINGHAM: Did you discuss it with anyone outside of St Vincent's Hospital?

Mr FAKTOR: No.

Mr JEREMY BUCKINGHAM: When did Mr Matt Peacock first contact St Vincent's Hospital?

Mr HALL: My understanding is that Mr Peacock wrote to one of the nursing staff on 13 November, and that staff member approached Mr Faktor and Mr Schembri advising that she had been approached by Matt Peacock. At that point, Mr Faktor contacted Mr Peacock, and I happy for him to address that.

Mr FAKTOR: I confirmed that there was an issue in relation to underdosing of chemotherapy. I explained that there had been an internal investigation, that we had just commenced an external inquiry into the issue, and that we were happy to relay the findings of that inquiry to him as soon as they were brought down.

Mr JEREMY BUCKINGHAM: You told him then that you had begun the external review and that you had already done an internal review?

Mr FAKTOR: That is correct.

Mr JEREMY BUCKINGHAM: Why was the internal review done by a trainee?

Mr HALL: As I said earlier, the hospital failed to understand the seriousness of the situation. It was done by a registrar, which is a little beyond a trainee. However, the comment is fair; it should have been handled by a more senior clinician. That was done at the direction of the director of clinical governance. It is absolutely true that a more senior clinician should have been involved.

Mr JEREMY BUCKINGHAM: Do you think that contributed to the fact that you totally cocked this up, that you did not take it seriously, and that you had a report produced by a trainee—a Dr P. Savage?

Mr HALL: Registrars do a lot of work in hospitals. However, in a circumstance like this a more senior member of staff should have conducted the investigation and carried out the work. Yes, I do think it would have impacted our understanding of the seriousness of the situation.

Mr JEREMY BUCKINGHAM: I note that that is another matter that did not appear in the other inquiry. The documents you have provided are fascinating, and I will refer to a couple of them. One is headed "Unposted Incident – Edit1" and deals with an incident that occurred at St Vincent's Mater Health. It is a complaint that has not been advanced. Can you expand on why that complaint was not advanced? It is a complaint from an individual about Dr Grygiel.

The CHAIR: What is the source of that document?

Mr JEREMY BUCKINGHAM: It is evidence provided by St Vincent's Hospital.

The Hon. WALT SECORD: Last night at 5.15 p.m.

Mr JEREMY BUCKINGHAM: Yes. It is very helpful. It is a response to a question on notice. I can table the document.

The Hon. NATASHA MACLAREN-JONES: The member might provide the witnesses with a copy so that they can respond.

The CHAIR: Do you need the document to respond?

Mr JEREMY BUCKINGHAM: They provided it to us.

Mr HALL: I will consult with one of my colleagues to ascertain exactly what document you are referring to so that I can respond to the question.

The CHAIR: We will obtain a copy of it so the witness can respond.

Mr JEREMY BUCKINGHAM: The other document in which I am particularly interested is the "H&N Chemotherapy Critical Incident Action Register Aug-Nov 2015". All but Mr Hall get a mention. It appears to be a to-do list. Why were none of the things listed in that register actioned?

Mr HALL: I would have to check.

Mr JEREMY BUCKINGHAM: It refers to communications and David Faktor and referring to "separate out national and local response requirements"; "briefing of identified stakeholders"; "media approach"; "national comms list", "spokespeople", and so on. Then there is a reference to Richard Gallagher and "Confirm—adverse results x Chemotherapy Treatment Plan", and so on. Why did none of those things happen?

Mr HALL: I would have to take the question about that specific document on notice. We have clearly said on a number of occasions that we should have handled a range of those issues differently. We have acknowledged that and apologised.

Mr JEREMY BUCKINGHAM: It appears to me that you were handling them. Forgive me, but a layperson might think that you had decided to handle them, but then decided to do it differently. It appears that you might not have wanted to do these things and that you did not want to tell anyone. It looks like a cover-up.

Mr HALL: You are right that we—

Mr JEREMY BUCKINGHAM: You were covering it up?

The Hon. BRONNIE TAYLOR: Let him finish.

Mr JEREMY BUCKINGHAM: He just said that I am right.

Mr HALL: You are right that we identified that we needed to do those things. The process was clear, and the documentation is clear from August onwards that we intended to have open disclosure with the ministry, with patients and with the media. You have already heard about the initial discussion with Matt Peacock from the ABC. When we clearly knew that the media was aware of the issue, we indicated that we would be happy to give him full access to the external report because we knew that it was something the public needed to know about. We absolutely supported transparency about that.

The issue is the timing of those actions. The timing was essentially about understanding the outcome of the internal inquiry. It is important to understand that and the outcome of the external inquiry to ensure that when patients were informed that they had enough accurate information to know what had happened in their treatment. I acknowledge that we should have commenced open disclosure earlier. What you have just read is the exactly the evidence that we provided all along—that is, that we intended to do that throughout this process.

Mr JEREMY BUCKINGHAM: I have another document that emerged from the Standing Order 52 process. It is minutes of a meeting of the St Vincent's Hospitals Cancer and Immunology Program Clinical Governance Committee of Wednesday 4 July. It does not say which year. However, section 8.1 states:

> **Chemotherapy Administration**
>
> - Chemotherapy being administered outside of HOAC
> - Report being finalised by the director of Pharmacy. Ashley to meet with Terry to discuss issues and concerns once this report is available.
> - Michelle Rule has a database of who is accredited for chemotherapy administration in the Hospital.
> - Discuss chemotherapy administration protocols at our next protocol meeting.

Was that meeting about the off-protocol chemotherapy treatment that is the subject of this inquiry?

Mr HALL: I will have to take the question on notice to confirm that. From what you have read, it sounds correct. I would expect the pharmacy department to be looking into the treatment regime at a high level. There is an awareness already at that point about the treatment regime, and I would expect the pharmacy to be looking at that.

Mr JEREMY BUCKINGHAM: I have been informed that this minute is from 2012.

Ms PREST: The names are those of former staff who were involved before the move to the Kinghorn building. That is some years ago. That would have been a routine review of protocols.

Mr JEREMY BUCKINGHAM: But it refers to chemotherapy administered outside HOAC.

Ms PREST: HOAC stands for haematology, oncology and ambulatory care centre.

Mr JEREMY BUCKINGHAM: Okay.

Ms PREST: They would have been standing departmental minutes.

Mr JEREMY BUCKINGHAM: I am just a layperson trying to get up to speed. There is another document from you, Ms Prest. It was copied to Brett Gardiner and Dr Schembri. It states:

> I have been advised that there was no formal RIB completed, however, a draft RIB (attached and incomplete) was completed at the time a Matter for Information was completed (dated 7 August 2005), notifying of the incident.

Why was the RIB never completed?

Ms PREST: I believe that would be a question to direct to the previous Director for Clinical Governance. That was a decision made at the time by the Director of Clinical Governance.

Mr JEREMY BUCKINGHAM: Who was that, again?

Ms PREST: Dr Brett Gardiner.

Mr JEREMY BUCKINGHAM: So that was a conscious decision not to proceed with an RIB?

Mr HALL: That is correct.

The Hon. COURTNEY HOUSSOS: Professor Gallagher, I wanted to bring you back to some testimony that we received from Dr Grygiel. In his testimony he referred to a meeting that was held on 31 August 2015 between you, Dr Brett Gardiner, the Director of Clinical Governance at the time, and him where he said that he was informed of the outcome of the internal investigation. He said, in his words, "The summary of those results was that I had been exonerated, that I had no case to answer and no patients had been damaged or hurt by my treatment". Is that your recollection of the meeting?

Associate Professor GALLAGHER: Clearly, his recollection of the meeting and my recollection of the meeting are completely different recollections of the meeting.

The Hon. COURTNEY HOUSSOS: Could you please enlighten the Committee as to what happened at the meeting?

Associate Professor GALLAGHER: Dr Grygiel was asked to explain his prescribing habit. He was made aware that there was an internal investigation, which was not completed at that point in time, and he was then instructed that he needed to follow the accepted guidelines, the eviQ guidelines, and he accepted that, and that was the meeting.

The Hon. COURTNEY HOUSSOS: So his words have been completely exonerated by that meeting.

Associate Professor GALLAGHER: My memory of that meeting and his memory of the meeting are diametrically opposed.

The Hon. COURTNEY HOUSSOS: He refers to a follow-up email that was sent that outlined the outcome of the meeting that was then replied to by, I am not sure whether it was you or Dr Gardiner, backing up that particular course of events, saying that he was exonerated, that there was no further need for concern.

Associate Professor GALLAGHER: As I said, I think that his memory and my memory are obviously completely different.

The Hon. COURTNEY HOUSSOS: Did you take some notes of the meeting? What would be the normal course of events surrounding a meeting such as this?

Associate Professor GALLAGHER: I would have expected that the Director of Clinical Governance would have kept some notes of the meeting.

The Hon. COURTNEY HOUSSOS: Not you?

Associate Professor GALLAGHER: Correct.

The Hon. COURTNEY HOUSSOS: And you, obviously, did not keep notes of this particular meeting?

Associate Professor GALLAGHER: The meeting was in the Director of Clinical Governance's office.

The Hon. COURTNEY HOUSSOS: But did you keep notes of the meeting?

Associate Professor GALLAGHER: No, I did not.

The Hon. COURTNEY HOUSSOS: So really all we have got to go on at this point is Dr Grygiel's testimony and your testimony, which are diametrically opposed.

Associate Professor GALLAGHER: His memory of the conversation is obviously very different to my memory of the conversation.

The Hon. COURTNEY HOUSSOS: Did you have any further conversations with Dr Grygiel between 31 August and 27 November—was that when you made the phone call from Sydney Airport?

Associate Professor GALLAGHER: It was in the last week or so. I cannot remember the exact time, I have to apologise.

The Hon. COURTNEY HOUSSOS: Let us say it was late November. Did you have any other conversations between 31 August and 27 November with Dr Grygiel about his underdosing regime?

Associate Professor GALLAGHER: No, because it was under investigation by the hospital and I was not a part of that investigation process. I would have had contact with him at some stage possibly—in a hallway or something like that—but no.

The Hon. COURTNEY HOUSSOS: At this point were you the chair of the multidisciplinary team?

Associate Professor GALLAGHER: No.

The Hon. COURTNEY HOUSSOS: What was your role then at the meeting between Brett Gardiner and Dr Grygiel?

Associate Professor GALLAGHER: I was there to listen to what was going on so that Dr Gardiner could have a conversation with Dr Grygiel so that we could make sure that he changed his prescribing habit. Essentially, the aim of the meeting was to alert him to the fact that there was an investigation and that he change his prescribing habit.

The Hon. COURTNEY HOUSSOS: So it was alerting him to the investigation; it was not actually to deliver the results of the investigation?

Associate Professor GALLAGHER: The investigation, as far as I was aware, was not completed at that point in time.

The Hon. COURTNEY HOUSSOS: So your role then at that meeting was more as an observer than as a—

Associate Professor GALLAGHER: Oh no, I made comment. I would not say I was an observer. I was there as the Director of Cancer Services, but essentially it was a meeting between Dr Grygiel and the Director of Clinical Governance. I participated, but that is what it was.

The Hon. COURTNEY HOUSSOS: Who was then responsible for communicating with Dr Grygiel at the outcome of the internal investigation?

Associate Professor GALLAGHER: I would have thought the Director of Clinical Governance, not me. I was not asked to.

The Hon. COURTNEY HOUSSOS: And you did not follow up with the Director of Clinical Governance to see what the outcome of the internal investigation was or if there was further—

Associate Professor GALLAGHER: Yes, I was aware of some of the outcomes.

The Hon. COURTNEY HOUSSOS: But you had no role in actually communicating that to—

Associate Professor GALLAGHER: Dr Grygiel? No.

The Hon. COURTNEY HOUSSOS: You were there at a key point of informing Dr Grygiel. From his recollection he feels from this point he was exonerated, that there was no further need. I accept you dispute that, but you were obviously considered to be a key person to be there at the point of informing him of the internal investigation. So I am trying to ascertain who would have been present when he was told about the outcome of the internal investigation.

Associate Professor GALLAGHER: I was not present.

The Hon. COURTNEY HOUSSOS: Do you know who was present?

Associate Professor GALLAGHER: I presume the Director of Clinical Governance.

The Hon. WALT SECORD: Mr Hall, what does St Vincent's Hospital do when they discover a doctor or a clinician has engaged in clinical mistakes or inappropriate behaviour or bullying? What do you actually do? What are the steps?

Mr HALL: The treatment of the clinical issue and the bullying issue are dealt with by separate departments and it would depend on the specific incidents, but in normal practice what we would hope would happen, if you took a clinical incident, is that there would be an informal discussion and that would be led by the Director of Clinical Governance and that would then be followed up by a range of investigations dependent on what the situation was. It may be a completely independent investigation or it may be an internal investigation and, depending on the outcome of the internal investigation, it may go to an external investigation. The goal is to really uncover everything that has happened. Where the internal process is used, a records analysis is done to look at what might have happened from a clinical point of view—it is quite a detailed process. The New South Wales department has made it very clear in audit reports to us that that process is successfully operating for most clinical incidents at St Vincent's.

In terms of bullying, the process would be similar but it is dependent on the type of bullying that was raised. But what would happen is there would be an informal discussion with all the people in relation to the bullying issue and that would then go through to a decision to say do we need to have an internal review or do we need to have an external review of this bullying situation? In both cases those should be independent from the individuals involved. They would make recommendations which would come back to the executive and the executive would then decide to act on the outcome of those reports. If the bullying was serious enough, either a formal written complaint would be made or if it is very serious it is quite possible a clinician or a member of staff could be dismissed.

The Hon. WALT SECORD: Going back to clinical malpractice, clinical errors, going off-protocol, what happens in that circumstance?

Mr HALL: I would expect in the situation where a doctor was going off-protocol and it was discovered, that the team would look at the off-protocol treatment and they would carry out an internal investigation. I would say that in that circumstance it would be wise to have an expert in a particular field assist in that internal investigation. Dependent on the outcomes of the internal investigation, then move to an external investigation and from that external investigation you would make decisions in terms of what should happen in what particular case.

The Hon. WALT SECORD: What could happen? Do you suggest they take an early retirement?

Mr HALL: I would say the organisation would be unlikely to do that.

The Hon. WALT SECORD: Well Dr Gallagher suggested that to Dr Grygiel?

Mr HALL: As Dr Gallagher said, he is a professional doctor having a collegiate discussion with a professional doctor.

The Hon. WALT SECORD: Do you go around to your colleagues suggesting that when they are in trouble they should take early retirement? Do you give that advice to people?

Associate Professor GALLAGHER: I gave Dr Grygiel that advice.

Mr JEREMY BUCKINGHAM: How was dose rate data from Dr Grygiel disclosed to you?

Associate Professor GALLAGHER: Dose rate data? Do you mean the prescribing of the 100 milligrams?

Mr JEREMY BUCKINGHAM: In general how is that data conveyed to you?

Associate Professor GALLAGHER: I was told about the dosing by Dr Stephen Cooper, radiation oncologist.

Mr JEREMY BUCKINGHAM: That is how you are told about it?

Associate Professor GALLAGHER: I am sorry, I may not understand what you are asking.

Mr JEREMY BUCKINGHAM: In terms of the chemotherapy, how are you informed of the doses?

Associate Professor GALLAGHER: I am not informed of the doses.

Mr JEREMY BUCKINGHAM: You were never informed in any way?

Associate Professor GALLAGHER: Occasionally in a letter from a medical oncologist about a patient every now and again someone might mention a drug but they do not mention the dosage.

Mr JEREMY BUCKINGHAM: So how did you become aware that there may have been an issue with Dr Grygiel's dosing?

Associate Professor GALLAGHER: Dr Stephen Cooper brought it to my attention in June.

Mr JEREMY BUCKINGHAM: In no other discussions with anyone else or no other letters or anything like that?

Associate Professor GALLAGHER: No.

Mr JEREMY BUCKINGHAM: That was the first time?

Associate Professor GALLAGHER: Yes.

The Hon. BRONNIE TAYLOR: When we talk about off-protocol dosing at times—and I am not underplaying anything—we are talking about individualising a dose for a patient—for example, a head-neck

patient who may have extensive disease and will possibly not have a good outcome. You are not going to prescribe an eviQ dose that may actually give them a worse rather than a positive affect, are you?

Associate Professor GALLAGHER: That is correct.

The Hon. BRONNIE TAYLOR: There was a standardised across the board generic dosing of 100 milligrams, is that correct?

Associate Professor GALLAGHER: I think that is essentially what was happening.

The Hon. BRONNIE TAYLOR: I am trying to make that very clear because it is important that we all recognise that medical professionals need the capacity to be able to change doses depending on a patient's clinical condition. The reality is that sometimes if you dose a patient according to an eviQ guideline you could potentially cause them to have a sepsis and die?

Associate Professor GALLAGHER: Yes, absolutely.

Mr HALL: Absolutely correct.

The Hon. BRONNIE TAYLOR: So the issue we are talking about is an across the board standardised dose that was not individualised to each patient's needs, requirements and clinical condition?

Associate Professor GALLAGHER: Correct.

The CHAIR: You gave evidence last time you were here about the multidisciplinary team?

Associate Professor GALLAGHER: Yes.

The CHAIR: But you would not know the dose?

Associate Professor GALLAGHER: Correct.

The CHAIR: My colleague has just put forward why it is very important to know the dose for every person.

Associate Professor GALLAGHER: I think that is referring to what Dr Grygiel was doing. I know that—my understanding of how medical oncologists work is that they do vary doses according to how patients are responding, how sick they maybe during treatment, some patients will abandon treatment altogether because they cannot tolerate any more chemotherapy or the doses will be decreased significantly. That is my understanding of how things work and how medical oncologists work their practice and decide on those things. They use some protocols as a guideline but that is my understanding, so if Dr Grygiel was doing that then I agree with that—I mean I agree with what has been said.

The Hon. BRONNIE TAYLOR: In your professional career have you ever come across a medical oncologist who is standard dosing a set group of patients—"A standard dose of 100 milligrams is what I am going to give you"—without individualising different dosages?

Associate Professor GALLAGHER: I have not and I suppose I probably never asked before—

The CHAIR: You would not know.

Associate Professor GALLAGHER: I would not know.

The Hon. BRONNIE TAYLOR: Would it be correct that it took a while for the evidence to come forward that a standardised approach was being done? Would that be a reasonable observation?

Associate Professor GALLAGHER: I think it is a reasonable observation, yes.

The CHAIR: Mr Hall, with your changed practices in multidisciplinary patient care will you now be tracking what doses people are on or will the practice be to leave that dosage out of the discussion?

Ms PREST: I am happy to answer that.

The CHAIR: Yes.

Ms PREST: Doses are really not discussed at the multidisciplinary team [MDT]. The MDT is a place where the patient's condition and diagnosis is confirmed based on evidence around pathology, imaging and so on. Usually the decision around doses that are used are left to the individual practitioner—just as much as Dr Cooper has probably described that his prescribing of radiation therapy is something that he would normally not discuss in an MDT, et cetera. So doses are then prescribed by the doctors—previously they were written on paper charts but now in our new MOSAIQ system they are in the electronic record, which are then auditable and able to be monitored and approved as such so that we can watch the process.

The CHAIR: I still have a great concern that this was a systemic failure of all who were meant to be holistically dealing with this patient. Dr Cooper brought it to people's attention but it should have been brought to attention long ago in a multidisciplinary team that this was off-protocol chemotherapy and I cannot believe that systemic breakdown is still not going to be addressed?

Mr HALL: Can I just answer that because I think that understanding is not quite correct? In terms of the MDT meeting, it would not normally be discussed there. Every surgeon, clinician is an expert in their field. I would not expect Dr Gallagher to actually know much about the dosage regime—he has a high level of knowledge but he would not have a knowledge around the individual patient. So what has been put in place at St Vincent's now is an electronic medication system that outlines the standard protocol dosing for each of the patients. Most oncologists will give patients standard dosing and they will get that treatment regime but if a clinician wants to go outside that—and as the Hon. Bronnie Taylor has said, that is absolutely necessary at times—we have to be very clear in this inquiry that these clinicians have to be able to make those decisions in individual cases because what is right for one person is absolutely wrong for another. If in the process they want to go outside it, what happens now is that they have to go and have a discussion with their colleagues, they have to get approval to go outside the standard dosing practice. That would not necessarily be discussed at the MDT, it might be, but they would have to go through a process now to say, "We want to go off protocol and this is the reason why." They would have to go and talk to their colleagues about it.

The CHAIR: I understand all that. I still cannot believe that you have a multidisciplinary team where all these healthcare experts are coming together to discuss the optimal care for a patient with cancer and not for a moment does anyone discuss how much chemotherapy they are having and whether they are having radical surgery? I understand the different experts being in the room and Dr Gallagher being a surgeon not being predisposed to an idea that Dr Grygiel might give this much chemotherapy, but I cannot for the life of me understand how all these experts can be in the same room and not seriously consider the full gamut of the treatment dosage because that would give you the optimal care of those patients.

I understand the level of expertise—I have been there and done that—but I cannot understand how you can seriously give optimal care without every person knowing exactly each step of the dosage or chemotherapy because it needs a very targeted amount based on the cancer type and the aggressiveness of the tumour. That is all the more reason that the chemotherapy would be absolutely tuned to a "T" and all the more reason that every person at every step in the process should have knowledge of what that person is on for their renal, liver and heart failure. I still cannot get to the bottom of why in the MDT no-one is saying what the patient is on. It is a higher level for some reason. Thus, we are sitting around a desk trying to work out why this got so far.

Ms PREST: I will add further detail. At the multidisciplinary team the medical oncologist might agree to take care of the patient. The patient will subsequently attend in the rooms to see the doctor. At that point in time some other parameters are needed to make a decision about what treatment will occur, for example the pathology reports will be looked at, recent blood counts, they will take weight and height to look at body surface area. At that point, when the patient is before them—in a normal MDT the patient is not present—in the case of head and neck MDTs the patients are present for the review and assessment.

A usual patient will be seeing the doctor for the first time in the rooms and that is when those nuances about the treatment and decisions might be made at that point in time. The doctor might be considering the chemotherapy eviQ protocol guidelines and there is quite some latitude around dose variation that might need to go on dependent upon the circumstances of that patient. It is when the patient is presenting before the doctor and having the one-on-one conversation where they get to confirm at that point and then the prescription process starts. That is when the checking processes proceed with the pharmacist checking and so on.

The CHAIR: I understand those are the processes but this one got through the net. I cannot believe there is one set of circumstances where it should have been caught with that many experts in one room.

Mr JEREMY BUCKINGHAM: I note that Associate Professor Schembri is away. It is difficult for us to proceed in these matters without him here. To the best of your ability, Mr Hall, who called who? Did Associate Professor Schembri call Professor Currow or did Professor Currow call him?

Mr HALL: My understanding is that Professor Schembri called Professor Currow. We can take that on notice and give you a specific answer to that question.

Mr JEREMY BUCKINGHAM: They only had one conversation and phone call between the two of them?

Mr HALL: It is my understanding that is the case. I will take it on notice and confirm for you the number of conversations.

Mr JEREMY BUCKINGHAM: The way it was characterised is that they were not lengthy conversations. Were they lengthy conversations? It seems to me that there was a bit to relay to Dr Chant. Do you know how long those conversations were? Was there a list of things that needed to be ticked off in terms of informally notifying the Government?

Mr HALL: I cannot comment on the length of conversation. I am happy to take that on notice. I know that the ministry and Dr Chant were informed that there was an issue. As I said earlier we underestimated the seriousness of the situation. That was still the situation at the time when Dr Chant was called. I would imagine she would not have got as full a briefing as she would get now. We acknowledged that was a problem and apologised for it.

Mr JEREMY BUCKINGHAM: You said Dr Chant and the ministry, they are the one entity?

Mr HALL: Yes.

Mr JEREMY BUCKINGHAM: By informing Dr Chant you were informing the ministry?

Mr HALL: We were informing the department.

Mr JEREMY BUCKINGHAM: The ministry was not informed?

Mr HALL: The department was informed.

Mr JEREMY BUCKINGHAM: But the ministry were never informed?

Mr HALL: Not by us that I have any knowledge of.

Mr JEREMY BUCKINGHAM: The internal investigation you did run by Dr Savage looked at 47 head and neck cancer patients treated with carboplatin but only those with Dr Gallagher as the treating surgeon. Were there other cases where Dr Grygiel used the flat dosing and Dr Gallagher was not the treating surgeon?

Mr HALL: The Currow inquiry covered a range of patients treated by different surgeons. The initial inquiry looked at Dr Gallagher's patients and my understanding is that was essentially because of ease of access to identify and understand if there was a problem. It is quite clear, and we have acknowledged, that initial inquiry was inadequate and needed to have more depth and an external expert to assist. That did not take place. We acknowledge the inquiry was not good enough and should have been done differently.

Mr JEREMY BUCKINGHAM: I appreciate that, Mr Hall. Were there other surgeons operating at St Vincent's? Was the ease of investigation why that cohort of 47 were picked? Were there other surgeons operating? I am fascinated because in SO 52 it has been highlighted as a key point.

Mr HALL: There were other surgeons operating. That was a decision made at the time. What should have happened under standard processes is we should have identified all the patients and all of them should have been reviewed across the portfolio. The Currow inquiry found there was more than 47 and they should all have been investigated in the original internal investigation.

Mr JEREMY BUCKINGHAM: The decision to limit it to those 47 was that it was easier to do?

Mr HALL: It allowed it to be done more quickly, which would allow us to identify prima facie whether there was a serious issue. Once we identified that we would have extended the inquiry out to look at all the patients who had been effected by it. In hindsight I would not take that approach. In the hospital in the future in terms of the new system if a similar thing happened we would identify all the patients and carry out a full independent or internal investigation bringing an external expert with knowledge of those drugs into the organisation to help with that. That should have happened at the time and it did not and we acknowledge that was a failure on our part.

The Hon. WALT SECORD: Mr Hall, Dr P. Savage, who Mr Buckingham referred to in the 47 cases, is that Dr Paul Savage? He is referred to on LinkedIn as a medical governance trainee. Can you give me an understanding, as I am not a doctor, where would that fit in in the hierarchy of being a doctor?

Ms PREST: Simply, he was allocated to the Director of Clinical Governance and reported directly to him.

The Hon. WALT SECORD: What organisation was he with at the time?

Ms PREST: He was employed by St Vincent's.

The Hon. WALT SECORD: He was a junior registrar sent to look at 47 cases involving the head of cancer services at St Vincent's Hospital?

Ms PREST: I am not sure what level of registrar he was.

The Hon. WALT SECORD: Are you familiar with his work, Associate Professor Gallagher?

Associate Professor GALLAGHER: I know who he is but I do not know how junior he was or was not. Sorry, I cannot answer that.

The Hon. WALT SECORD: He was obviously quite junior because you do not know who he was.

Mr FAKTOR: I understand that he was a trainee medical administrator. He was training to be a medical administrator and working within medical administration.

The Hon. WALT SECORD: You had a trainee conduct this serious investigation into chemotherapy under dosing? St Vincent's Hospital had a trainee do it?

Mr HALL: To be clear, this is someone who—

The Hon. WALT SECORD: My next question: You used this trainee's report as the basis to tell the chief health officer of New South Wales that everything is fine at St Vincent's?

Mr HALL: Firstly, when you talk about someone being a trainee, he is a qualified clinician and had a range of experience, post qualification, and he has chosen to go into medical administration. I have doctors who are regarded as administrative trainees who have significant experience in the clinical field.

The Hon. WALT SECORD: He is so junior that Associate Professor Gallagher did not know who he was.

Mr HALL: We should come back on notice and give you his qualifications so you understand his background. That said, in a normal practice we should have brought in an external expert in this particular drug to review the practice and we failed in that regard and I acknowledge we failed in that regard. In terms of the information provided to Dr Chant, yes, we had the outcome of the internal inquiry which was delivered by the registrar and that was used to relay the information to Dr Chant. The report has been provided to the Committee, and clearly it had findings. It underestimated the seriousness of the problem at that point. It did enough to ensure that we carried out an external review. An external review was carried out by an expert medical oncologist.

The Hon. WALT SECORD: Mr Faktor was nodding. Do you want to add something to that?

Mr FAKTOR: No, no. It gave rise to our escalating the issue to an external inquiry.

The Hon. COURTNEY HOUSSOS: Professor Gallagher, I just wanted to refer to your email. We were provided with a copy not long ago. It followed up on the conversation that you had on the 27th. Sorry, it was not on 27 November; the email came through on 27 November. It said, "John, have you considered what we discussed last Sunday? I arrive back on Sunday. If I don't hear from you I will contact on Monday." My colleague Mr Secord spoke about this earlier. I just wanted to ask, did you follow up with Dr Grygiel after the email?

Associate Professor GALLAGHER: No.

The Hon. COURTNEY HOUSSOS: Not at all?

Associate Professor GALLAGHER: No.

The Hon. COURTNEY HOUSSOS: Have you ever suggested to any of your other colleagues that they should seek an early retirement?

Associate Professor GALLAGHER: No.

The Hon. COURTNEY HOUSSOS: So, this was the first and only time that you have done that?

Associate Professor GALLAGHER: Yes.

The Hon. COURTNEY HOUSSOS: So it would be somewhat unusual for you to—

Associate Professor GALLAGHER: He was due to retire, but, yes, I suppose I would not normally suggest to someone that they should retire. He was due to retire.

The Hon. COURTNEY HOUSSOS: Last time you spoke to us about how you continued to refer patients to Dr Grygiel even after knowing concerns had been raised with his prescribing regime. If you had known in August 2015 what you know now about his practices would you have continued to refer your patients to Dr Grygiel?

Associate Professor GALLAGHER: As I explained before, I do not directly refer my patients to Dr Grygiel. There is no letter that exists that I have ever referred a patient directly to Dr Grygiel. It is via the radiation oncologists that this referral process occurs, because they are the ones that ultimately make the decision about the use of chemotherapy. We agree to it, depending on what they discuss and agree. What was the—

The Hon. COURTNEY HOUSSOS: According to your testimony the last time you came before us, you did continue to refer. I appreciate that that might not be the technicalities of it, but you did say that you continued to refer patients.

Associate Professor GALLAGHER: I became aware in August that Dr Grygiel had ceased his previous treatment regimen—what he was doing with the dosing. There was no alternative until the new head of department was appointed for the treatment on the campus.

The Hon. COURTNEY HOUSSOS: With respect, Professor Gallagher, is your answer that, yes, you would have continued to refer them?

Associate Professor GALLAGHER: It is important that the patient is the person who comes first in all of this. Part of it is that the chemo therapy is a small part of the treatment program—

The Hon. COURTNEY HOUSSOS: Small but crucial.

Associate Professor GALLAGHER: —and that those patients really need to have the people who look after them the most—the surgeon and the radiation oncologist—to be kept in the same area. So, yes, I kept referring them, for the good of the patients.

The Hon. COURTNEY HOUSSOS: For the good of the patients it was better to refer them to someone who was in the immediate vicinity who had had questions raised about their prescribing protocols.

Associate Professor GALLAGHER: Who we know was prescribing appropriately at that point in time.

The Hon. COURTNEY HOUSSOS: So you have no concerns about any of the treatment that was provided between August and February.

Associate Professor GALLAGHER: No.

The Hon. COURTNEY HOUSSOS: How many of your patients were still treated by Dr Grygiel after you discovered the under-dosing?

Associate Professor GALLAGHER: I do not know.

The Hon. COURTNEY HOUSSOS: Can you take that on notice?

Associate Professor GALLAGHER: I can take it on notice.

The Hon. COURTNEY HOUSSOS: Mr Hall, I want to ask you one question about the external investigation. According to the Currow report, the first person that was approach to conduct the external investigation was contacted in late November, from what I understand. They declined to participate.

Associate Professor GALLAGHER: Yes.

The Hon. COURTNEY HOUSSOS: Why did they decline?

Associate Professor GALLAGHER: I would have to take that on notice. I think it was a time constraint, but I am happy to take that on notice and come back.

The Hon. COURTNEY HOUSSOS: I think we would be interested in who that person was. We are happy to take that confidentially, if required.

Associate Professor GALLAGHER: Yes.

The CHAIR: I would just like to sort out the level of Dr Savage. It is not unusual for obstetrics registrars to do caesarean sections on their own and report back to the surgeon, is it, if they are specialising in that area?

Associate Professor GALLAGHER: It would not be unusual, at all, as long as they were at an appropriate level.

The CHAIR: So it is not unusual. As they lift their level and their qualifications they will be given greater responsibility under guidance—

Associate Professor GALLAGHER: Absolutely.

The CHAIR: —even if the head surgeon or obstetrics surgeon is down the corridor, feet up, reading the Telegraph.

Mr HALL: Absolutely. That language around "a junior doctor" would be used quite often for people who are carrying out quite significant—

The CHAIR: Or an anaesthetic registrar to be sitting there guiding someone through, unconsciously, while reading the *Sydney Morning Herald*—

Associate Professor GALLAGHER: We hope not.

The CHAIR: —and looking at their stocks, maybe. The point is that these registrars are highly trained and ready to move on to another level of responsibility.

Associate Professor GALLAGHER: Absolutely.

The CHAIR: Is that the essence of what you are saying about this person—giving them, given the fact that their interest is in medical administration, an opportunity to grow even further in their expertise?

Associate Professor GALLAGHER: Absolutely. It is a standard practice. It is a way of training clinicians through the processes. I agree that it would be totally wrong to say that this is a junior administrative person. They are a highly qualified clinician. That said, from a practice purpose going forwards we should have brought in an external expert in this type of oncology. To that extent we have acknowledged that that was a failing. In this case I think he was qualified to work within the department as a medical administrative registrar.

The CHAIR: There is a pretty good chance that many of us have been operated on by a registrar, not knowing that the surgeon was literally in the OT, somewhere, signing off on it. Is that correct? Would that be a fair comment, if they are at a certain level?

Associate Professor GALLAGHER: No, I think it depends on the supervising surgeons.

The CHAIR: Yes, but it is not unusual for that to happen throughout the system, if the competence is there.

Associate Professor GALLAGHER: No, it would certainly happen within the system.

The Hon. BRONNIE TAYLOR: Mr Hall, I know that MOSAIQ helps; that is fantastic, and will provide another area of cover, but faced with a similar situation where there seems to be one particular professional—I will not pre-empt things—would you do the same? Do you feel confident that your processes have now changed and that you are more aware of situations? Do you feel confident that this sort of thing will not go unnoticed again?

Mr HALL: I am very confident that the processes we have in place are absolutely the best standard to identify something like this happening again. I should be very clear: in surgical practice this would have been picked up automatically; we would have known about it straight away and dealt with it. Going into this area, which is slightly more complex, it was clear that the systems were not good enough. The fact that we did not have the electronic dosing system was a problem. We knew that. We had identified that and wanted to bring it in even before this came up. What we have now is a very thorough process. It would be fair to say that the team at St Vincent's Hospital have done a lot of work to identify the process that we would go through in the future.

As I outlined earlier, we would go through the steps that I talked about earlier. Particularly, I think we would be overly conscious now of reporting through the department and making sure that they were aware of any issue that came up. Equally, we would make sure that we had a thorough investigation internally and externally of any problems that arose again. So I am very confident that we have good systems in place.

The Hon. BRONNIE TAYLOR: Yes, I would imagine that you would be hyper vigilant, now. I go back to the point of annual performance reviews. Last time you gave evidence it was said, basically, that they had not been happening regularly. Is there a process in place, now, to make sure that there are annual performance reviews in terms of your medical staff?

Mr HALL: There is a process in place for medical staff that annual performance reviews should take place. I understand Dr Dalley, who was the head of unit, is going to be giving evidence. My understanding is his view was he did give regular performance reviews to Dr Grygiel and they could not find them. Absolutely his view is those reviews took place. Yes, we do have a process in place to do annual reviews.

The Hon. BRONNIE TAYLOR: You say they could not find them. When I was a nurse I had a performance development plan. I had a form that I went through with my supervisor. I would keep the form for

a day and then we would review it. It would have goals and areas I would have to pick up and areas where I was doing well. There is always a paper trail. Apparently reviews were done, but there is no evidence of that documentation. Is that correct?

Mr HALL: What we have done is that there is not enough evidence of the documentation, so as well as bringing in new clinical systems for the dosing we are also in the process of bringing in a new human resources system, which will keep complete electronic records of all these reviews. I will literally be able to push a button and tell you that 3,200 of our clinicians have had their reviews, we have them online and they are available. It is a paper-based system led by the consultants. In Dr Dalley's case, I am absolutely sure he would have carried out the reviews, but it is paper based and Dr Dalley left in 2013. It has not been easy to track down his records. Unfortunately, historically that has happened, and we have recognised we need to amend that by putting in place a new system to ensure that everyone has the process electronically recorded.

The Hon. BRONNIE TAYLOR: Associate Professor Gallagher, you have spoken about a meeting you had with Dr Grygiel and the Director of Medical Governance talking about Dr Grygiel's standardised dosing. I imagine the responsibilities for clinical governance are with the Director of Clinical Governance not with the Director of Cancer Services. Would that be reasonable?

Associate Professor GALLAGHER: Correct.

The Hon. BRONNIE TAYLOR: I wanted to clarify that, having been in a similar position to yours in a much smaller place and knowing it definitely was not my place to tell medical doctors what to do. It is the director of clinical governance's responsibility to ensure that clinical governance is up to scratch.

Mr HALL: Absolutely.

Associate Professor GALLAGHER: That is correct.

Mr JEREMY BUCKINGHAM: Who gave evidence to the section 122 inquiries about the recurrence of head and neck cancers that in part precipitated concern and caused the initial internal investigation? Who in your organisation was concerned about that?

Associate Professor GALLAGHER: Dr Cooper.

Mr JEREMY BUCKINGHAM: Did he say that people were presenting with recurring cancer who should not have been?

Associate Professor GALLAGHER: No, he made the comment that he was concerned that there might have been some recurrences or there might have been an increased number of recurrences. This was all around the same time as he made the comments about the dosing, so I cannot say much more than he brought up both of these things at the same time.

Mr JEREMY BUCKINGHAM: Did he say that people have got cancer again and they are getting a flat dose?

Associate Professor GALLAGHER: He made a comment that people had recurred—

Mr JEREMY BUCKINGHAM: And he was concerned about it?

Associate Professor GALLAGHER: Yes, and he was concerned about it. I suppose his questioning was: Could it be related to that?

Mr JEREMY BUCKINGHAM: It is a pretty serious thing for a serious clinician to raise that these people have cancer and they probably not should not have it and potentially they have been getting less chemo than they should have been getting.

Associate Professor GALLAGHER: I do not know that it is fair to say that. Unfortunately for patients who have head and neck cancer, when you have advanced head and neck cancer it recurs. Unfortunately only 20 per cent of patients long term are going to survive.

Mr JEREMY BUCKINGHAM: He is an expert. Did he make those representations to you? Was that the basis of his representations to you?

Associate Professor GALLAGHER: Not the basis, his basis was the flat dosing and on top of that he brought up later—in fact, it was later that he brought up an issue that he had been thinking about—the fact that some of the recurrences we had seen had been related to that.

Mr JEREMY BUCKINGHAM: The internal investigation kicked off in August and ran until October. When did St Vincent's decide to go to an external investigation?

Mr HALL: I would have to take the exact date on notice. But at the end of the internal investigation it was the view of the team, which had been led by the Director of Clinical Governance, that we needed to get a more detailed understanding of the issue and we needed to have an expert oncologist in this field carry out a report for us.

Mr JEREMY BUCKINGHAM: The decision to go to an external review did not occur at the same time as the internal investigation was running?

Mr HALL: Certainly it would have been standard practice to have in their minds that you would do an internal investigation and, depending on the outcome, you would look at an external investigation. That would be totally normal. You would say you would do an internal investigation, look at the outcomes and once you understood the outcomes then look at whether you needed to go to an external investigation.

Mr JEREMY BUCKINGHAM: But what would not be normal would be to have an internal investigation and an external investigation as well.

Mr HALL: That might happen at times. It is possible that it could happen.

Mr JEREMY BUCKINGHAM: Is that what happened in this case?

Mr HALL: I will take on notice exactly the process, but my understanding is that the external investigation really emerged as a process as the internal investigation was going on.

Mr JEREMY BUCKINGHAM: That is what it looks like. The evidence we have received is that there was a decision on 6 August to proceed to an external investigation. Effectively you decided to do an internal investigation and almost immediately decided to do an external investigation as well.

Mr HALL: It would be fairly standard practice to have that kind of discussion. It is a question of getting the outcomes of the internal investigation—

Mr JEREMY BUCKINGHAM: Can you rule out that you did not initiate an external investigation before the internal investigation had reported?

Mr HALL: I would have to take that on notice, but my expectation is there would be discussions about looking at an external investigation throughout the process of the internal investigation, and a decision probably would be made at different points depending on what the internal investigation identified.

Mr JEREMY BUCKINGHAM: That is exactly right. A reasonable person might surmise that the internal investigation is turning up some concerning things, like recurrences of cancer and flat dosing. Then the organisation would decide what to do and could kick straight into an external investigation to manage the public relations side rather than escalating it to the ministry or, in a formal way, to the department.

Mr HALL: To be clear, because I know you have immense details in terms of our records, from 5 August onwards we always had an intention that we would go to open disclosure of patients. The thinking which we have acknowledged was wrong at the time is that we should have gone to open disclosure with the patients earlier and said we were going through an independent review and we would go through an external review. The heart of the thinking was that people did not want to cause further distress to a group of patients who were suffering very significant cancers and, as Associate Professor Gallagher has said, a number of whom were most likely to die. We did not want to give them more stress while they were undergoing treatment without fully understanding what had happened.

This is a quite unique situation, and most medical professionals would say they have not really seen anything like this before. Absolutely, they wanted to make sure that they had the facts and evidence in front of them. Dr Grygiel had an excellent reputation in this field, and we wanted to make sure that we had good facts so that we could tell patients what had happened to them without distressing them. In hindsight, we should have talked to them earlier and taken them through the process. That was a failing on our part, which we have acknowledged a number of times. As I understand it, 5 August was the date when we said we absolutely needed to look at going to open disclosure on this issue. Regardless of what the ministry or the public or the media think, we absolutely would have gone to open disclosure on this issue.

Mr JEREMY BUCKINGHAM: There is a contradiction in what you have said, and the *Hansard* will record it. You said a decision was made to go to open disclosure and yet you did not. A decision was made to initiate a reportable incident brief, but it never eventuated. You never went to formally notify the ministry. You never informed the patients. It appears to me that you covered up—you were working to try to keep this in house, under wraps. The level of concern was clear from the very outset. You had senior clinicians ringing the alarm bells on this, and it was clear you had a big problem on your hands. You knew that straight away and you pull the wrong rein. Rather than shining light on it, you did an internal investigation and straightaway you

kicked off an external investigation. It looks to me like you hoped to throw a blanket on it, rather than doing what you said you should have done, which is—

The Hon. NATASHA MACLAREN-JONES: Point of order: Is there a question or just a continuing statement from Mr Buckingham?

Mr JEREMY BUCKINGHAM: Probably just a continuing statement because I would like to put it on the record that I think there is a contradiction.

The Hon. NATASHA MACLAREN-JONES: Further to the point of order: We are here to ask questions rather than hear Jeremy Buckingham badger a witness.

The CHAIR: Order! Mr Jeremy Buckingham will ask the question or move on.

Mr JEREMY BUCKINGHAM: Is there not a contradiction, Mr Hall, in what you just said that: we did go to open disclosure; we should have gone to open disclosure?

Mr HALL: We decided in August that we would go to open disclosure, which was absolutely the right thing. The only discussion which was an issue, and we acknowledge should have been done earlier, was the timing to do that. There was never any point in the organisation where anyone would even consider for a second that we would not go to open disclosure. This is a common practice in Health. We talk to patients about problems that happen. Sometimes it is done almost immediately with family and the patient. In this case, which is a very complex issue with very fragile patients, we acknowledge we made a mistake. We should have gone to open disclosure earlier.

There was never any point though where we had any discussion and I have not seen a single point of reference that would highlight anything other than we would go to open disclosure and that would always be our practice. The issue was the timing and the reasoning behind it is we did not want to cause distress to the patients but we acknowledge that because of how the thing has worked out it has actually probably caused a lot more stress for the patients and we have continually apologised for that process. We should have done it differently.

The CHAIR: So what assessment was done? Where a patient was in dire straits, their world is falling apart, their cancer treatment is not going well, what sort of assessment did you do to work out whether you gave that disclosure to patients and whether you would just do it blanket, knowing jolly well that it could be the last straw for them? What sort of assessments did you do to work that out?

Mr HALL: Professor Gallagher might want to talk about some of the internal discussions.

Associate Professor GALLAGHER: When open disclosure took place, the decision was that all—as far as I knew we spoke to all patients and it did not matter where they were in the scheme of things.

The CHAIR: So mentally it did not matter if they were fragile; you had open disclosure to come clean with what the situation was?

Associate Professor GALLAGHER: I think people were very cognisant of the fact that some people may be fragile and others would not be. There was a mechanism that if it was felt that somebody was more distressed than others or had greater concerns or there was a concern about the conversation, then that was followed up.

The CHAIR: Was any assessment done where the open disclosure was enough to take them over the line; those who passed away may have passed away because of the depth of new information about the treatment?

Associate Professor GALLAGHER: No-one has specifically looked at that. I have got to say, at least amongst my own patients, I am not aware of any cases like that.

Ms PREST: Mr Chair, if I could add some further detail to that?

The CHAIR: Yes, please.

Ms PREST: The team that spoke with all the patients and families consisted of both cancer care coordinator nurses as well as the staff from the psychosocial support team, so social workers and others. As we thought about all of the patients in that group, we identified that there had been some patients who were deceased already and we made every effort to speak with their family members. We looked at them in that regard, if you like, and thought about the sort of patients that we would be phoning. Those patients who were distressed as a result of the phone call were offered continuing support, so they were offered either urgent arrangements for further support from a psychosocial point of view or follow-up reviews by their doctors, so quite a number of actions sort of came as a result of those disclosure calls.

The CHAIR: Where are the records of that happening, what was the result of who needed extra psychological care or social care?

Ms PREST: Correct.

The CHAIR: But where are the records of that?

Ms PREST: I believe that those documents were provided to the cancer inquiry.

Mr HALL: We have an ongoing process particularly in terms of psychological support for families and patients who require it. As you identified, it is a very, very challenged group of patients. That was a decision that was made. You can look at it and understand to an extent why people made that decision but I think we absolutely acknowledge that what was essentially patient interest in the end turned out to be totally against their interests. It would have been better to go to open disclosure straightaway and we would do that in any case in the future where this happened.

The Hon. WALT SECORD: Mr Hall, why did Dr Brett Gardiner leave St Vincent's Hospital on 10 June?

Mr HALL: Dr Gardiner resigned his position and left the organisation.

The Hon. WALT SECORD: Why?

Mr HALL: You would have to speak to Dr Gardiner to get his full explanation for that.

The Hon. WALT SECORD: Would you not be privy to that?

Mr HALL: I have got a loose understanding. Dr Gallagher, I think, along with a number of other staff, found that time period particularly stressful and I think probably for his health he thought that was a wise decision.

Mr JEREMY BUCKINGHAM: I think you mean Dr Gardiner.

Mr HALL: Sorry, Dr Gardiner, yes. Dr Gardiner is appearing so I am sure you can ask him.

The Hon. WALT SECORD: I am just surprised that you would not know as he was director of clinical governance; that you would not take an interest in such a senior position person leaving?

Mr HALL: I certainly attempted to meet with Dr Gardiner to talk about how things had travelled for him. It was a particularly short meeting and I have not had any further discussion with him from that point onwards and once he had chosen to tender his resignation we accepted that and left it at that.

The Hon. WALT SECORD: Are you familiar with a person called Linda Mackinlay?

Mr HALL: The name does not ring a bell, no.

The Hon. WALT SECORD: She is the ER/IR legal counsel for St Vincent's Health Network.

Mr HALL: Okay.

The Hon. WALT SECORD: Ms Prest, you nodded. Are you familiar with her?

Ms PREST: Now that you have mentioned that name, yes.

The Hon. WALT SECORD: What does she do in the organisation?

Ms PREST: I have not met her. I understand she works with our Human Resources [HR] department.

The Hon. WALT SECORD: Does she do what we would determine to be investigations into bullying and things that may occur in those kinds of areas?

Ms PREST: I would imagine as a member of the HR department.

The Hon. WALT SECORD: If you are not familiar with her work, then I seek on notice a report that she has conducted involving bullying at St Vincent's on 9 November—a record of interview that she conducted. I seek that on notice.

The CHAIR: You seek leave to table it.

The Hon. WALT SECORD: No, I request it from St Vincent's.

The CHAIR: Right, to take that on notice.

The Hon. WALT SECORD: So 9 November—record of interview by Linda Mackinlay ER/IR legal counsel at St Vincent's Health Network.

Mr JEREMY BUCKINGHAM: The email on 10 February from Dr Gallagher to the CEO says, "Do patients need to be informed?" And then it says, "In the end no harm appears to have been done and it would almost certainly cause distress." That is only half right, is it not? Could you reflect on that, Professor Gallagher, in terms of whether or not you still maintain that no harm has been done?

Associate Professor GALLAGHER: In the context of the email, that was a discussion at that point in time as to what was going on and how the open disclosure process should occur and the question was about open disclosure on that particular day. I think on reflection, yes, I would say that by not having done open disclosure earlier that had, itself, caused harm and also part of that email is that it is not actually clear from a clinical point of view about the impact of all of this on the actual outcomes of patients.

The CHAIR: Thank you for your time and for reappearing. It has been very helpful to clarify some earlier evidence received by the Committee. You have 21 days to reply to questions taken on notice and in light of your evidence we will probably have more questions. Thank you for your time and for appearing again. We appreciate it.

(The witnesses withdrew)

(Short adjournment)

DAVID DALLEY, former Head of Medical Oncology, St Vincent's Health Network Sydney, sworn and examined

The CHAIR: Thank you for appearing before the Committee this afternoon. I ask you to be careful when using individuals' names during the hearing to avoid causing unnecessary harm to people's reputations. Please ensure that your comments are relevant to the terms of reference. I remind participants to respect the privacy of individuals. It is important to remember that parliamentary privilege does not apply to what a witness may say outside of their evidence. I urge witnesses to be careful about any comments they make to the media or to others after they complete their evidence because such comments would not be protected by parliamentary privilege if a person took action for defamation. Do you wish to make an opening statement?

Dr DALLEY: I was the head of the Medical Oncology Department from November 1983 until my retirement in December 2013. I do not recall John Grygiel discussing his dosing of Carboplatin with me. When attending meetings or at journal club, we would discuss the latest findings. I am sure we would have discussed Carboplatin used with radiotherapy, but I cannot recall Dr Grygiel ever discussing the dose of Carboplatin he used. I know that we were concerned about the increased toxicity combined modality caused. I was trained to use evidence-based treatment proven in clinical trials. It was only recently that I found two trials that use a dose much less than that used previously. One of those trials did use a fixed dose of Carboplatin. However, both of those trials were small, and thus can be criticised. John is a very experienced medical oncologist who also worked as a pharmacist and in the pharmaceutical industry. I would be surprised if he used a low dose without evidence.

Did he do any harm? It is impossible to determine, but it is unlikely. I say this because the benefit of chemotherapy when combined with radio therapy is small but significant. The initial studies used full-dose chemotherapy in the belief that patients would live longer and the rate of metastases would be reduced. The trial results showed small survival benefits, but in general no reduction in distant metastases. However, there was increased toxicity. The main aim of combined chemo-radiotherapy is local control. When used to enhance the effects of radiotherapy, in theory full cytotoxic doses of chemotherapy should not be required. The most efficacious dose of chemotherapy when combined with radiotherapy is unknown as there have been no dose finding studies. There are studies that indicate less advanced efficacy. As I said, one of these doses also used a fixed dose of Carboplatin.

The Hon. WALT SECORD: You made reference to a "club".

Dr DALLEY: Pardon?

The Hon. WALT SECORD: You said you may have had discussions about the latest findings at a "club".

Dr DALLEY: We had regular meetings at conferences, we had regular journal clubs, teaching sessions—

The Hon. WALT SECORD: I want to know about the club.

Dr DALLEY: They were journal club meetings at which we would discuss the latest treatments.

The Hon. WALT SECORD: You understand that one of the reasons the Committee has asked you to give evidence is that there is a discrepancy between the evidence that Dr Grygiel presented and your statement today. He said that he had a friendly discussion with you about doses of chemotherapy. Do you understand the context of that and how he may have misunderstood?

Dr DALLEY: I repeat that I cannot recall him mentioning the dose he used during those journal club meetings or in teaching sessions.

The Hon. WALT SECORD: What would happen at those club meetings? Did you get together to discuss the latest science journals and overseas discoveries?

Dr DALLEY: Yes. We had regular teaching sessions that included journal clubs. Once or twice a year we would to go to conferences and bring back the latest information.

The Hon. WALT SECORD: What was your relationship with him? Was it professional and cordial?

Dr DALLEY: It was cordial; we got on quite well. I had no complaints about him.

The Hon. WALT SECORD: Could you have had a discussion with him about the protocols in 2006 when they were put in place? I acknowledge that that is some time ago.

Dr DALLEY: EviQ was introduced because Robyn Ward, who was one of the oncologists at our hospital, decided that we should have uniform protocols and she created a St Vincent's Hospital protocol book. She then went to St George and Prince of Wales hospitals and got them to cooperate and we had a combined book. Then the NSW Cancer Institute got formed and took that protocol book and became CI-SCaT and then became eviQ. We discussed trials that you could go on quite in detail and we had more discussions in the last few years before I retired, because at that stage I had been trying to get a database for many, many years, and then I had a patient give money and so we could purchase it. With the database we agreed that only protocols which were evidence-based would go on it. I am sure John may well have brought up what about non-eviQ protocols, because there are quite a few protocols we use which are not on eviQ. If there is a protocol someone wants to use it would have to go before a committee and agreed that was worthwhile. I was not involved with that because MOSAIQ had not started at the time I left.

The Hon. WALT SECORD: Did you participate in Professor Currow's inquiry?

Dr DALLEY: I did, yes.

The Hon. WALT SECORD: What was your contribution?

Dr DALLEY: As I am doing here, giving evidence. It was the first time I recall being told the dose John used. David Currow told me. I heard on the news it was low dose, but he was the first person to tell me it was 100 milligrams and fixed doses.

The Hon. WALT SECORD: And what advice or testimony did you give to Professor Currow's inquiry?

Dr DALLEY: My disappointment to the committee was that there was no practising medical oncologist on it. Again, he had expert people contribute, but most of them were radiotherapists and not medical oncologists.

The Hon. WALT SECORD: What could a practising medical oncologist provide? What kind of insights could a practising medical oncologist provide?

Dr DALLEY: We are the ones who know the trials, who know the drugs. I do not comment about radiotherapists' treatment. I know a bit about it, I did quite a bit of work when I was a junior, but I am not expert enough to talk about it.

The CHAIR: Can we just explore that a little more? I think the Hon. Walt Secord is trying to ask what would the outcome be if your sort of expertise was on that committee? How would it look different?

Dr DALLEY: On the Currow—

The CHAIR: Yes, on the Currow report.

Dr DALLEY: I gave evidence and I pointed out that I was not aware of any trials except the two I have mentioned here. I said, as I say here, I am not sure he has done any damage because we do not know the

dose. It is a huge difference giving chemotherapy to cure cancer cells alone than to give it with radiotherapy for sensitisation. I do not know whether a 100 milligrams fixed dose is good enough or not, but I am sure the dose that was used is too high. But I still use that dose because it was the only evidence I had.

The CHAIR: Would it be an unusual practice, given your great history in this oncology area, to have a multidisciplinary team and not discuss what individual patients are having in all sorts of medication, never mind the chemotherapy?

Dr DALLEY: No. Multidisciplinary teams are there to work out what the best treatment is. Again, I would not comment about the dose of radiotherapy to the radiotherapists and I would not expect them to comment about the dose of chemotherapy.

The CHAIR: But you would have to think for the best outcome for individual patients that knowing their height, weight, their blood levels and blood gases and whether they have the potential for renal failure or heart failure or liver failure—surely, it is part of your job to know exactly where the patient is up to in every aspect of their treatment, all sorts of treatment by all experts. I find it hard that you would not know what was the plan of the radiologist, for instance, what they are going to do and what they are going to try and apply.

Dr DALLEY: I did not say that. I said I would not comment about the dose of radiation. The idea of the meeting is to work out the most efficacious treatment for that patient. Yes, we may not know all the factors about it, but we knew, because the patients came, their comorbidities, and if someone was very unwell we would not be suggesting a treatment; we would modify the treatment—

The CHAIR: But you would speak up if you knew that would contribute to a mortality situation, would you not, if you knew the radiotherapist—

Dr DALLEY: That would be discussed, yes, but we would not have the minutiae, like what is the correct renal function and things like that. If it was decided that combined modality therapy or chemotherapy by itself was the best treatment, we would then assess the patients far more thoroughly with all the blood tests and things like this.

The Hon. WALT SECORD: One quick follow-up to what I asked earlier. Do you think that the David Currow inquiry was limited because of the lack of appropriately trained practising medical oncologists?

Dr DALLEY: That is my criticism of it, yes. I have lost track of some of the medical oncologists. I only recognised Joanna Dewar as the medical oncologist; all the rest were radiotherapists.

The CHAIR: Are you aware of studies in the United States about off-protocol treatment, given your great history in oncology? It is not unusual to have off-protocol chemotherapy treatments in the US, is it?

Dr DALLEY: I would not know about them unless there were studies of protocols.

The CHAIR: They were studies. I am sorry, I do not have it at hand to quote to you where it was, but I have previous evidence there are a lot of oncologists using that type of thing, that is all.

Dr DALLEY: I think we all have used non-protocol therapy because there are not enough protocols to cover every situation and also trials exclude so many patients. If your liver function tests are slightly abnormal you will be excluded. How do we exclude you with a liver test that is slightly abnormal? We adjust the doses and see what happens. That is off protocol but we are following the protocol, and that is what eviQ is trying to do. EviQ is not guidelines; eviQ is taking published data and working out the best way of administering it; the best information sheet for the patient that was not made to the guidelines. At that meeting we would try and say if someone had abnormal liver function tests: "What sort of dose reduction should we recommend?"

The CHAIR: From my reading, for example, it is not unusual to lower the recommended dose for capecitabine by a percentage before you even start administering it?

Dr DALLEY: I am not sure what that has got to do with this head and neck but a lot of things have been used with xeloda—

The CHAIR: My point is that eviQ says this but not every treating doctor or oncologist may come in at that level—for example, they may drop it by 25 per cent?

Dr DALLEY: I am not aware of that. I am aware that we had an argument on capecitabine about fixed dosing and for a couple of years fixed dosing was in eviQ. I looked up subsequently and that has now been changed to a milligram per metre squared.

Mr JEREMY BUCKINGHAM: Good afternoon and my apologies for being late to this session. How long did you work alongside Dr Grygiel?

Dr DALLEY: I started in 1983 and I think John came in about 1996; so quite a few years. That year may be wrong but that will give you some idea; it was quite a long time.

Mr JEREMY BUCKINGHAM: So nearly 20 years. How many medical oncologists are there in New South Wales? Hundreds?

Dr DALLEY: No, I would say probably more in the order of 50 but I am purely guessing.

Mr JEREMY BUCKINGHAM: And you are passionate about what you do? You love what you do?

Dr DALLEY: I did. I love what I do now—I am retired! I dedicated to my life to oncology. I loved the patients, I loved what we were doing. I was one of the first trainees in oncology and there the theory was if you give high enough doses of chemotherapy you are going to cure more cancers, and we knew that was wrong. I went to Canada and learnt about quality of life, and I think that was the best thing that came out of my training. I think I was someone who cared for people and they cared for me.

Mr JEREMY BUCKINGHAM: You are passionate about what you do. In the field of head and neck cancers how many options are on the table for oncologists in terms of types of medications—the platins? I am a layperson but how many options or choices are there in terms of the different chemotherapies?

Dr DALLEY: There are quite a few. The standard ones are cisplatin, carboplatin and erbitux—I cannot remember the real name of erbitux. But there are other drugs that work: methotrexate works, in cysteine activity bleomycin had some activity but they are minor activities and—

Mr JEREMY BUCKINGHAM: There are probably three or four?

Dr DALLEY: The three main ones: the two platins and erbitux.

Mr JEREMY BUCKINGHAM: You have three choices and you also have to take into consideration all the other things about your patient—where the cancer is up to, where the cancer is, comorbidities, body mass and all the rest of it. It would seem to be that the dose or amount of drug that a person is given is a matter of discussion, study and conjecture and it has been for a long time in your particular field.

Dr DALLEY: It is certainly a matter of conjecture and the reason being is that the dose is calculated—usually drug companies do the initial trials, they escalate the dose until they get maximum toxicity and then they come down one level. That is the maximum tolerated drug dose recommended for trial; it is not the most efficacious dose.

Mr JEREMY BUCKINGHAM: That is a key point. You said you went to Canada and other doctors who have looked at these things—in terms of quality of life, working with the radiotherapy and all of those things—had a different view. They are the people at the front line—for example, BMW designs a car but other people go out and drive it. You were the person really doing that. It seems remarkable to me that you could work next to someone for 20 years, for you to be passionate in your field, and there could only have been a certain amount of things for you guys to talk about, yet the dosage that you were prescribing, and in particular Dr Grygiel was prescribing, was not a matter that you discussed? From Dr Grygiel's evidence, it appeared to me that his view, which was held over decades, was that 100 milligrams would just about do it—that was about the sweet spot. It seems remarkable that would not be something that you would be well aware of.

Dr DALLEY: My understanding was that he would be using what we used as per eviQ. I had never heard of low-dose, fixed-dosing platin. I cannot see why I should be questioning him when I believed he would be using the same thing I would be using.

Mr JEREMY BUCKINGHAM: I just find it remarkable that over two decades in such a small cohort of people—maybe three or four oncologists or whatever the number is at St Vincent's; it is like a marriage, you know each other intimately—that the rest of the group would be not be aware until 20 years later of what Dr Grygiel's particular view was as to the best medicine and the best dosage a doctor could prescribe.

Dr DALLEY: I do not think it is 20 years later.

Mr JEREMY BUCKINGHAM: Well 10 years at least. There was a suggestion by Dr Grygiel that you were well aware of this 10 years ago and he was doing it up until just months ago.

Dr DALLEY: All I can say is that I cannot remember him talking about his dose and I do not think it was my job to inquire into the actual doses. We discussed often enough concurrent therapy and the doses on what trials. I can remember a year or two before I retired going through all the evidence to our head and neck meeting, presenting the data and the data was the published papers.

The Hon. COURTNEY HOUSSOS: I take this opportunity to thank you for your time because your testimony has been really informative for us. One of the key issues that we have found over the course of this inquiry has been the lack of supervision of Dr Grygiel and the lack of information that was available within the broader St Vincent's community. Some people have characterised you as Dr Grygiel's immediate supervisor. Would you characterise your role as that?

Dr DALLEY: I was head of the department, yes.

The Hon. COURTNEY HOUSSOS: What supervision would you provide to Dr Grygiel as the head of the department?

Dr DALLEY: We would have meetings to discuss his performance but not in such detail that we would go into dosing. There are so many cancers you cannot discuss all the trials and things.

The Hon. COURTNEY HOUSSOS: What are the kinds of things you would discuss in the course of evaluating his performance?

Dr DALLEY: The hospital had a format that was about keeping up with your education, ensuring that he attended meetings, that he took students, participated in our journal clubs, and things like that.

The Hon. COURTNEY HOUSSOS: More of a broad strategic view rather than technical?

Dr DALLEY: Dr Grygiel is a very experienced oncologist. He has had nearly the same length of time practising oncology as I have. He was one of the first oncology trainees as well. You have to give him some leeway.

The Hon. WALT SECORD: What do you mean "leeway"?

Dr DALLEY: Respect his dosing. He is very experienced.

The Hon. SCOTT FARLOW: Dr Dalley, are you effectively saying it is horses for courses in a sense and it is not a book that is published and people follow blindly? You have to be responsive to patients and a senior medical professional would be given that autonomy?

Dr DALLEY: Yes, that is correct, thank you. You have to have some leeway. If you do not have the patient fitting the criteria of that protocol or who is slightly unwell or the blood test shows an abnormality you have leeway to change doses. I would not be on to any of my staff and say, "Are you doing it according to the protocol?", because I expect they would be. I also expected the staff to inform me, that did not happen either.

The Hon. COURTNEY HOUSSOS: When you say "the staff", who would the staff be?

Dr DALLEY: Mainly the pharmacists. If I made a mistake, and we all make mistakes, writing a chemotherapy order they were quickly on to me and saying, "Is this correct?"

The Hon. COURTNEY HOUSSOS: That was your experience, if something was unusual with your dosing they would come back to you immediately?

Dr DALLEY: Yes, because they obviously knew it was wrong and did not want to harm the patient.

The Hon. COURTNEY HOUSSOS: The key issue this inquiry is investigating is the lack of personalisation of care. That there was the 100-milligram dosage provided across the board irrespective of the outcome. The testimony from Dr Grygiel, to be frank, is that you authorised this as his boss, as his supervisor. There were two conversations he refers to, one in 2006 and one in 2013, that effectively signed off on this. You, as his OE is the colloquial term, boss, perhaps not the correct medical term, were the one responsible for signing off on this.

Dr DALLEY: I entirely disagree with that. I would have discussed concurrent chemotherapy but not dosing. We discussed eviQ so much, especially in the last two years when we purchased eviQ, and getting protocols ready. Everyone knew it had to go before a committee. There is no way that low dose fixed dosing carboplatin would have got through the committee.

The CHAIR: We have had evidence tabled today by Avant Mutual Group Limited representing Dr John Grygiel. There are two significant points. I will quote what they say. They say there are two points they would like to emphasise: section 122 inquiring into consistency of approach was an emphasis on rigid criterion for complying with accepted eviQ guidelines in the treatment of St Vincent's patients with carboplatin.

Dr DALLEY: Can I comment that they are not guidelines.

The CHAIR: I will finish and you can put your expertise to the question: It appears in regard to capecitabine there was more acceptance to deviate from the guidelines when it became apparent that many

oncologists were prescribing significantly less than the prescribed eviQ dose. We note that the report into treatment in the Western New South Wales LHD states at paragraph 30 that: "Due to the capecitabine associated toxicity a large proportion of capecitabine could be expected to be within 25 per cent of the commonly used starting point." Paragraph 48 notes: "As explained in paragraph 37 the inquiry's clinical experts indicated that due to the associated toxicity many medical oncologists would commence capecitabine treatment at a dose of 20 to 25 per cent lower than the dose used in the defining clinical trial." And also 20 to 25 per cent lower than what is recommended in the eviQ guidelines. Do you wish to comment?

Dr DALLEY: eviQ are not guidelines.

The CHAIR: They can be overwritten, over authorised?

Dr DALLEY: Yes. They are comments on published trials. You do not have to stick to them.

The CHAIR: They are guidelines?

Dr DALLEY: No. They are a summary of what people think are the best trials for each disease?

The CHAIR: They are not compulsory?

Dr DALLEY: They are not compulsory. I think they probably should be. I was on the committee for quite some time and it came up quite often, "Should we do it this way?" And people said, "No, they are not guidelines. We have to base it on what the trial did."

The CHAIR: The next question is basically what this inquiry is about: Was it unreasonable for Dr Grygiel to move outside the suggestions of trials that you say are on eviQ and dose accordingly?

Dr DALLEY: If there was evidence. To me evidence is a clinical trial that showed that dose was efficacious. You can do it but I am not aware of those trials being available for the dose being used.

The CHAIR: Would you say that the fact that Dr Grygiel was able to perform a lower dose or a flat dose, as it has been known, for such a time without anyone seeming to be aware of his line of treatment for different patients was a systemic failure?

Dr DALLEY: I understand he was approached by several people and he explained that it was his dose and it did not go any further. To me that is a failure.

The CHAIR: Were they patients or senior colleagues?

Dr DALLEY: All I can say is what I have read in some of the transcripts. No-one came to me with it. That is one thing you have to look at in the future. I think every unit should have a database which is linked to the Cancer Institute looking at mortality and morbidity, so we can compare ourselves with it. And there has to be a way of changing protocols on it that if it happens more than once there has to be someone in charge to go back.

The CHAIR: It should be co-signed or co-authored?

Dr DALLEY: Yes.

The CHAIR: Even if you are the clinical expert in that area?

Dr DALLEY: It does not matter if you are the clinical expert or not.

The CHAIR: Some other doctor that would co-author that authorisation?

Dr DALLEY: Yes.

The CHAIR: Do you think that Dr Grygiel, with his experience, could have been informally running a trial with this dose level; taking into account your expertise and knowledge of the man?

Dr DALLEY: No.

The CHAIR: Do you think he was trying to find a breakthrough?

Dr DALLEY: No, I do not think he was. I think he believed firmly that low doses were sufficient. A trial is where you are unsure and you believe something and you want to prove it. It is all since I retired that I read all this and I think he had a firm belief.

The CHAIR: You would be aware that oncology has grown immensely in the last 30 years. There was a lot of experimentation, in my view, in the early days, with dosage of all sorts of things to get ahead of the cancer. Would that be a fair comment?

Dr DALLEY: It would because the trials were not done. One of the problems with some of the data we have is that the Americans did not get carboplatin until quite late. It was a European drug and they did not have US trials. Therefore, the number of trials with carboplatin is much less than with cisplatin. There will always be places where you will be using treatment which is not according to protocol because there is no protocol for it. If you have someone who has failed the standard therapies—there may be three therapies—who is very well but getting symptoms and wants more treatment, you are going to look at what drugs are available and use anything that has been shown to have some activity. That is not on the protocol.

The Hon. NATASHA MACLAREN-JONES: In relation to your comments that eviQ is not guidelines, but in fact a summary of doses—

Dr DALLEY: A summary of the trial.

The Hon. NATASHA MACLAREN-JONES: A summary of the trials. Could you talk us through how that is presented? In the event that you did not want to give the dose that was on that summary, would you then recommend that eviQ be amended to reflect that? I am not exactly sure, because we have not seen the data that is in eviQ.

Dr DALLEY: That was the idea of the meetings. We had regular meetings—they became specialised; we had one for breast cancer and one for head and neck cancers—and the idea was that if something came up, you would discuss it. Those little things usually do not come up. They come up with the patient. There is one thing that you can do. When cisplatin was used three-weekly there were not too many trials looking at it weekly. There were some, but the evidence was not as strong. I would say to patients, "This is what you could use three-weekly. It is toxic. Only 40 per cent of people get the full dosing. Or we could divide the dose up and give it weekly, which makes far more sense." It has been proven that that is correct. EviQ took that same view and said that even though the trials are not as strong as the ones with three-weekly platin it is better tolerated and probably just as efficacious.

The Hon. NATASHA MACLAREN-JONES: In the event of your coming across evidence that supported your giving a different dose than the dose on the eviQ, would you take a step to share that information?

Dr DALLEY: Yes. If that came up that would be a new entry on EviQ. I think there are a few examples of that. Certainly with carboplatin, when I was there there were two doses—1.5 times the area under the curve, and two. One of the people on the committee wanted to change it to a standard dose of two times the area under the curve. I said, "You can't do that, because the trial suggested 1.5 for this situation and two for this." So there are two protocols for it.

The Hon. NATASHA MACLAREN-JONES: Are you aware of any occasions where Dr Grygiel tried to present his evidence in relation to his dosing?

Dr DALLEY: No. If he had evidence, I think we would all be using it.

The CHAIR: Further to the second point of that letter that I was referring to about radio sensitisation, this paper is in regard to that. It is by Dr Haines, who has done a couple of articles about this particular topic. It says, "As indicated, low dose of the chemotherapy is radio-sensitisation. It is to change the structure and function of cells, without severely damaging them, making them more susceptible to the lethal effects of the primary radiation treatment." The paper goes on to say, "We agree that the combination of chemotherapy and radiotherapy is far more toxic than radio therapy alone." The paper goes on to say—and I think this is the important bit—"We also recognise that there is no formula to calculate the dose for maximal radio sensitisation."

Dr Haines indicates, "Recent data reveals that it is the completion of the schedule of radiotherapy within the defined protocol time, and not the completion of the protocol chemotherapy that determines the outcome for the patient". Do you want to comment on those two paragraphs?

Dr DALLEY: I agree. We do not know the most efficacious dose. We all believe that it is not the high doses we use. One thing that is clear from the use of chemotherapy is that if you delay radiotherapy you affect the outcome—both local recurrence and survival. That is one of the reasons I changed from three-weekly cisplatin to weekly—because I could get more drug in and did not have to stop the radiotherapy. Far more important than the dose of chemotherapy is that you get the radiotherapy in on time.

The CHAIR: Do you want to comment further on that last line that I read out in the second paragraph that there is "no formula to calculate the dose for maximal radio sensitisation"? That is exactly where Dr Grygiel was going—maybe a smaller amount could have the same effect.

Dr DALLEY: Yes. There was a paper I got yesterday which looked at cell cultures and different doses but there are no human studies looking at increasing doses with a conclusion. I found one with increasing doses but there was no conclusion about which dose was best.

The Hon. COURTNEY HOUSSOS: I want to bring you back to the Currow inquiry—the section 122 inquiry. Have you read the final report?

Dr DALLEY: Yes, I have.

The Hon. COURTNEY HOUSSOS: And the interim report?

Dr DALLEY: Both, yes.

The Hon. COURTNEY HOUSSOS: I would be interested in your thoughts. You highlighted some of the issues that you have with it. Are there any other concerns that you had with the report that you would like to highlight?

Dr DALLEY: It is quoted in there that cisplatin is better than carboplatin, and he quoted the Hellenic study. The Hellenic study was a 124-patient, three-armed study and the carboplatin was seven times the area under curve three-weekly. One hundred and twenty-four patients is not enough. The margin of error is huge, and you cannot say from that that cisplatin is better than carboplatin. There are two other studies which disagree with it, but all studies are small. My feeling is that cisplatin may be a bit better than carboplatin but it is marginal.

Another point is that he talked about a minimal effective dose of cisplatin being 200 milligrams per metre squared. There was one trial which looked at 100 milligrams per metre squared of cisplatin and found that if you only got two courses you did not do as well as if you had three courses. The conclusion they have drawn from that is that you need a minimum of 200 milligrams per metre squared. That does not prove that at all. Maybe a lesser reduction would have been better if you got three courses in. He says, "EviQ is intended to provide guidance on optimal prescribing. It is intended to be a review of a trial so that similar doses and modifications in patient information sheets can be used." That is a minor thing, but they were the major criticisms.

The Hon. COURTNEY HOUSSOS: I keep coming back to the question of dosing, and who it is that is responsible for monitoring the dosing. I appreciate that in a busy hospital, when you are head of a department, perhaps the micro-level that is the dose that the patient is receiving, might not necessarily come up in a conversation. Is there anywhere, apart from in feedback from pharmacists, where monitoring of that dosage would occur? It does not seem to come up in the multi-disciplinary teams.

Dr DALLEY: No. That is why I was after a database for so long. I was trying for 15 years to get a database, because it would pick up these errors and you could do something about it.

The Hon. COURTNEY HOUSSOS: Do you think that that is now covered through eviQ, or do you think that this—

Dr DALLEY: Not through eviQ; through MOSAIQ.

The Hon. COURTNEY HOUSSOS: My apologies. Yes, MOSAIQ.

Dr DALLEY: Yes, provided there is an extra thing—because you can change MOSAIQ, but there has to be a safety thing put in, that if it is changed more than once it has to go back to the person and ask why they are doing it, so that it cannot keep on happening.

The Hon. COURTNEY HOUSSOS: Did you have the opportunity to provide this feedback to Professor Currow?

Dr DALLEY: I cannot remember, but we talked about a database because Professor Currow, when he was at Westmead or Nepean, started looking into databases. We paid $10,000 from a trust fund to use his database, which did not turn out to be what we wanted. I think we did mention databases. I said, "You know I have been looking for 15 years?"

The Hon. COURTNEY HOUSSOS: Did you know Professor Currow prior to him doing that?

Dr DALLEY: No, we did not use it because it did not do what we wanted.

The CHAIR: The American study I was talking about—if you look at the *Hansard* record of proceedings you can follow the reference point—was a study of 440 oncologists in the US in about 2008. A lot of the oncologists said that while they would not use off-protocol chemotherapy, it should be an option. What are your thoughts on that comment?

Dr DALLEY: I am very wary of what comes out of the States because a lot of it is by private oncologists, who are there to make their money. I think the advantage we have is that most medical oncologists work in a public hospital and money is not the issue. Most of us are using what we think is best for the patient. We still think that the best trials are the best ones to use.

The CHAIR: But if you do not fit—

Dr DALLEY: If you do not fit, yes, we have said—

The CHAIR: —as you know, the trials are normally set on really tight frameworks and it does not take much to be knocked out of the trial.

Dr DALLEY: —we have all used off-protocol—

The CHAIR: Do you think it would be reasonable for a patient to ask their oncologist to get a low or flat dose of chemotherapy, if they felt that was appropriate for their particular treatment? Should the oncologist and the patient be allowed to undertake that treatment?

Dr DALLEY: If a patient came to me and asked to use low-dose chemotherapy, I would say, "What evidence do you have? You are doing something which is not standard practice." We would go through it. Would I give it to them? It would depend on the situation and whether you are using concurrent therapy. If it was with radiotherapy, maybe I would say yes because I really believe we are giving too much chemotherapy with radiotherapy. If it is by itself, I would say no because we are not getting the cytotoxic effects; the dose would not be high enough.

The CHAIR: Given your great history on consent, how did you deal with getting the consent of the patient to undertake chemotherapy?

Dr DALLEY: I was very careful about it. We would discuss it. I would give them either the eviQ information sheet or my own and we would go through it and discuss it. I would record in my letters that we had discussed the side effects of treatment and the outcome aims. They were well informed. We did also educate the nurses.

The CHAIR: Would the patient sign off on that?

Dr DALLEY: Not necessarily, no.

The CHAIR: Would it just be verbal informed consent?

Dr DALLEY: Yes.

The CHAIR: I thank you for assisting us in our inquiry with your great history in oncology. If you have taken questions on notice or if we send additional questions, you will have 21 days in which to answer these questions and the secretariat will assist you with any queries you may have. Your evidence has been very helpful.

(The witness withdrew)

BRETT PATRICK GARDINER, Former Director, Clinical Governance, St Vincent's Health Network, Sydney, sworn and examined

The CHAIR: Dr Gardiner, at your request the Select Committee has resolved to issue a summons for you to appear and give evidence this afternoon. The Committee has taken this step in response to advice from your legal representatives that you are subject to confidentiality obligations, which do not apply if you are compelled to give evidence under summons. The position of the Legislative Council is that summons is not required to protect you from legal or other repercussions that may stem from breaching the terms of a confidentiality obligation. This protection is provided by virtue of this being a parliamentary proceeding with the consequent rights afforded under article 9 of the Bill of Rights 1689 and section 12 of the Parliamentary Evidence Act 1901.

Nevertheless, as we understand that the issuing of a summons would provide a level of reassurance to you, and given a recent precedent in earlier Legislative Council select inquiries, the Committee has issued a summons for you to appear today. I do note that you may feel more comfortable giving parts of your evidence in camera, and that is an option that you can pursue if we hit such questions during proceedings. If you indicate you would prefer to answer questions in camera, we will put those questions to one side and take your evidence in camera at the end.

Please be careful when using individual names during the hearing in order to avoid unnecessary harm to people's reputations. Please ensure your comments are relevant to the terms of reference. I also remind participants to respect the privacy of individual patients. It is important to remember that parliamentary privilege does not apply to what witnesses may say outside of their evidence at the hearing, and so I urge witnesses to be careful about any comments they make to the media or to others after completing their evidence as such comments would not be protected by parliamentary privilege if another person decided to take action for defamation. Do you have an opening statement?

Dr GARDINER: I do. I was the Chief Medical Officer and Director of Clinical Governance at St Vincent's Hospital between January 2010 and June 2016. I am no longer employed by St Vincent's. I no longer have access to documents or my diary, which I would otherwise be able to access if I was an employee. I apologise to the Committee that I am unable to refer to specific documents or my diary for specific dates. I have no independent recollection of when I was first told about any issue of chemotherapy prescribing. However, I do believe the Director of Cancer Services raised it with me at a date I can no longer recall but I recall asking him to obtain further information about the matter. I recall sending an email on 5 August 2015 in which I notified the CEO and others of what I understood to be a potential issue relating to chemotherapy underdosing of head and neck patients in which I suggested a process of information-gathering take place with a view to conducting an external review.

I participated in a meeting on 7 August 2015 at which time the chemotherapy-prescribing issue was discussed. Present at the meeting were the Chief Operating Officer, the Director of Cancer Services, the Manager of Cancer Services, the Chief Pharmacist and two other oncology pharmacists, as well as one person from the Quality and Safety Unit. I believe this meeting was organised by the Manager of Cancer Services. At this meeting I was informed of a number of matters including the following: first, Dr Grygiel had changed his prescribing practice; second, the MOSAIQ electronic system was shortly to be introduced, which included the eviQ protocols, and these would have the effect of controlling the chemotherapy prescribing the set guidelines; third, a new policy was being introduced to mandate a process to follow in the event someone wanted to prescribe outside the guidelines; fourth, pharmacy could monitor the chemotherapy prescribing; and, lastly, Dr Grygiel's prescribing was a radiosensitising dose and was not the primary treatment for the patient.

I was left with the impression that such prescribing had not had an adverse effect on patients. At the conclusion of this meeting it was planned that the Director of Cancer Services and I were to arrange to speak to Dr Grygiel. It was also my understanding that the Manager of Cancer Services was taking steps to obtain patient information. However, there was a significant delay in this process which I very much regret that I did not manage more closely.

On 31 August 2015 I had a meeting with the Director of Cancer Services and Dr Grygiel which included seeking information from Dr Grygiel as to the basis for his prescribing and confirming to him that we were in the process of undertaking a review. Dr Grygiel confirmed that he had changed his practice and would prescribe in accordance with the eviQ protocol. On 6 October I had a meeting with the Director of Cancer Services and a radiation oncologist which prompted me to confirm the need for an external review and to ask the Director of Cancer Services to make inquiries about a suitable reviewer. I followed this up from time to time

until I went on a period of extended leave commencing 19 November 2015. I was on leave between 19 November 2015 and 1 February 2016.

During this period the brief and terms of reference for the external review were prepared without my input. Upon my return from leave I made inquiries as to the external review report. I did not see that report until 17 February 2016. It was not until I received the external review report that I appreciated the degree of concern. I have reflected on my own role in this review and I regret that I did not manage the process in a more timely way. I wish that I had appreciated the seriousness of the issue earlier in time and had been more proactive in managing the review and implementing a disclosure process. I do accept my shortcomings in this process and I sincerely apologise for them. In particular, I want to apologise to the patients and their family and friends who have been left with uncertainty and all the stress that comes with that. I am sorry.

The CHAIR: Thank you, Dr Gardiner.

The Hon. WALT SECORD: Thank you, Dr Gardiner, for coming. When did you leave the service of St Vincent's Hospital?

Dr GARDINER: June this year.

The Hon. WALT SECORD: June 10, 2016?

Dr GARDINER: That is correct.

The Hon. WALT SECORD: What was the official rationale for your departure?

Dr GARDINER: I resigned.

The CHAIR: Can I ask why you resigned?

Dr GARDINER: I had a number of reasons for resigning. Principally for me is that it affected me quite greatly. I had to look after my mental and physical health. I found it very difficult to participate in things. I had previously considered what I would be doing this year after last year and basically I had had enough. I love St Vincent's; there were a lot of good things we did. It was hard for me to go but that was really what I did, really for myself.

The CHAIR: Can I be pretty blunt: Were you pushed?

Dr GARDINER: Well, I was not pushed. This was my decision.

The CHAIR: Were you bullied?

Dr GARDINER: Was I bullied? Well, with that—

The Hon. WALT SECORD: Take your time?

Dr GARDINER: Was I bullied? There were various people who spoke to me during the period of time and there were things that happened so was I bullied? I did feel from one aspect I was bullied but not withstanding any of that, I had considered where I was and I essentially wanted to resign. I needed to do something for myself.

The CHAIR: Did you resign taking responsibility for, as you say, the regret? Was your resignation in light of that; that you actually accepted full responsibility for that lack of action and all those things that you just told us that you live in regret of?

Dr GARDINER: There are a lot of things I regret. I was a member of a team with this. I do accept my responsibility with this. I do not accept full responsibility for this. We were a member of the team with this. In terms of my resignation letter—I should remember exactly what I put in it but I did not put all these things that I have said to you. I have reflected on this quite a lot but I want to be honest with the Committee.

Mr JEREMY BUCKINGHAM: Thank you, Dr Gardiner. I really appreciate your frankness and you turning up here today. When you say that last year was difficult for you, was it because of these matters? Was it because from on or about the June period these issues regarding the flat dosing had emerged? Is that why it was difficult and is that one of the reasons you went on extended leave?

Dr GARDINER: No. During last year I experienced some health problems, including some depression and anxiety, and had a number of periods of leave during 2015 and 2016. I had been sick a lot of that time with time off and I kept pushing myself to do more and that is what I did. I planned to take a long period of leave; it was planned leave. Originally I wanted three months and it got down to 2½ months. I had not appreciated at that time, so it was before this had happened.

Mr JEREMY BUCKINGHAM: But this did not help?

Dr GARDINER: This did not help.

Mr JEREMY BUCKINGHAM: Dr Gallagher maintains that he had raised this issue with you of the off-protocol flat dosing—whatever you want to call it—of chemotherapy patients on a number of occasions. How do you respond to that assertion?

Dr GARDINER: I can only say what I can remember and I have thought very long and hard about what was said to me and there are things that I cannot remember. What I do recall was that at some time the Director of Cancer Services, Dr Gallagher, did say something to me—and I am trying to place exactly where it was. I cannot put the time. Dr Gallagher was off on leave himself and had broken his foot at some stage in this process and I cannot pinpoint a discussion. I do know that for me to write that email, which I did on for 5 August, that I had spoken to Dr Gallagher. Dr Gallagher was the person who told me about the issue. I cannot say that there were multiple discussions because I do not believe that is the case.

Mr JEREMY BUCKINGHAM: You say you were bullied. Can you expand on that? Were you bullied about this issue? Were you being bullied by Dr Gallagher to do something about it or by other people not to do something about it?

Dr GARDINER: I was not bullied by Dr Gallagher to do anything about this.

Mr JEREMY BUCKINGHAM: But did you feel bullied or pressured by others not to do something about this?

Dr GARDINER: No.

The CHAIR: Who was on the panel? You said you do not accept full responsibility. Who do you feel should accept total responsibility, obviously including yourself?

Dr GARDINER: That is something I think the Committee needs to examine. I was a member of the group. I believe there would be many people at St Vincent's Hospital who have some regret about what they said or did not say or do. I think a lot of this weighs on people's hearts

The CHAIR: I understand that, but who are the senior players? Who should be shouldering the responsibility?

Dr GARDINER: I think we were all responsible. I can only speak for myself in terms of not being as proactive and as timely with that—

The CHAIR: I understand that, but who else should take some responsibility for not dealing with this systemic issue earlier?

Dr GARDINER: I always believed it was a systemic issue. We had a doctor prescribing in a particular way in a major hospital for a long time. We all bear some responsibility for that.

The CHAIR: Dr Cooper was involved in some care, Dr Gallagher was involved in some care, and Mr Hall was in charge of St Vincent's Hospital in terms of culture and practice. There are different doctors involved in this scenario. It appears that all of them failed to deal with this systemic breakdown. You say that you accept part of the responsibility, and that is creditable. I am trying to work out who are the other key players who should be shouldering some of that responsibility. I cannot guess who they are; I need to know who in your world you feel should embrace some responsibility.

Dr GARDINER: I can answer that question only by saying that we all bear some responsibility.

Mr JEREMY BUCKINGHAM: The issue of bullying has been raised, and it is part of the systemic breakdown. People should feel safe representing different views in their workplace. The Committee is particularly interested in finding out who you felt bullied you.

The CHAIR: Your counsel are welcome to provide you with advice on these questions.

The Hon. SCOTT FARLOW: As indicated, we can take evidence in camera.

The CHAIR: Do not feel any pressure. If you do not feel able to answer, that is your call.

The Hon. BRONNIE TAYLOR: There is no pressure; it is entirely up to you.

Mr JEREMY BUCKINGHAM: There is pressure on him.

Dr GARDINER: I would like to respond to that question in camera.

The CHAIR: The Committee will hear evidence in camera later.

Mr JEREMY BUCKINGHAM: I will pursue a different line of questioning. Can you reflect on the initiation of the first internal review? How did it come about? What was your role? How was a person appointed without any medical oncologist involved? What is your recollection of that process?

Dr GARDINER: I sent the email on 5 August. I initiated this because I wanted a group of people to provide some details about patients and what needed to happen. A meeting occurred on Friday afternoon at about 4.00 p.m. I did not call that meeting, but I did attend it. I had not prepared myself as well as I could. That is me looking at myself. However, I asked for a review to be undertaken. Following the meeting, I asked for the manager of cancer services to provide more information. I was away for the next two weeks, so I did not have another meeting in that period. I came back and met with Dr Grygiel on 31 August. That is where things were at at that time.

Mr JEREMY BUCKINGHAM: You said you thought a review was appropriate, and in that intervening period the review was kicked off, people were appointed and so on. A decision was made at the meeting on 31 August about a larger external review.

Dr GARDINER: No. I wanted some more information; it was required. The manager of cancer services went on leave for a period towards the end of August and did not come back to work until early October. I needed more information at that time. As I said in my opening statement, I had always intended that there would be an external review, and I indicated the need for that on 6 October. I followed that up on 8 October in terms of saying that we needed to kick this off.

Mr JEREMY BUCKINGHAM: I appreciate your evidence. Thank you.

The Hon. COURTNEY HOUSSOS: Thank you for appearing before the Committee this afternoon. We can see how difficult it is for you to provide this evidence. However, I cannot underscore enough how important and valuable it is. The Committee has received some conflicting evidence. It appears that you are the third party in some of those meetings. If at any point you want to stop me, please do so. I refer to the 31 August meeting between you, Dr Grygiel and Dr Gallagher. I do not know whether you have read the transcripts.

Dr GARDINER: I have read them.

The Hon. COURTNEY HOUSSOS: Dr Grygiel said that he was "completely exonerated". We heard from Professor Gallagher earlier today that that is not his recollection of the meeting; his recollection is quite different. Can you explain your recollections of the purpose of that meeting?

Dr GARDINER: The purpose of that meeting was, first, to understand why Dr Grygiel was prescribing in a particular way and, secondly, to ensure that while he had already agreed to use the eviQ protocols he would actually do so. In terms of the word "exonerated", that is not correct. Whilst I cannot remember all the various things that people said at the meeting, for me it was not an exoneration.

The Hon. WALT SECORD: Do you understand the circumstance where Dr Grygiel could misunderstand the tenor of the meeting?

Dr GARDINER: That is possible because there were no criticisms levelled at Dr Grygiel at that meeting. The thing is I did not know the seriousness of this issue; it was not at that time a matter of saying you were right or not right or anything like that.

The Hon. COURTNEY HOUSSOS: But it is clear that your recommendation throughout was that there was a need to seek more information internally, then through an external review, and obviously that is what you were advocating for. Is that correct?

Dr GARDINER: Absolutely.

The Hon. COURTNEY HOUSSOS: Did you participate in Professor Currow's inquiry?

Dr GARDINER: Yes, I attended that inquiry on two occasions.

The Hon. COURTNEY HOUSSOS: I am not sure whether you were on leave at this point, but part of the purpose, it seems to me, of the 31 August meeting was to inform Dr Grygiel that there was an investigation underway.

Dr GARDINER: Yes.

The Hon. COURTNEY HOUSSOS: Was there a subsequent meeting with Dr Grygiel to say, "This is the conclusion of the internal investigation and these are the outcomes of it? "

Dr GARDINER: No.

Mr JEREMY BUCKINGHAM: When you recommended an external review was there any resistance to that?

Dr GARDINER: No.

Mr JEREMY BUCKINGHAM: From anyone in the organisation?

Dr GARDINER: Not at all.

The Hon. WALT SECORD: Do you feel that there are individuals at St Vincent's now who still have not taken responsibility for what happened?

Dr GARDINER: I do not know what is in other people's minds. I think anybody at St Vincent's with this needs to do some soul-searching as individual clinicians or health managers. We have all got a responsibility to ensure that we do our best to lift our performance, and people will reflect on what they have actually done. It is not for me to say; I do not blame people. This was a systemic issue where there are a lot of things that I think we all could have done better.

The Hon. COURTNEY HOUSSOS: In your process of saying we need to collect internal information and then seek an external investigation, did you ever propose notifying NSW Health or more broadly? Was that ever part of the discussions that you had?

Dr GARDINER: It was in my initial email of 5 August, I believe, that we would proceed to work this up for a brief-up. That was how I envisaged it.

The Hon. COURTNEY HOUSSOS: So on 5 August you were emailing, essentially, your superiors in the organisation, saying "We need to be telling people what is going on here"?

Dr GARDINER: That is what I did.

The CHAIR: We need to clear the public gallery because we are going to go in camera and get some evidence that is of a private and confidential nature.

The Committee adjourned at 17:03.