REPORT OF PROCEEDINGS BEFORE

GENERAL PURPOSE STANDING COMMITTEE NO. 2

INQUIRY INTO COMPLAINTS HANDLING WITHIN NSW HEALTH

At Sydney on Friday, 12 March 2004

The Committee met at 9.30 a.m.

PRESENT

Reverend the Hon. Gordon Moyes (Chair)

The Hon. Dr Arthur Chesterfield-Evans
The Hon. Amanda Fazio
The Hon. Patricia Forsythe
The Hon. Robyn Parker
The Hon. Peter Primrose
The Hon. Christine Robertson

NOLA THERESE FRASER, beauty therapist and individual complainant,

SHEREE ANN MARTIN, beautician and individual complainant,

VANESSA LEANNE BRAGG, individual complainant,

KATHERINE MARIE GROVER, registered nurse, sworn and examined:

CHAIR: Welcome to the first public hearing of the inquiry by General Purpose Standing Committee No. 2 into the complaints handling procedures within NSW Health. Before we commence, I would like to make some comments about aspects of this Committee's inquiry.

This inquiry will raise difficult issues for many participants: The relatives and friends of people who have experienced an adverse event in the health system, health workers who have sought to draw attention to poor practices, as well as practitioners and managers whose abilities and professionalism have been challenged. I therefore ask the media and any other persons in the audience to demonstrate sensitivity in any approach made to witnesses during this inquiry, particularly immediately after the giving of their evidence.

The inquiry terms of reference require the Committee to examine the system for handling complaints in New South Wales and whether the health system in New South Wales encourages people to reflect upon errors. People's individual experiences of this system will help the Committee understand how the complaint handling system works or does not work. I ask everyone who is interacting with the Committee to reflect upon the terms of reference and to assist the Committee to use these difficult experiences to improve the health system. The Committee does not propose to duplicate other inquiries or investigate or conciliate individual complaints.

It should be remembered that the privilege which applies to parliamentary proceedings, including committee hearings, is absolute. It exists so that Parliament can properly investigate matters such as this. It is not intended to provide a forum for people to make adverse reflection about others. The terms of reference refer to failings of systems, not individuals. I therefore ask witnesses to minimise their mention of individual health care workers unless it is absolutely essential to address the terms of reference. Individuals who are subject to adverse comments in this forum may be invited to respond to the criticisms raised either in writing or as a later witness before the Committee. This is not an automatic right but rather a decision of the Committee which will depend upon the circumstances of the evidence given.

I would also ask that witnesses be mindful of the ethical and legal implications of disclosing personal information about patients. Health practitioners and managers should only discuss personal information about a client or a patient if they are specific to the terms of reference and that person has authorised them to do so. I would also ask my fellow Committee members to consider the ethical duties owed by practitioners to patients when pursuing their lines of questioning.

It is likely that some of the matters raised during the hearings may be the subject of legal proceedings elsewhere, such as the Industrial Relations Commission, a disciplinary tribunal or the special inquiry being conducted by Bret Walker. The sub judice convention requires the Committee to consider the impact of discussing a matter that is being considered by a court of law. The weight of opinion supports the view that a parliamentary committee may discuss a matter that is being considered by another inquiry. This would include investigations undertaken by the ICAC. Nevertheless, I remind people today that this inquiry is about systemic issues and not the culpability or otherwise of particular individuals. If you have concerns about any of these issues, please raise them at any time with the Committee and we will consider your concerns.

I would like to make a brief statement in relation to my own position as Chair of this Committee as well as the superintendent of Wesley Mission. Wesley Mission does operate various health care services, including private hospitals, a large schedule 5 public hospital and aged care and mental health facilities. For the public record, I would like to state that I formally resigned as chair of the board of the public hospital in 1994 and as

superintendent of Wesley Mission in 2002, although it is yet to be filled by a replacement person. For the purposes of this inquiry, I am the Chair of the Committee, not the superintendent of Wesley Mission, and I will act accordingly. In the event of any matters being raised during the inquiry in relation to any of Wesley's operated facilities, I will refrain from taking any action in relation to anything I may see or hear.

Today we will be hearing from several nurses who have raised serious concerns about patient safety and complaint management in the South West Sydney Area Health Service. Their evidence will be followed by a short morning tea break at approximately 11.30 a.m. After the break we will hear from Ms Sara Flegg, a former patient of the Campbelltown Hospital. After the luncheon recess, the General Secretary of the New South Wales Nurses Association will appear, followed by the President of the New South Wales Nurses Registration Board and the Chairman of the Nurses Tribunal. Our final witnesses of the day will be the President and Deputy Registrar of the New South Wales Medical Board.

The Committee has previously resolved to authorise the media to broadcast sound and video excerpts of its public proceedings. Copies of the guidelines governing the broadcast of the proceedings are available from the table by the door. I point out that, in accordance with the Legislative Council guidelines for the broadcast of proceedings, the members of the Committee and witnesses may be filmed or recorded. People in the public gallery should not be the primary focus of any film or photographs. In reporting the proceedings of this Committee, the media must take responsibility for what they publish or what interpretation is placed on anything that is said before this Committee.

Witnesses, members and their staff are advised that any messages should be delivered through the attendant on duty or through the Committee clerks.

I advise that, under the Standing Orders of the Legislative Council, evidence given before the Committee and any documents presented to the Committee which have not yet been tabled in Parliament may not, except with the permission of this Committee, be disclosed or published by any member of such Committee or by any other person.

At the conclusion of formal questions it is customary for the Chair to inform witnesses of the possibility of presenting in camera evidence by making this kind of statement: I want you to know that if you should consider at any stage - and can I repeat that to our witnesses: if you should consider at any stage - that certain evidence or documents you may wish to present should be heard or seen in private by the Committee, the Committee will consider your request. However, the Committee or the Legislative Council itself may subsequently publish that evidence if they decide that it is in the public interest to do so.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: As regards the possibility of confidentiality being overruled by the Legislative Council or the Committee, that has not yet happened, so it would create quite a precedent if it did happen. Historically, respect for confidentiality has been absolute, and I think that should be noted.

CHAIR: I have made a statement about my involvement over the years - 40 years - with the health system. Is there any other member of the Committee who would like to make a personal statement?

The Hon. CHRISTINE ROBERTSON: The Chairman would like me to make a statement to inform this particular inquiry that I have had many years' experience within the health system. I started nursing training in 1966 at Royal Prince Alfred Hospital and finished within the health sector in March of last year, at which time I was the Director of Population Health and Planning within New England Area Health Service. This is, of course, well documented in my maiden speech and my biography, but I think it is important that people recognise that this is the case and I believe myself that it will add value to the deliberations of this Committee.

The Hon. PETER PRIMROSE: I previously advised the Committee when we started that I was actually the chair of the then Macarthur Health Service until 1988.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: My background is that I am a doctor. I was a student and then a resident at Royal Prince Alfred Hospital from 1971, I think, to 1976; I was a registrar in Port Kembla Hospital; I worked for two years in the United Kingdom and a further two years in Royal North Shore Hospital in 1981 and 1982, and I have been involved with occupational medicine in New South Wales, so I come with some previous opinions due to that experience. I believe that this would add to the situation.

The Hon. ROBYN PARKER: I should also state that, whilst I do not have any direct medical experience, I am married to a general practitioner. I have managed his practice from time to time, although I no longer do that. He does not work in the public system, but has previously, so I have that perspective to bring to this Committee.

CHAIR: Ms Fraser, do you wish to make a brief opening statement?

Ms FRASER: Is it all right if Sheree makes an opening statement on behalf of three of us?

CHAIR: Yes.

Ms MARTIN: I will make this statement on behalf of Ms Bragg and Ms Fraser and myself. My colleagues and I come before you today to help you expose the culture of cover up that exists, as testimony to the difficulties faced by health care professionals who try to report faults within the system. After all avenues within Macarthur Health Service, that being ward managers, continuum managers, the general manager and director of medicine, were exhausted by myself and my colleagues we took our concerns to South West Sydney Area Health Service, which again fell on deaf ears. We were then forced to seek help and advice from the appropriate channels outside of the health service including the New South Wales Nurses' Association and the New South Wales Nurses' Registration Board.

On 5 November 2002 we had a meeting with the Honourable Craig Knowles, the then Minister for Health, in his Ingleburn office. We conveyed to him the episodes of unsafe and inadequate care within Macarthur Health Service, poor management practices, corruption, maladministration, bullying and harassment of staff and a culture that discouraged reporting within Macarthur health system. As they say, the rest is history and I do not feel I need to dwell on the events of that day. Suffice to say that when we left Mr Knowles' office we felt effectively warned off. Mr Knowles passed our concerns to the audit section of the New South Wales Department of Health. In mid November 2002 we were all individually interviewed by them. We were informed of our rights regarding making a protected disclosure. They then forwarded their recommendations to the HCCC.

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

In February 2003 the Department of Health released a press statement saying they could not substantiate any significant departures from national or State health care standards and there would be no findings in Macarthur Health Service that would support a loss of community confidence. We had not given evidence to the HCCC investigators. We had not been interviewed by the independent panel of experts. We had not passed on our documentary evidence. We were crushed. We had now been fighting this for ten months. In our opinion the HCCC had no interest in conducting this investigation. We had exhausted all the appropriate health services, Government statutory regulatory bodies, they had effectively silenced us.

Our motivation being to ensure the public were receiving a safe standard of health care forced us to take the next step, which was to go to the media. Some people within the community and our peers have condemned our choice to go public. Maybe we were naive to believe that the truth should be told, the real truth. Without the media we would not be sitting here today and we believe that only serves to highlight the inadequacy of the current systems, that this one single action was the catalyst for justice to be served.

We then went to Mr Alan Jones, five days later we were granted an interview with the independent panel of reviewers for the HCCC. People within the community and our peers think that we brought our

concerns straight to the media; this is not true. We battled for ten months behind the scenes. We faced criticism from within the health service, both managerial and from our colleagues. We fought hard with the HCCC to take our allegations seriously, which they most certainly were. We were spending up to 50 hours a week on this cause and still are. Because of this cause we have lost sleep, homes, friends, faith in the system and in some cases even family. We battled on for a further fourteen months; having interviews with the HCCC, members of Parliament, solicitors, barristers, the Institute of Clinical Excellence, the ICAC, the media and now the Walker Inquiry. We get up every day and work as nurses; we just do not get paid for it.

We are now at the two year mark and really not much closer to the truth than we were back in 2002. While a few people have been resigned or have been dismissed, the people at the centre of our allegations remain in power and the culture of cover up and fear still exists within South West Sydney Health Service. Our allegations have never changed, only people's reaction to them. We have exposed ourselves publicly because we were forced to. It was never our intention to sensationalise this cause. However, the sad truth of all this is that many people have tried before us and have been beaten down. We have got closer than anyone has ever before to exposing the culture within the health service. We got here because of who we are, we are nurses, we are passionate, we are dedicated, we are advocates, but we are tired.

For evil to prevail all it takes is for good men to do nothing. Chair, honourable members, as a society we have done nothing for too long.

CHAIR: Before we have questions, I would ask if others of you would like to make a statement?

Ms GROVER: Yes, Mr Chair.

CHAIR: Would you do that?

Ms GROVER: Good morning and thank you for the opportunity to address this Committee. I am a registered nurse, certified midwife and nurse academic. I have worked in tertiary referral hospitals, metropolitan peripheral hospitals and in the rural health setting. I have been considered an expert midwife clinician and have worked as the delivery suite founding manager at Campbelltown. I was nominated to New South Wales Health as an example of a successful nurse executive and I have worked as after hours managers at Liverpool and Campbelltown Health Services. I hold a Bachelor of Health Management and I am currently undertaking the final chapter of a thesis for the Masters of Health Management, Honours by Research.

Following extreme harassment from senior managers at the Liverpool health service I have spent the last three years in exile working as an agency nurse. In 1986 I was a nursing unit manager of Campbelltown Health Service and I was fortunate enough to have benefited from the leadership and vision of the then general manager, Dr Liz Gale. I embraced quality management, innovation, teamwork and camaraderie. In approximately 1995 the management of Campbelltown Health Service changed and the bullying began. I resigned from Campbelltown as a direct result of harassment from the director of nursing. I achieved a promotional position at the Liverpool Health Service as an after hours senior nurse manager. My enthusiasm for the principles of total quality management, team work and open honest transparent practice review were not shared by my Liverpool colleagues. I worked in an extremely difficult environment due to a serious lack of documented procedures and policies and an unwillingness to share information and follow expected due process, the examples being the issues I have raised concerning the patient who allegedly received a lethal dose of morphine from a medical officer and the twenty-two year old Koori patient who was scheduled and found dead in the mental health unit.

I worked in an unsupported environment. I was frequently verbally abused by senior management. That was reported to the then director of nursing with no action. As a consequence of my raising concerns I was then falsely accused of leave fraud. I demanded review of my leave records and indicated that I would willingly bear the consequences of such inquiry. The allegations were found to be not proved. I have found extreme protracted psychological distress including increasing anxiety and panic. Such panic attacks were reported on one shift to the director of nursing who diarised an appointment for me two weeks from Friday. I was forced to take sick leave and stress leave. On return to work on the worker's compensation program I was located in a deserted building, frequently given on days, had absolutely nothing to do. I then took more leave and was forced to resign because I basically ran out of leave and the health service felt they could not provide a suitable position for me.

In 2001, following the forced resignation, to meet my mortgage I was required to re-invent myself as a clinician. I had not worked as a clinician since 1986 and I got a job with the nursing agency. I have been unable since to secure a management position anywhere in Sydney and it has been proven to me that my worker's compensation details have been shared with directors of nursing when I have applied for positions at other hospitals. That was confirmed to me prior to interview last year. In 2002 I was contacted by the HCCC regarding my concerns about events at Liverpool and I was informed by the HCCC that the Liverpool events were of no consequence and they were not interested.

In conclusion, the terms of reference at this Committee are to establish a culture of learning and willingness to share information about errors and system failures and to assess whether the system encourages open and active discussion and improvement in clinical care. My experience of the Liverpool Health Service was exemplified by poor standards, verbal abuse and intimidation. This violent culture precludes intelligent sharing and honesty. To speak out is to be a target. The effect of working within the Liverpool Health Service is not limited to termination of bright futures. It erodes self confidence, self esteem and ultimately hijacks the careers of nurses like myself who demand open, honest practices within a supportive, no blame workplace. Thank you, very much.

CHAIR: Thank you, Ms Grover. Do either of you other two wish to make any statements?

Ms FRASER: No.

Ms BRAGG: No.

CHAIR: We will open for questions.

The Hon. PATRICIA FORSYTHE: Ms Grover, if I could go to an issue you raised in the written submission you provided to us. Perhaps you could give us an explanation. On page six under the heading of "Gagging" you have referred to the director of nursing at Liverpool Health Service expressly forbidding contact with area senior managers regarding issues of concern. You then give an example about which I will need some explanation. You talk about during the 2000 Olympics there were discrepancies relating to record keeping of presentations of competitors, visitors, media personnel and you finish by saying, "Demand was made to ensure discrepancies in record keeping was not made known to the area director of nursing or SOCOG". What are you talking about?

Ms GROVER: Liverpool was one of the nominated treatment facilities to offer health services to our Olympic visitors and competitors and media. Obviously it was important to have scrupulous medical keeping about who presented and why they presented to make sure we tracked them appropriately through the health service and that was reported then to the area director of nursing who was the coordinator of that process. What was happening was we were losing people because we would have people come in, they would not be recorded, we would have relieving bed managers who would not know what the process was. At the end of the day when we had to total up the presentations, two and two would make nine and we would not know who came in, why they were recorded, why they presented, and so as after hours managers we were concerned that our records were clearly not correct. So I emailed the area director of nursing to say it would be appropriate, because it became clear that we were using different methodologies during business hours and after hours and there were going to be discrepancies, so the request was made that we use the same methodology with continuity of process, if you like, so that our record keeping would be appropriate and accurate, and I was reprimanded for that because it was not the wish of the director of nursing that it be known that our record keeping was appalling. We really did not know who we had in the health service; how long they had been there and what they presented for.

The Hon. PATRICIA FORSYTHE: Did you have competitors and people involved in the Olympics?

Ms GROVER: Yes. It was embarrassing.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Can I ask why they were different from other people coming to casualty? They were coming through the emergency department, were they?

Ms GROVER: That is right.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Why were they different from other emergency patients?

Ms GROVER: They were just catalogued differently. It was a question that was asked of patients who presented: Are you anything to do with the Olympics? Are you a volunteer; are you a competitor; are you a visitor? If they were, then there was a notification allegedly to the bed managers during the day and the after hours managers during the night to make sure that we tracked them and knew what was happening with them.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Do you not track and know what is happening with all patients?

Ms GROVER: We lose a few occasionally at Liverpool.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: But if they come in presumably the doctor or whoever sees them keeps a record in the file and that file is accessible next time they come in?

Ms GROVER: Well, it would be.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Why is it different?

Ms GROVER: It was I guess from a media perspective that they wanted to know who had been presented to the health service from the Olympics. The health service was not looking for any unfavourable media attention, I guess.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: So they were put in a separate filing system?

Ms GROVER: Separate notification system, not filing system, so that we knew who was in the health service at any given time and what their connection was with the Olympics.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: But they were still traceable and they could have been included at a later date administratively in that there were X patients who were the normal type, if you like, Y patients who were associated with the Olympics, and the total patients would be X plus Y, would it not?

Ms GROVER: Well, it should be, but if we had a competitor, for example, who had presented, it would be appropriate because of the media exposure and so on that the health service knew exactly what was happening with that person. It is embarrassing for the media to ring the public relations people to make an inquiry on the status of competitor X and the health service does not know that they are there. That happens.

The Hon. AMANDA FAZIO: Can I ask a question about page 6 of your submission. As you know, the second part of our terms of reference is for the Committee to do an assessment of whether the system encourages open and active discussion and improvement in clinical care. You raised an issue on page 6 which was of concern to me - it is headed "Closed Shop" - where you say that nursing staff who offered improvement suggestions for practice and procedure experienced a closed shop culture effect with a gross unwillingness to change despite potential improvement and you quote the case of MRSA. Could you elaborate a little more on that, because I would have thought that improvements in the handling of patients with MRSA would have been--

Ms GROVER: Highly desirable.

The Hon. AMANDA FAZIO: High concern, yes.

Ms GROVER: When I went to Liverpool it became obvious that there was a significant problem with MRSA, which is not unusual, I mean it is a problem for most hospitals. During the course of my early days there I noticed that a lot of the staff on the ward, because of the pace that they work at, would, for example, put on a pair of gloves to attend a patient, come out of the room and then go and answer the phone, put the phone down and get some linen off the linen trolley and then go and make a cup of tea, so we had the same gloves, if you like, touching lots of surfaces and when there was a 49 percent positive colonisation rate in the environmental swabbing I could see a definite link between this practice and the spread of MRSA. I was fairly concerned about it and I spoke to the director of nursing and she suggested I write a paper on MRSA and its spread, which I did. I described what I had seen in terms of contamination of surfaces and suggested that if that practice were to change there could be considerable improvement in the contamination rates of MRSA. The infection control clinical nurse consultant took great umbrage at the fact that I had raised concerns about the spread of MRSA, so rather than deal with the problem at hand, which was a significant problem, it was suggested that I let it go and not upset her any more, and that was the end of that.

CHAIR: There are standard procedures for dealing with infection control.

Ms GROVER: Of course.

CHAIR: Were those standard procedures being followed?

Ms GROVER: I do not believe so.

CHAIR: To your complaint on that issue you felt silenced?

Ms GROVER: Absolutely. Absolutely.

The Hon. ROBYN PARKER: Could I just turn to ask a question of Nola Fraser: How did Victoria Walker, a departmental officer of NSW Health, manage your complaints?

Ms FRASER: Victoria was the senior investigator of NSW Health and she took our statements. She said to me that a lot of things would have happened that did not happen at the time. She said that it was crucial that I give her all the evidence that I had, that I was under the whistleblowers legislation, because it was just a matter of time. She told me that the police were going to go and serve a search warrant to the CEO of Liverpool Hospital to submit to Macarthur health service and that they were going to go and take the notes. My experience with her was that a lot of things that she said would happen did not happen. She also read her recommendations to Robyn Kruk to us after the investigations and they were very damning of what she had found and the recommendations were very strong. She spoke of "managing your corruption"; she spoke of referral immediately to the ICAC and to the police; she spoke of the bullying and harassment, an environment where patients were being harmed and that action was warranted immediately, and that did not happen.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: So she believed you, effectively?

Ms FRASER: Absolutely, without a doubt.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: She was impressed by what you said and her recommendations reflected what you had said to her?

Ms FRASER: Absolutely. She was impressed by all of us that she interviewed and she made comment that she had interviewed a lot of hospitals and she knew people who were telling the truth and, without a doubt, she had no doubt that we were telling the truth.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Had she interviewed other people, or do you not know that?

Ms FRASER: I am aware that she did interview other people. She interviewed eight people initially.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: And she put those recommendations in?

Ms FRASER: Yes, she did.

The Hon. AMANDA FAZIO: When was this?

Ms FRASER: This was about 15 November 2002.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: It was just after you had seen the Minister, effectively?

Ms FRASER: That is correct.

The Hon. PATRICIA FORSYTHE: Did your talking to her arise out of seeing the Minister, were you referred at that point, or was it just coincidental of time?

Ms FRASER: No, we went to see the Minister for Health and as a result of that he referred it to NSW Health and she was the investigator.

The Hon. AMANDA FAZIO: So she was in that audit branch that Ms Martin referred to in her opening statement?

Ms FRASER: That is correct, yes.

The Hon. PATRICIA FORSYTHE: And the next step was the HCCC?

Ms FRASER: That is correct.

The Hon. PATRICIA FORSYTHE: How do you feel about the HCCC inquiry process?

Ms FRASER: The HCCC did not encourage us to put any complaints in. They discouraged us. I felt threatened by them. They said that all the information that was passed on from NSW Health - in good faith we gave that over and we were told that we were protected under the whistleblowers legislation. All of a sudden, when we got to the HCCC, that did not exist and they were just concerned about the documents, concerned about me being prosecuted, that I could go to gaol for this and that I would really need to think very seriously about what I wanted to hand over to them, what I wanted to tell them, and at the end of the day they are not there to make anybody accountable and this is going to be a very long drawn-out process for nothing, so do you really want to do this?

The Hon. PATRICIA FORSYTHE: They did not view your information as a protected disclosure. Why was that?

Ms FRASER: We do not know. At the time my brother, who was a solicitor, came with me. He went in and tried to negotiate with them to be reasonable over this for at least two hours and he came out having serious concerns about us and about the direction they wanted to take.

The Hon. PATRICIA FORSYTHE: So somewhere between seeing the audit section of NSW Health and the HCCC attitudes changed towards you?

Ms FRASER: Absolutely, and also somewhere between seeing the audit section of NSW Health and the HCCC our concerns were very watered down, but Victoria Walker read her recommendations to us and they were very strong.

The Hon. AMANDA FAZIO: Was Victoria Walker the only person from the audit section in NSW

Health with whom you dealt?

Ms FRASER: No, there was another man, I think his name was Steve McGirkin. She was in charge of the investigation and he helped her.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You said that the department of health said that there had been no departure from standards, I think in February 2003, which was three of four months later, and you said that no evidence had been taken from the nurses. I think that was in the initial statement from Sheree. Evidence had been taken by Victoria Walker at that time, though?

Ms FRASER: That is correct, but we only gave her a little bit because she did not need any more for the initial inquiry.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: So they had not taken exhaustive evidence from you?

Ms FRASER: No, they had not taken paperwork that I had, not everything; they had not taken our testimony. There were so many more cases that were in our minds that we could then pass on to the HCCC.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: But the general thrust of the recommendations which were favourable to you, which came from Victoria Walker, obviously had been reversed or ignored or they were not the final department of health position?

Ms FRASER: Definitely not. She made strong recommendations for the concerns to be directly dealt with by the ICAC and the police, none of which has happened.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Between her and the final result of the department, obviously her report had been suppressed?

Ms FRASER: That is correct.

The Hon. AMANDA FAZIO: What was the nature of these documents that you had in your possession? Were they clinical records of individual patients?

Ms FRASER: No, not complete records. I may have filled out an incident form and photocopied the appropriate page of that incident form and submitted that, not the whole record.

The Hon. PATRICIA FORSYTHE: At that time how many cases were you concerned about that you would have talked to Victoria Walker about?

Ms FRASER: Including the paperwork that I gave her? Probably about 70.

The Hon. PATRICIA FORSYTHE: Seventy, over what period of time?

Ms FRASER: From 1998 until 2002. That was just 70 that I gave.

The Hon. PATRICIA FORSYTHE: And prior to going to see Craig Knowles, what dealings had you had with the HCCC?

Ms FRASER: I saw Craig Knowles in November 2002. I attempted to report what was happening at Campbelltown and Camden hospitals to the HCCC in October 2001.

The Hon. PATRICIA FORSYTHE: 2001?

Ms FRASER: Yes, almost 12 months before going to the Minister.

The Hon. PATRICIA FORSYTHE: How were you dealt with?

Ms FRASER: I phoned them and I told them the situation and they said they were not the appropriate body. They said they deal with a case. They will look at one case only, and as you can imagine this was far greater than one case, this was a whole culture, and they just told me that they were not the appropriate body to deal with it.

The Hon. ROBYN PARKER: Did they suggest who the appropriate body was?

Ms FRASER: No.

The Hon. AMANDA FAZIO: You say 70 incident notification forms. When each incident occurred in the hospital you filled in the notification form and you lodged it with the appropriate people. What happened generally that you came to feel that the complaints processes were not being dealt with appropriately at the hospital? What action was taken by them after you put in the notification?

Ms FRASER: There appeared to be no action, in that there was no follow up, there was no feed back. The same dangerous practices happened over and over again. I sat on a committee called the Critical Care Committee at which a lot of these cases were discussed and they seemed to miss the root of the problem and seemed to blame everybody. It was more a thing about blaming rather than fixing.

The Hon. AMANDA FAZIO: You have mentioned the Critical Care Committee. You claim on the first page of your submission you raised issues formally at the Critical Care Committee and directly with the director of medicine and nursing and "No appropriate action was taken. My concerns were just covered up", and you were ostracised and labelled a "troublemaker". My understanding from having watched the Sunday Program was that you in fact, according to them - the minutes of those meetings, the Critical Care Committee, showed you did not attend regularly and when you did attend you did not raise any issues relating to these. What is your explanation?

Ms FRASER: The Sunday Program misrepresented what I said. They took answers from other questions they asked me and put them into other questions. It was not a true reflection of what I said. That is all I can say about the Sunday Program. The reality of what I said was that the committee does not meet over the Christmas break because a lot of people are on leave. So, January/February the committee is closed. March and April and every other time I attended I did raise concerns. They were never minuted because the administrators felt that my standards were too high and that Campbelltown Hospital has its own rules and I need to either get on the bus or get off. They were not minuted because they did not think that it was a problem. They really thought I was the problem.

The Hon. AMANDA FAZIO: What is your explanation then for also on the Sunday Program you said that there were hundreds, if not thousands, of incidents involved in this and yet you say there are only approximately 70 incident notifications that you had gathered between 1998 and 2001?

Ms FRASER: Can I just clarify something? There were about 70 that I had with me, not that I had notified. I did not photocopy every incident form. I only started photocopying when it became evident that they were doing nothing and I needed to prove at work in my folder that I had raised these issues with them. They tend to go back to the person raising the concerns, that it was your fault, you did not tell me this, so then we all started keeping incident forms.

The Hon. AMANDA FAZIO: Can I ask, so we can gauge, you said the response to some of your complaints were that your standards, the level of incident you were reporting was not being reported by other people. Could I get a feeling from Ms Bragg and Ms Martin about how many notification forms you would have put in?

Ms FRASER: Could I answer another question you asked about the thousands, so called, on the Sunday Program. What that was referring to was certainly not deaths, it was thousands of mismanagement practices that I had witnessed in over five years. That was the answer to that question that he asked me and he took that out of context and portrayed it for something that it was not.

The Hon. AMANDA FAZIO: Could I get a feeling from the other two; Ms Martin and Ms Bragg. I mean what would need to happen for you to lodge an incident form?

Ms BRAGG: An incident form could be anything from a doctor misdiagnosing a patient to a nursing staff member giving an incorrect dose of medication. It can be something simple to something severe. I used to write out the incident forms initially, my first few years that I was there, and in my later few years I stopped writing incident forms. It was general talk that it did nothing anyway. Even though you still hoped that there was something being done, you knew that there was no action being taken because there was no change. I was lucky in that my nursing unit manager was on the floor a lot and around and therefore I often complained to her verbally and Deborah Collins recognised that as a recognised form of complaint the last time she was here. That is often what I did.

Ms MARTIN: It is all documented that when I put in a series of incident forms on my ward my nurse unit manager disciplined me for a breach of patient confidentiality. She felt that by coming onto a shift four hours later by looking at the previous blood pressure I was breaking confidentiality. The blood pressure charts are a graph which is used to indicate a change or stabilisation of the observations. So, for example, there were six forms I put in about patient's blood pressure meeting the MET criteria, no MET being called. A hearing, an investigation was conducted and the upshot of that was I breached confidentiality by looking at the previous entry of blood pressure.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: What is a MET?

Ms MARTIN: Medical emergency team. If the patient's observations fit the set of observations you must call the medical emergency team. So, basically my response to putting in an incident form was managerial criticism and discipline. It cannot be a breach of confidentiality to look at the patient's previous blood pressure to get a determination whether it has dropped or risen or what his or her normal blood pressure is.

The Hon. PATRICIA FORSYTHE: Are there any guidelines that would suggest that you had breached anything?

Ms MARTIN: No, and the HCCC have found I did not. Associate Professor Deborah Piccone has apologised for me to the disciplinary action. What I am trying to point out to the honourable member is that there would be many more incident forms if, when we submitted one, this was not the approach to it. I was told by my nurse unit manager after I put some under her door unsigned, because I knew what would happen to me, "Are these yours?" "Well, yes, they are", in front of everybody. "Well, you are really making a lot of work for me". It was just this whole merry-go-round.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Can I ask Katherine Grover: you said that you had been with Dr Liz Gale at Campbelltown some years before and that she had been very encouraging of total quality management, which was the fashion then.

Ms GROVER: I think it is still the fashion.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: It changes its name, does it not? What time was that?

Ms GROVER: 1986 and I left there in 1997. Liz Gale came about 1989, something like that.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Until when?

Ms GROVER: Until about 1996, I suppose. She left not long before I left.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: While she was there there was quite good responsiveness of the system if a problem was identified?

Ms GROVER: Campbelltown was a great place to work. It was only when the management changed that the standards changed. There was bullying, there was harassment, there was lack of attention to issues

that were notified. There was no action to incident forms that were submitted. It was a very different place to work. It was just a shame.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You would say from your experience that it depends very much on the personalities of the people at the top as to what happens?

Ms GROVER: Absolutely.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: It is not a uniform standard throughout the health system?

Ms GROVER: Not at all.

The Hon. PATRICIA FORSYTHE: Could I return to Nola? We were talking about issues to do with the Critical Care Committee and the Sunday Program, and at that point I think we moved away. In relation to the Sunday Program there were some suggestions about your attendance at the critical care program. Was that the period in which you were job sharing?

Ms FRASER: No, I was job sharing - from memory I think it was 1998 to the year 2000. I did not attend occasionally because I was working as the after hours hospital manager and I had work commitments such as night duty. I was not expected to finish at eight and then turn up there at ten. I did not attend a hundred per cent but my attendance has been consistent. It has been quite high compared to a lot of the other managers on that committee.

The Hon. PATRICIA FORSYTHE: In relation to the Sunday Program they seem to have much information about you. Is it true that they had all your personnel records and privileged material and, if so, do you know how they obtained that material, was it from you?

Ms FRASER: No, that was not from me. They did have a lot of information from me. They told me they got it from the Department of Health and they told me they got the minutes of the meeting from a certain person within Macarthur Health Service. I don't want to name names.

The Hon. PATRICIA FORSYTHE: They said a certain name?

Ms FRASER: They told me a certain name.

The Hon. PATRICIA FORSYTHE: Are you prepared to name that person?

Ms FRASER: If the Chair allows, I just didn't think this was going to be personal.

The Hon. PETER PRIMROSE: Before that occurs I think we may need to deliberate on whether that is appropriate.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Perhaps it could be a confidential communication at another time.

CHAIR: Could you write that down and it will be given to the Committee in confidence.

The Hon. PATRICIA FORSYTHE: Could I go a little further about your attempts to get your concerns about the system known by relevant bodies, in particular the New South Wales Nurses' Registration Board. Could you detail your attempts to have complaints known to them?

Ms FRASER: After exhausting every avenue, I decided to turn to the New South Wales Nurses' Registration Board because they do govern our practices, and they told me that they do not make nurses accountable, that nurses can practice in this fashion. I described some clinical incidents, and it is not their role to make nurses accountable. At that stage I was a little bit frustrated because I was dealing with the HCCC as well who said they do not make anyone accountable. Basically in New South Wales the reality of the health system is that nurses can practice any way they like, whether it is at a competent level or a criminal level and

there are no avenues to adequately deal with it. That is the reality of what we are seeing today in New South Wales.

The Hon. AMANDA FAZIO: Isn't that an exaggeration to say at a "criminal level"?

Ms FRASER: No, that is not an exaggeration at all.

The Hon. AMANDA FAZIO: How can you justify that statement?

Ms FRASER: I am unable to talk about that because it is under investigation.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Are you saying a degree of negligence that is beyond negligence? "Criminal" does imply a mental state of malice, I understand.

Ms FRASER: Correct.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: That is more than indifference and more than ignorance.

CHAIR: More than neglect.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: More than neglect, more than ignorance, but with active malice, that is criminal mentality.

The Hon. PETER PRIMROSE: You are saying that nurses are deliberately setting out to harm patients?

Ms FRASER: What I am saying is that what we have witnessed and what we have seen and what is documented is that you do not have to go and actively do anything to hurt somebody. It is your willing inactions that will harm someone.

The Hon. PETER PRIMROSE: That is my point. Nurses are deliberately taking actions or not taking actions that are, in your view, criminal and that is common?

Ms FRASER: In my view, nurses are not responding to patient's needs, that are retrievable, and they have done this knowing the consequences for that patient and as a result deaths have occurred or poor patient outcomes have occurred and, yes, that practice does happen regularly. The outcomes of those practices, whether it is death or whether they happen to survive, to us is not the real issue. It is the process. You can have a lot of patients who die but as long as the care is adequate that is not an issue.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Can I come back to this "criminal" thing because I think it is a very sensational sort of word. Both manslaughter and murder are crimes, but manslaughter does not involve an intention to kill, it involves carelessness and neglect, if you like, driving too fast or whatever. When you say "criminal" you mean in the context of neglect or indifference. I mean actively killing somebody is murder as opposed to indifference, being manslaughter.

The Hon. PETER PRIMROSE: Well, you are really asking for legal advice from a witness.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: When you say "criminal", if I understand you correctly, you are talking in the sense of indifference or neglect rather than active malice: "I want to kill this person".

CHAIR: Can I suggest that the witness answer the question to the best of her non-legal knowledge.

Ms FRASER: What was the question?

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: I am wanting you to define "criminal".

CHAIR: No.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: I have given two examples of manslaughter versus murder.

The Hon. PETER PRIMROSE: But you have not explained them properly.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Well, one is active malice and one is indifference, that is the difference. It is not rocket science.

Ms FRASER: Could I explain what I mean when I say "criminal"?

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Yes.

Ms FRASER: What I mean when I say "criminal" is not the legal terminology, it is not the law, what I am saying is that nurses and some doctors - some nurses and some doctors, this is not everybody - intentionally do not do or respond to a patient the way that they should and consequently a patient suffers, suffers a loss of a limb or some form of morbidity or death. When I say "criminal", it is through intent: They know what they should do; they choose not to do it knowing the consequences. Now nurses and doctors can act like this but without the intent. They do not know and, in reality, they are ignorant and I do not think that that is criminal at all. That is what I mean by "criminal".

The Hon. AMANDA FAZIO: I know your submission to us is confidential so I am not going to read it on to the record, but some of the language used in it is also fairly dramatic. Aren't you worried that by using this sort of language when you are talking about unnamed people in the health system that, in effect, you are probably having the impact of denigrating nurses and medical practitioners in general and that, as a result of this, less people will be likely to come forward and make complaints about inadequacies that they perceive in the system?

Ms FRASER: You may believe it is dramatic. This is just the truth and I think people should reserve judgment for those who were there, who saw it, and exactly what I have said is exactly what happened. It does sound dramatic; it does sound unbelievable. We lived it. I lived with it for six years and I could not believe what I was seeing. I am finding it difficult to believe what I saw, let alone trying to convince all you people that this is what is happening there.

CHAIR: Could I just remind members that the written evidence is in fact available after today. It is not confidential.

The Hon. AMANDA FAZIO: Ms Martin and Ms Bragg, do you also believe that there is intent when you see standards of care that you do not believe are appropriate? Do you believe it is intentional?

Ms BRAGG: I do, in that whilst I do work with some good nurses and doctors I also work with doctors and nurses who have the knowledge to prevent any further decline in the patient and choose not to utilise that knowledge; therefore the patient suffers or dies. To me that is intentional.

CHAIR: Can I just clarify a point that Ms Fraser made: You were talking primarily about nurses and then once or twice the word "doctor" came in. Are you referring to both doctors and nurses in practice?

Ms FRASER: That is correct.

Ms MARTIN: There is a medical emergency team (MET) policy in operation within South West Sydney Area Health Service. It is a very simple policy, anyone who can read can follow it. It sets out standard observations and if you fall below or above the set guidelines you press a bell on a wall. It is very simple: That is all you have to do. In my experience there, I was prevented from pressing the bell with nurses physically

standing in front of the bell and putting their hand over it when a patient met the criteria. That is deliberate. That is a deliberate attempt at the patient not getting medical aid. Is it criminal? I do not know. The nurse has the bell; they have the knowledge to read an observation and take an observation, and their duty, as their job, is to press the bell. My duty is to press it and I was obstructed in doing that.

The Hon. PATRICIA FORSYTHE: How many times are you talking about?

Ms MARTIN: I am saying, in three months, at least 20 times I was prevented from pressing the MET bell. Actually it was a great joke, when I was passing the desk they would go "Here she comes, quick, quick, cover the bell, she's going to press it".

The Hon. PATRICIA FORSYTHE: Are you talking about the observational aspects of a patient's condition, heart rate--

Ms MARTIN: Blood pressure, respiration.

The Hon. PATRICIA FORSYTHE: And you have a policy that says at a certain point, if there is some emergency or problem, press the button and get additional help?

Ms MARTIN: Yes, it is a well-documented, proven methodology that prevents the patient from deteriorating to a point where they may not be retrievable, so rather than take the guesswork out of "Is my patient sick", you are given this guideline, it is on the back of your ID which is around your neck so you can refer to it at any time and, if you do a blood pressure and it fits the guidelines, you press the bell.

The Hon. CHRISTINE ROBERTSON: It is a quality program?

Ms MARTIN: It is.

The Hon. CHRISTINE ROBERTSON: This is replacing what in the old days would be like the resuscitation team?

Ms MARTIN: Yes.

The Hon. CHRISTINE ROBERTSON: You are working off when there are indicators there could be a problem?

Ms MARTIN: Exactly.

Ms GROVER: Pre-resuscitation.

The Hon. CHRISTINE ROBERTSON: In the old days - and excuse me going back to the old days, but I need to understand this and I have not been in clinical services for a long time - the resuscitation team meant that there would be a lot of heroics, so there was always a knowledge about which people you would not be delivering heroics for. I need to understand what you are saying. For example, somebody who was 90 years of age who had end stage cardiac disease you most definitely would not--

Ms MARTIN: Yes, I would, unless the patient was not for resuscitation. That is the law. If I have a 90 year-old patient who is not for resuscitation, who is not for active treatment, and that is documented, then there are no heroics.

The Hon. CHRISTINE ROBERTSON: That is what I needed to understand.

Ms MARTIN: Yes. These are patients who are 40 years old who drop a blood pressure to 60 on 40 and who I feel need urgent medical attention and I am prevented from getting that because, as you say, the nurses on the ward do not want heroics. It is not heroics.

The Hon. CHRISTINE ROBERTSON: No, I was talking about resuscitation.

CHAIR: And we have clarified it: It is where there is no written instruction.

Ms MARTIN: That is right.

The Hon. PATRICIA FORSYTHE: Is this a systemic issue in the hospital? You have talked about a three-month period. Are we talking about a couple of other nurses who had a different perspective or viewpoint in terms of policy or are we talking about a broader systemic issue in the way in which the hospital wanted to see the management of patients?

Ms MARTIN: We are talking about a culture and it is like chipping away at ice. I can recall an incident with a gentleman who arrived from the ED fitting the MET criteria. I said to the registered nurse I was working with, "This patient's blood pressure is X; his pulse is Y. It is way above the guidelines, I am calling a MET". She physically stood over the bell. I was very frustrated and I said to her, "Please tell me how are you helping the patient by not calling the medical emergency team?" She said, "They know, they know". I said, "What do you mean, they know?" She said, "Well, he's come from ED, he had a blood pressure down there of that and a pulse down there of that, therefore they know". I said, "But we have an obligation to press it, it is required of us, it is part of our employment. How are you helping the patient?" She said, "It doesn't matter about the patient, I'm not going to press it. They know". This went on for ten minutes and I said, "I'm going to press it", and she stood in front of it. In the end she could not stand it any more and she let me press it. The MET team came up, the gentleman was in VT, he was given drugs, they could not revert him and he went to ICU for four days. I do not know if he survived. When he left I said, "Can you see why it was important to press the bell?" She said, "Yes, yes, but I don't want the drama".

The Hon. PATRICIA FORSYTHE: Are these the sorts of cases that you sought to bring to the attention of the Minister?

Ms MARTIN: Bring to the attention of management.

The Hon. PATRICIA FORSYTHE: Did you talk about these sorts of things with Craig Knowles?

Ms MARTIN: Yes, and the incident where I went to the Director of Acute Services - I was concerned for Mrs X for two days, she is deteriorating, no one will see her, she is for active treatment and there has been no discussion of her end of life care. I came on duty and was told that she had died. I said, "Oh dear, they ended up documenting her?" No, they did not document her. She died. I said, "Oh dear, you had to resuscitate her?" "No, we didn't resuscitate her." I said, "What do you mean, you didn't resuscitate her?" "Well, she was dead." I said, "I know she was dead, but if she had died in the shopping centre someone would have resuscitated her", and they said, "Yes, you know, that's really odd because someone else said that to me, but she was old" and I said, "Well, what does that matter?" I was totally distressed. I went to the Nurse Unit Manager and told her. She said, "You know what they're like, you know the mentality, there's nothing I can do". So I went to the Director of Acute Services and I told her the story and she sat there and listened to me and then when I was finished she said, "You're already on a warning and I hate to tell you this but you've now breached patient confidentiality and you may lose your registration over this". I said, "What do you mean?" She said, "Well, you've looked in that lady's notes" and I said, "But I was directly involved in her care". She said, "Yes, but once she passed away you had no right to open her notes and see that she was dead".

Ms GROVER: As is the policy of South Western Sydney: Any patient that is deceased, you can no longer access their notes.

Ms FRASER: Can I clarify something about the MET criteria and about age related decision-making? If a decision was made not to resuscitate a patient, and that was made at a professional level, a patient would not be resuscitated, but in reality what we are speaking about is a 10 day old baby, a two year old child, a 26 year old asthmatic, a 38 year old lady who was found dead in her bed who had indications well before that she

needed help, a 40 year old lady, a 30 year old man. What we are talking about is a widespread culture.

Ms MARTIN: There is no discrimination.

Ms FRASER: There is no discrimination on who they deliver substandard care for. This is not a deliberate order by a doctor not to resuscitate somebody, this is a general standard of care and that is what we are seeing there today.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Can I ask one last question?

CHAIR: We will continue until 11 o'clock.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Falsification of notes, it was an allegation of falsification of notes. I think, Sheree, were you the person who made that allegation?

Ms FRASER: That was reported to me.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Were the notes made up, were they altered or hidden, what happened to the notes?

Ms FRASER: What happened was a lady collapsed in the middle of the night and the nurse in charge asked the doctor to review her from the emergency department and he came up immediately because he was not busy, there was nobody in the emergency department. He did not talk to the patient, he did not look at the patient, he did not assess the patient, he did not do a physical examination on the patient and went and proceeded to write a full physical examination of this patient in the medical notes. The nurse on duty, it was very late at night, called me at home and I asked her to fill out an incident form and document it in the notes, because if it is not documented in the notes it never happened. We were discouraged from documenting anything in the notes that would incriminate Macarthur Health Service.

Consequently this nurse documented it in the notes and ten hours later this lady was a medical emergency call as a direct result of that fall. I submitted an e-mail, because this doctor was back on duty in two days time, and he is working in isolation on his own and that standard is totally unacceptable. So I e-mailed the administrators and the only thing they could see was that I was the troublemaker for putting this in writing and it was not an issue. This doctor was allowed to come back and practice in that fashion. The nurse that put in the incident form and wrote in the notes was bullied out of that place within a few weeks.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: She had asked your advice, she rang you because you were senior?

Ms FRASER: I was the nurse unit manager of the ward at the time and I was responsible for what happens there at a medical and nursing level.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: That nurse was bullied and left her employment?

Ms FRASER: Not only was she bullied, she was assaulted by a nurse for calling a medical emergency one day.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: That is a separate issue from the one you are talking about?

Ms FRASER: That is correct.

The Hon. ROBYN PARKER: Can I ask Ms Fraser, and perhaps others might comment, when you were knocking on doors to get some action and attention to the concerns that you were feeling, what sort of support did you get from the Nurses' Association?

Ms FRASER: None whatsoever. Their attitude to me was when I attempted to call them, "You know what they are like there, we have lots of complaints", you know, "The general manager is a very powerful person. We do not want to get her offside. You are not going to change anything. You are better off just to leave, and basically they can do whatever they like to you."

The Hon. ROBYN PARKER: This is your association as nurses, I would assume?

Ms GROVER: Jennifer Collins was the president of the New South Wales Nurses' Association for many years. There is a strong feeling among the senior nursing community that there is collusion between the New South Wales Nurses' Association and the Labor party.

CHAIR: Mr Primrose.

The Hon. ROBYN PARKER: I did ask the question of all of the nurses. I have only heard two responses so far on the Nurses' Association. I would like to hear what the others have to say.

CHAIR: I will keep that in mind.

The Hon. PETER PRIMROSE: Can I go back, without quibbling about legal definitions of words such as "criminality", so I can get an idea of the handling, the size of what you are talking about, can you give us a rough idea of what percentage of practicing nurses and doctors in New South Wales you regard as being engaged in criminal activity?

Ms FRASER: I could not give you a percentage.

The Hon. PETER PRIMROSE: Can you get a rough guess?

Ms FRASER: This is not about guessing. This is about a standard of care at Campbelltown and Camden hospitals that is alarming. I am not into numbers and I am not into percentages. If you want a percent you need to go and audit the notes. I am not going to guess, but the standard of care there is unacceptable and it is an occurrence that happens far too frequently.

The Hon. PETER PRIMROSE: Would it be the general or limited to a very small number?

Ms GROVER: There is a significant problem out there in the clinical environment because we have new graduate nurses who are trained in the university, who are employed to the health services by the consortium with the promise of mentored guidance and supervised clinical procedures. Once they get to the workplace it is over, they are on their own, and that is why we are seeing so many of these problems.

Ms FRASER: Not only that, when they do occur and management either does nothing about it or punishes the people who reported it, that deters people and that practice then becomes acceptable.

The Hon. PETER PRIMROSE: You are talking about people jumping in front of bells and things. Is that common or not?

Ms GROVER: There is fear in the culture of raising concerns because you then become a target.

The Hon. PETER PRIMROSE: I am talking about taking the actions that have been taken.

Ms FRASER: I would not say it is common because not many people call the medical emergency bell. That is why it is not common. Sheree called the medical emergency bell.

CHAIR: The nurses have given evidence about their experience. We do not expect them to be able to answer for all health areas and all nurses from time to time.

The Hon. PETER PRIMROSE: Mr Chairman, I am asking the question.

CHAIR: I know you are asking. I am saying it is an irrelevant question which they are not

appropriately equipped to answer.

The Hon. PETER PRIMROSE: I would be like to be able to ask questions. I am happy to have this discussion in private but I do not wish to be censored.

CHAIR: Would you give an indication if you can speak for New South Wales?

Ms FRASER: I can not give you a percentage. What I can say to you is as a manager of Camden Hospital, in the six months I was there, most people who called a medical emergency were either bullied, physically attacked or ostracised out of the place.

The Hon. PETER PRIMROSE: Physically attacked?

Ms FRASER: Absolutely.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Most people?

Ms FRASER: Most people who called one.

The Hon. PETER PRIMROSE: In what way were they physically attacked?

Ms FRASER: They were punched, and this has all been investigated.

The Hon. PETER PRIMROSE: Investigated by whom?

Ms FRASER: Well, the ICAC. I was the manager on the ward, this was reported to me, I followed it up, and there was verbal abuse. If I went up to a nurse and said, "Why didn't you call the medical emergency?" She would swear at me, tell me she did not care. This was in front of the management there. So I can not give you a percentage but what I can give you is the fact that what we saw was of concern to the community.

Ms MARTIN: I can just add that over a ten day period I documented six incidents of nurses obstructing the bell or not calling a MET, if that makes it any clearer.

The Hon. AMANDA FAZIO: The one question I wanted to follow up was in relation to the New South Wales Nurses' Association. Were you all members of the Nurses' Association?

Ms BRAGG: I wasn't.

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

I wrote to Mr Brett Holmes expressing my disgust with the Nurses' Association. He was very verbal in *The Lamp,* which is the magazine that sets out talking about how bad it was for the nurses and doctors working at Camden Hospital. He was never verbal in supporting the fact that some of his members were trying to advocate for their patients. I found overall that the Nurses' Association wanted nothing to do with anyone who came up against Jennifer Collins, because she was too powerful. I asked for removal of my disciplinary warning off my records and the lady said to me, and Mr Holmes has acknowledged this, "You have annoyed her. There is absolutely no way she will take it off once you make her mad".

The Hon. AMANDA FAZIO: Can I ask, Ms Fraser, in your submission you ask--

CHAIR: No. Ms Robertson.

The Hon. AMANDA FAZIO: --why did Mr Knowles give Brett Holmes a substantial amount of money to win his campaign?

The Hon. CHRISTINE ROBERTSON: I would like to hear if others have got comments to make about the Nurses' Association.

CHAIR: Do any other nurses want to answer that question of Robyn Parker?

Ms GROVER: I certainly did not raise my concerns with the association because in the past I have been made very aware that it is the philosophy of the association that if they can't win it they won't have anything to do with it. The advice will be: We are not the appropriate body, go and see management. They are unsupportive. Jennifer Collins was one of their own and there was no way we were going to come up against her. That was obvious.

The Hon. ROBYN PARKER: In joining the association, what did you see their role as being?

Ms GROVER: I have been a member for 30 years.

The Hon. ROBYN PARKER: And what was your expectation?

Ms GROVER: My expectation is for support industrially in terms of wages and conditions and legal representation should I be required to go to court. That would be the end of my expectation of them.

Ms MARTIN: My expectation of them was to ensure that I was not harmed by my employer, that I was given all fair and reasonable justice and that I was not subjected to unfair disciplinary proceedings, which I was, and they were of no help to me.

The Hon. PATRICIA FORSYTHE: The next witness we are seeing is Sara Flegg. Ms Bragg, I understand that you dealt with her, and it was a case that you had been involved with and I think spoke to the HCCC. Could you give us your perspective on that case?

Ms BRAGG: Sara Flegg's case was a typical example. Although it was severe, it was a typical example of the poor decision-making that goes on at Campbelltown Hospital. She was in a critical condition when she arrived to me and shortly after she was intubated and ventilated, put on life support, and she needed to be shipped out. A doctor overrode that decision and cancelled the Care Flight, which delayed her transfer. The worst part about that was, after all was said and done, there was a meeting about it and I saw the minutes of the meeting afterwards and the outcome was that there be better communication between the registrar and the VMO, which actually had nothing to do with the incident itself. What happened in the incident was that it was poor management. It was under diagnosis. The outcome was a way of obscuring what actually happened and therefore it was never going to resolve anything, which is actually what used to happen all the time at Campbelltown.

The Hon. PATRICIA FORSYTHE: Is that one of the cases that you spoke to the HCCC about?

Ms BRAGG: Yes, it is.

The Hon. CHRISTINE ROBERTSON: I would like to hear what each of you think could be implemented that would improve the situation within hospital centres and what do you think would assist you to go back to work in your institutions? I would also like to thank you for, in your submissions, working towards our terms of reference.

Ms MARTIN: I do not know what is going to change. I can only speak from the Campbelltown and Camden point of view and the culture there. I believe that we have to move away from reporting incidents as a form of dobbing or a form of criticism. If you report something and you look at it objectively and you change

the way that you do it, what is going to come out of it is something positive, but at Campbelltown Hospital report writing is something negative, it is seen as something negative instead of something positive. It is very hard to change a culture overnight. Campbelltown Hospital is like 99 big red juicy shiny apples and a rotten one put in a barrel, the lid is closed and you open it in three months, six months, twelve months, five years and unfortunately a lot of them are rotten. I do not think it is all intentional, but if we were all allowed to practise in the way we wanted and there was never ever any disciplinary action taken against us, unless we follow protocol instead of not following protocol, standards would drop. We would practise in a very different way, as you would as members. You would get up and say whatever you wanted. There have to be definitive guides and we need to follow those. I think there really needs to be legislation to make nurses and doctors accountable to report as opposed to being disciplined for reporting, just as if we saw someone not breathing in a shopping centre and we did not render first aid we would be held accountable for not assisting that person. Doesn't it go the same way? If we are able to help or change the system, we should be obligated to do that, and we really believe that legislation should be brought in to say to the doctors and nurses: Hey, it is not dobbing any more, it is something that we require of you as part of your job.

(The witnesses withdrew)

(Short adjournment)

(Evidence continued in camera)

(Conclusion of evidence in camera)

(Public hearing resumed)

SARA JANE FLEGG, sworn and examined, and

VANESSA LEANNE BRAGG, on former oath:

CHAIR: I realise that this may be a distressing time for you, but we would appreciate any advice or experience that you can relate to us. Would you like to make a statement first?

Ms FLEGG: No, thank you.

The Hon. PATRICIA FORSYTHE: We have heard from Vanessa that you were a patient. Can you tell us your experience of the system?

Ms FLEGG: I don't know how to answer that.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Perhaps what happened to you?

Ms FLEGG: Well, I was 34 weeks' pregnant, my lungs collapsed and I was in ICU. From what I have been told, because I cannot remember anything, I just went downhill. My baby's heart rate was at 175 beats per minute, which is really bad. The doctor did not want to do a caesarean to save my life. Another doctor cancelled Care Flight. They finally got me out of there to Liverpool Hospital where my daughter was born. My daughter now has cerebral palsy because of it and every day--

The Hon. PATRICIA FORSYTHE: How old is your daughter now?

Ms FLEGG: She is four and a half. She is gorgeous.

The Hon. AMANDA FAZIO: When did you find out that the HCCC was looking at the matter?

Ms FLEGG: On 20 January I received a phone call from a gentleman who did not give me his name and told me he was from the department of health. He said to me that he was ringing up to enquire about my care at Campbelltown Hospital and what I thought of it. As I said to him, to the best of my knowledge, I got best of care. He said, "Great, good, I'm going to send you out some documents to sign". On the Wednesday, the next day, I was reading the paper and saw an article with Vanessa, and I knew that Vanessa had looked after me in ICU and something just clicked, so I went to every Bragg in the phone book and rang it. It took me until 9.30 at night and I found Vanessa and I said to her, "I got this phone call" and Vanessa said, "Oh my God, you don't know", and she told me. Now that was how I found out. I do not think I would have ever found out if I did not ring Vanessa up myself and I still want to know what those documents are that this gentleman was going to send me, but we also found out that he was not from the department of health, he was from the HCCC.

The Hon. AMANDA FAZIO: And when he rang you he did not say to you that they were investigating?

Ms FLEGG: No, he just said he was going to send me out some documents for me to sign and to get them back to him as quickly as possible.

The Hon. PATRICIA FORSYTHE: But you did not see those documents?

Ms FLEGG: No. I asked him what they were and he said, "I can't divulge that information". I said, "Well, I can't sign anything without looking at them". I never received them.

The Hon. PATRICIA FORSYTHE: When was that?

Ms FLEGG: 20 January.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: This year?

Ms FLEGG: Yes.

The Hon. AMANDA FAZIO: Have you had any other contact with the HCCC since that phone call?

Ms FLEGG: Well, you could say that. I had a lady ring me up saying "I am from ICAC, I am here to help you. Can you tell me about the phone call on 20 January?" I told her. A couple of days later I get another phone call from another gentleman: "I am from ICAC, can you please tell me about the phone call?" I went, "Hang on, someone just rang me a couple of days ago about this" and he said, "Who?" I told him her name and I said, "Look, she gave me a 1-800 number". I gave him the 1-800 number and he said, "I will ring you back in 20 minutes". He rang me back and he said, "She is from HCCC." I know I can't muddle them up because I had never heard of them before then and I wrote down everything, every conversation I had.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Are you suggesting that the person from HCCC pretended that they were from the ICAC?

Ms FLEGG: Yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Or are you saying that you may not have been clear about where they were from?

Ms FLEGG: No, they pretended they were from ICAC.

The Hon. AMANDA FAZIO: At the time of your daughter's birth were you aware of any possible problems with her delivery or at that time were you dissatisfied with any aspects of the care that you received?

Ms FLEGG: I was out to it, I don't know. I was on life support. I mean that is pretty hard but, as my husband said, he said "They kept telling us to get out of the room so many times, we didn't know what was going on".

The Hon. AMANDA FAZIO: And in the days after your daughter's birth when you were still in hospital did any staff or anyone mention to you that there had been any complications?

Ms FLEGG: When they brought me out it was a week later, so I did not get to see my daughter until a week later. I had the mentality of a 10 year old, so when I woke up I got told, "You have a baby" and I was going, "What baby?" So I cannot tell you much because the first year was pretty hair-raising because I had to learn how to look after a child, even though I had had three children previously.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: So you had some brain damage as well?

Ms FLEGG: Yes, I have lost all memory from earlier, before.

The Hon. PATRICIA FORSYTHE: Can I ask whether your husband was given any explanation or was approached about your condition, what had happened?

Ms FLEGG: First of all, there was the thing that the helicopter was not going to come because they were doing construction on Campbelltown Hospital and they were scared that dirt was going to get down the tube. We have now found out that that was false, it was because it was cancelled. The nurse came out and said to my husband and my sister-in-law, who was also there, "Look, she is really sick, we need to get her out of here". Then when the Care Flight staff came the gentleman turned around and said to my husband, "You'd better kiss your wife goodbye because they're not going to make it, your wife and your baby are not going to make it to the hospital, we might have to caesar her in the ambulance".

The Hon. ROBYN PARKER: Who was it who cancelled the flight?

Ms FLEGG: The doctor.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: I am sorry if I sound rude here: You were out to this and this is what you have been told since. In a sense you are giving evidence from a point where you have no actual memory personally, so you do not even remember going into hospital?

Ms FLEGG: I can remember going to the hospital.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Were you short of breath from an asthma attack or something? What was the problem?

Ms FLEGG: My lungs had started to deflate.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: What did you notice?

Ms FLEGG: I walked into a room and went to take a breath and could not breathe. It was as simple as that. I could not take that breath.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: I do not know whether we could get Vanessa Bragg to tell us what happened because it is not immediately clear to me what the sequence of events was.

CHAIR: Vanessa, you were there?

Ms BRAGG: Yes, I was.

CHAIR: And treating her at that time?

Ms BRAGG: Yes, I was.

CHAIR: So this is first hand evidence?

Ms BRAGG: That is correct.

The Hon. CHRISTINE ROBERTSON: You were in intensive care after the accident and emergency service, were you?

Ms BRAGG: I was in intensive care. I received her from delivery.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: She came from the delivery room?

Ms BRAGG: Yes, because she was 34 weeks gestation.

Ms FLEGG: My father took me straight to the labour ward. I have a friend who is a midwife there.

The Hon. CHRISTINE ROBERTSON: So you went to the delivery ward with hypoxia? "Hypoxia" means short of air.

Ms FLEGG: Short of air, yes. All I can remember is looking at the ground, seeing the nurse's feet and a wheelchair. I remember going in and the doctor saying to my friend, who is the midwife, "She is very sick, we need to move her" and a big machine, which I have been told was an x-ray machine, taking x-rays of my lungs.

The Hon. CHRISTINE ROBERTSON: So the actual accident and emergency service was done

almost in ICU?

Ms BRAGG: It was bypassed.

The Hon. CHRISTINE ROBERTSON: So you went to ICU with this lack of oxygen?

Ms FLEGG: Yes.

The Hon. CHRISTINE ROBERTSON: Can Vanessa tell us exactly what happened?

Ms BRAGG: By the time she came to me she was in acute respiratory distress and it was obvious that she was critical and needed treatment straight away. Because of several reasons, because of decreased level of consciousness, et cetera, we had to intubate and ventilate her and then we had major problems from then on. We were not able to ventilate her. Normally you can ventilate someone and keep their oxygen levels adequately and we could not with her for about three reasons. In simple terms: (1) She had asthma, so her lungs could not expand; (2) she had pneumonia, so they were full, and (3) the sheer volume that the baby was taking up was stopping her lungs from expanding. For us to be able to treat her at all we had to eliminate at least one problem, which would have been to give her a caesarean. When we put her on the ventilator I could not ventilate her because her pressures were so high due to these three things, so I actually had to hand-bag her. On 100 percent oxygen we could not get her oxygen levels greater than 85 percent, so she was very hypoxic and, if she was hypoxic, therefore the baby was hypoxic. If we were going to treat her or save her we had to caesar her and have the child taken out. The doctor would not do it; he refused.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: The obstetrician?

Ms BRAGG: The obstetrician refused to do it, he said the patient was too unstable, but we told him that this was a clear-cut case, that there is no option. The choice is either caesar or death; if we don't caesar her she will die. He still would not do it, so the ICU registrar at the time said, "I will transfer her out". I contacted Care Flight and handed the phone to the O&G registrar and then went back to continue to basically try to keep Sara alive, because that is what we were doing, and without me knowing he actually cancelled Care Flight saying to the Care Flight doctor, because this is what he told me, "The nurse and doctor are overreacting. She is fine; don't worry about it. Cancel Care Flight and I will call a general duties ambulance". After about 20 minutes - I think it was about 20 minutes - I felt it was unusual that Care Flight had not contacted me with some preliminary instructions.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Meet us downstairs at X time, et cetera?

Ms BRAGG: Yes, prepare this, that, et cetera, so I rang them and they said, "Oh no, the doctor cancelled, he said that you and the doctor were overreacting". I said, "Oh no, please, listen to me" and I said probably two instructions or two parameters of what was wrong with her and I could hear him yelling out, "Gear up, gear up" to his crew. He then told me that the other doctor had actually called a general duties ambulance and again he said, "We will be there as soon as possible. We may have to caesar her as soon as we get there, but we will just try to get her out of there", and he hung up the phone. When I turned around, sure to his words, the general duties ambulance had been called.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Did you speak to the relatives about the situation?

Ms BRAGG: I was actually in trying to save Sara and then when she went I think--

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: When Sara went in to the ambulance?

Ms BRAGG: Yes, when Sara went to the ambulance, the family followed. Normally in that situation, because I am hands on and trying to resuscitate her basically, there are other nurses. One will deal with the family, one will deal with other things.

The Hon. CHRISTINE ROBERTSON: Did you do an incident report?

Ms BRAGG: I spoke actually with my Nursing Unit Manager the next day and we had a meeting over that because Rose Hill, who was the ICU registrar, and I both made a complaint. We were both very, very upset from that and both of us actually received counselling for it. We were invited to this meeting, and this is the meeting where they turned around and said that the problem was the communication between the registrar and the VMO when in actual fact they were both there, so that was not the problem.

The Hon. CHRISTINE ROBERTSON: So there was no positive system outcome following this incident report?

Ms BRAGG: No, there was not.

The Hon. PATRICIA FORSYTHE: Is this one of the cases that you referred to the HCCC?

Ms BRAGG: Yes.

The Hon. PATRICIA FORSYTHE: Sara, is it true that the HCCC could not find you to investigate your case, but Channel 10 could when your case became public and, if so, do you know why that was the situation?

Ms FLEGG: No, I don't. Yes, it is true that Channel 10 found me before anybody else did, but I do not know why they could not have found me. My daughter has to go through the health system to get physio, occupational and speech therapy, so our addresses are all over the files. We are in and out of hospital with Jessica all the time: Campbelltown Hospital. The address is on the file. I have been to the hospital while we have been in our new accommodation.

The Hon. AMANDA FAZIO: How has NSW Health responded to any subsequent inquiries that you and your family have made for information regarding the circumstances surrounding Jessica's birth?

Ms FLEGG: They haven't really.

The Hon. AMANDA FAZIO: Have you approached them for information?

Ms FLEGG: No, I have not. It is hard to say. I remember, after I had Jessica, I saw the doctor who actually looked after me year after year, every year, and he told me that I got nothing but best care, but that was because I said to him, "Look, I can't get over what has happened to me, the parts I can't remember, I need to know so I can just get over it" and he said to me, "But you don't need to".

The Hon. AMANDA FAZIO: Was he the doctor at Liverpool?

Ms FLEGG: No, he was the doctor at Campbelltown Hospital. He told me I did not need to see my files because, as he knows because he was there, I got absolute best care. I trusted this doctor and he loved seeing Jessica, I had to take Jessica with me each time.

The Hon. AMANDA FAZIO: Are you contemplating taking legal action against the area health service?

Ms FLEGG: I am contemplating it. It is just the lies. I don't know if it would have been different if I was told when it happened, but four and a half years later? That is disgraceful. The perinatal and morbidity meeting was held six months after Jessica was born. Why didn't they contact me then?

The Hon. AMANDA FAZIO: Have you ever been advised in any way of any formal complaints mechanisms that were available to you as a user of the health service?

Ms FLEGG: No. Really I have not had any help, from my experience of Health, ICAC and HCCC, they have done nothing but lie to me the whole time. First they cover up that there was anything wrong and then they cover up saying, "Hi, I'm from ICAC"; "Hi, I'm from HCCC" and I don't know where I am, thinking okay, well, I've given this information to this person and this person's gone, "No, you shouldn't have given it to them, they're not really from this place, they're from there".

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Did you take notes of the conversations at the time?

Ms FLEGG: Yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: When the people called you?

Ms FLEGG: Yes, I did.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: So, as they talked to you, you wrote down their name and where they came from and the substance of the conversations?

Ms FLEGG: Yes, the date and time.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: In all cases?

Ms FLEGG: In all cases.

Ms BRAGG: Can I just add to that: After her first phone call to me and she was quite confused with what was happening, because of what I had been through in the past year, I said, "Okay, whenever you get a phone call you have to write it down there and then", so she did exactly that for every phone call.

Ms FLEGG: I also got a phone call from the actual doctor. My husband took it. He wanted to apologise for all the events.

The Hon. PATRICIA FORSYTHE: When was that?

Ms FLEGG: That was on 27 January.

The Hon. PATRICIA FORSYTHE: So when it became public?

Ms FLEGG: Yes. He rang up to see if I wanted to talk to him so he could help me out with everything.

CHAIR: The notes you took at the time are very important pieces of primary evidence. Would you make those notes available just to this Committee in confidence?

Ms FLEGG: Yes. I haven't got them with me, but yes.

CHAIR: They will be available only to the Committee.

Ms FLEGG: I have done most of them in stat decs.

The Hon. PATRICIA FORSYTHE: Mr Chairman, you have offered that they be made available just to the Committee. I wonder if Ms Flegg would mind if they were more widely available? It may well be you are quite happy for them to be more publicly available?

Ms FLEGG: I think I would have to talk to my solicitor about that.

CHAIR: We can discuss that later at our meeting and you can take some legal advice on that. We want to continue to support and protect you as far as possible.

Ms FLEGG: Thank you.

The Hon. AMANDA FAZIO: You said you had three other children. Were they born in Campbelltown Hospital?

Ms FLEGG: No, they were all born in Camden Hospital, actually in the birthing centre before they crumbled it all down.

The Hon. AMANDA FAZIO: And were you quite happy with the standard of care that you received then?

Ms FLEGG: It was brilliant. It was a birthing centre. I didn't have to deal with doctors or nurses. I didn't have to deal with anyone, it was just the midwife.

The Hon. PATRICIA FORSYTHE: What period of time was that when your children were born?

Ms FLEGG: Luke is 11, Kevin is 10, Kirsteray is 9. I actually had very good - the first one I have just remembered, sorry, was born in the labour ward because they thought he was two weeks early and they don't take them under so many weeks at the birthing centre, but there were no complications. I have never had any complications with any of them.

The Hon. ROBYN PARKER: Can I just ask a question of Vanessa? When Sara contacted you, you commented to us "Oh no, she doesn't know". What had you expected would happen?

Ms BRAGG: Because she was one of my original instances that I complained about, I would have expected by that time that HCCC would have contacted her and for her to have been notified. I had no idea that she wouldn't know what I was doing. That conversation with her actually was a very emotional one and very very difficult because in that period of time Sara had actually visited me several times in intensive care, just to say thank you for the treatment, and she was one of the cases I was referring to when I said it was so awful to lie to someone.

The Hon. AMANDA FAZIO: So when Sarah came to see you, you thought she was aware of--

Ms BRAGG: No, I knew she wasn't aware at that stage because she kept thanking us for everything, and when something happens, I go to a nursing manager and say, "What's the follow-up, what's the follow-up, what's the follow-up", and she would say, "It has been dealt with, it has been dealt with, it has been dealt with", and so then when Sarah comes to me and says "thank you" I presume--

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: But you didn't take it up at that time. You didn't take it up until she rang you after the--

Ms BRAGG: I knew I couldn't.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You couldn't because you would have been back in trouble with the hospital?

Ms BRAGG: Yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: So you would have liked to as a human being?

Ms BRAGG: Absolutely. It hurt to not tell the truth.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: What would you like to see come out of this inquiry?

Ms BRAGG: To come out of this inquiry I want to see Campbelltown Hospital made safer and I want patients to be able to go in there and be treated with the best of care at all times, not just by whoever happens to be on, whether it be a nurse or a doctor. There are many times when you work, you keep an eye on other wards, or I did, kept an eye on other wards, to try and counteract any bad thing that might be happening in other wards. So I want - safety monitors I think would be a great thing at Campbelltown Hospital.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: What do you mean by safety monitors?

Ms BRAGG: Safety monitors, yes, specifically to monitor incidents of near misses and things like that.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: An audit team?

Ms BRAGG: Yes, some clinician that takes the time to read notes, particularly to pick up the mistakes earlier where interventions can be made. I would like to see that, and one more thing I want to see is - you mentioned before about caring about other nurses and doctors. I particularly care about the other nurses and doctors at that hospital, and as a casual lecturer at the University of Western Sydney I also care about the nurses coming forward too. I want those people - I want nurses in particular, because that is where my roots are - to be professional people and aspire to be, but to do that we have to get rid of the rot first, and there is a lot of rot there unfortunately.

The Hon. AMANDA FAZIO: Could I just ask you a couple of questions. One, the doctor who offered the initial suggestion to perform a caesarian on Sarah, is he still working at that hospital?

Ms BRAGG: I believe he actually retired after the HCCC counselled him.

The Hon. AMANDA FAZIO: And the second thing I wanted to ask is do you think the system and the features that New South Wales Health has in place - do you think they are okay but it is just that they were not being implemented, that the culture did not allow them to implement it properly, or do you think the systems and procedures themselves need to be refined or improved?

Ms BRAGG: I think the systems and procedures do not allow for a more concrete view of the outcomes. In other words, you can review something and have an outcome but if you do not actually analyse that outcome and do anything about it, there is no point in using it in the first place. But also the management there in particular, I haven't worked at any other hospitals but that one, so I cannot compare, but what I can say is at that hospital I never met so many people who did not care about improvement. I was taught about best practice and to strive for best practice and that is what I believe in and that is what I would teach my students too, but they didn't seem to care. It was if it is adequate, it is adequate.

The Hon. AMANDA FAZIO: Did you work there for very long?

Ms BRAGG: From 1989 - about 13 years I think.

The Hon. AMANDA FAZIO: Were practices better when you first started there?

Ms BRAGG: Absolutely. It has deteriorated markedly, particularly - I am trying to avoid blaming certain people, but particularly the nursing unit manager who had taken over. There is no effort being made. I have worked under a few nursing unit managers in ICU and some of them have been fantastic and wanted to improve the situation and improve the knowledge of nurses, but this nurse unit manager did not appear to care whether nursing staff were adequately educated on what was happening and whether patients were adequately treated.

CHAIR: Is that the present nursing unit manager?

Ms BRAGG: Yes, it is. She is still there.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You mentioned the implications of ongoing education. I understand there was ongoing education for the hospital as a whole, is that correct?

Ms BRAGG: There was supposed to be ongoing education, but to my knowledge it rarely occurs. In ICU in particular it was often cancelled because of staffing.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Shortages?

Ms BRAGG: Also in two examples - I ran an ECG course and taught an ECG course and particularly I wanted the accident and emergency staff to attend because a lot of them, even though they had been there for a long time, could not recognise basic ECG rhythms. The first time I noticed that after the first couple of sessions it was accident and emergency nurses that dropped out and did not bother turning up and they were the ones I felt that really needed it.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Was that because of pressure brought from the area, do you think,or disinterest?

Ms BRAGG: Disinterest, because I worked with them as well and they were not interested. They were the same group of people who accused me of thinking I knew everything because I would want to - when I was working in accident and emergency I would want to say, "What has happened here? This isn't right. We have to fix this, this, this and this", and then the second time with the ECG course, it had to be cancelled because the educator at that time had failed to advertise it and no-one knew about it.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: So was there an ongoing system of nurses being educated for a week, a year or at some regular period for updates, in-service training if I can call it that?

Ms BRAGG: There was supposed to be. There were mandatory ones in occupational health and safety but nothing else.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: There were no clinical courses, there was no in-service training?

Ms BRAGG: No, and when there was, they were superficial, such as if we had say a meeting or an in-service and a patient was selected so we could learn from that patient, it would be a superficial review of that patient with no outcome basically - there was no outcome. I have actually sat at meetings where the comment has been "Gee, we really stuffed up on that one, didn't we".

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: If there wasn't regular training along a timetable for people, was there training after an event, in other words a debrief, "This case was sub-optimally managed and therefore let's all learn from this"? Were there incidental training meetings like that?

Ms BRAGG: No.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: There was a full-time trainer, was there not, for the nurses?

Ms BRAGG: A full-time educator, yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: What did they do?

Ms BRAGG: I have no idea. She never worked down in ICU.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: They worked elsewhere in the hospital?

Ms BRAGG: I am not--

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You couldn't comment?

Ms BRAGG: I couldn't comment, no.

The Hon. AMANDA FAZIO: What would need to change for you to go back to work there?

Ms BRAGG: I have to be honest and say I could never go back.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Do you have a comment about what you would like as an outcome from this inquiry?

Ms FLEGG: The hospital needs to be made safer. The staff, like Vanessa says, do need training. I have, apart from this, had a couple of incidences there at the hospital where the nurses treat you - excuse the language - like crap. I have been injected with things I have been allergic to and then the nurses tell me I am a drug addict. This is seven months after I had my daughter. They need a lot of training. They don't know how to handle the patients. It is disgusting, absolutely disgusting, and I want everybody who cuts us up, they need to be brought up on some reprimand, because what it is going to show people if nothing is done. It is not going to show anyone anything. They are going to think, "We got away with it", and they need to be brought to justice.

(The witnesses withdrew)

(Luncheon adjournment)

CHAIR: Could I just remind the media, they should not focus on people in the public gallery and their reactions.

BRETT HOLMES, General Secretary, New South Wales Nurses' Association, affirmed and examined,

JAN GRIEG, Organiser, New South Wales Nurses' Association,

ANGELA GARVEY, Professional Officer, New South Wales Nurses' Association and

KATHERINE SULLIVAN, Community and Government Relations Officer, New South Wales Nurses' Association, sworn and examined:

CHAIR: Mr Holmes, do you wish to make an opening statement?

Mr HOLMES: Yes, I do. The Nurses' Association is the trade union and professional body for nurses in New South Wales. We have a membership of over 49,000 nurses working in all areas of nursing. The Nurses' Association is firmly of the view that the majority of nurses in New South Wales subscribe to an ethos of learning that embraces a willingness to share information about errors and system failures. However, in a context where the public policy agenda is being manipulated by some commercial media interests, the commitment of these nurses to openness and transparency must surely be strained.

The public confidence has been similarly eroded by sensationalist media reporting of the crisis in Macarthur Area Health Service. No-one disputes that the public health system is currently labouring under acute pressures that threaten the quality of patient care. Virtually all of our representations to the Department of Health on a range of issues highlight the damaging effect and implications of patient care of the existing resource deficits.

We acknowledge that there have been errors documented and established in our public health system. We believe it must be recognised that there is a robust body of evidence that clearly indicates the rate of errors and adverse events in hospitals is growing in this country and also around the world. Fortunately, there is an equal body of research evolving to guide improvements.

We are very concerned as an organization that over the past number of years the health system, both here in New South Wales and across Australia has been attempting to move towards a position of open disclosure, which encourages health workers to identify errors, to come forward and to disclose those and try and address those, with the patients informed of what has happened, and where necessary give an apology for the outcome that has occurred to a particular patient or the family.

I am gravely concerned that the activities that we have seen over the preceding six months will have an adverse impact on people's willingness to go down the path of open disclosure. Whilst people are committed to improving our health system, the fact that we see continual claims by some parts of the media, and I must say by some politicians, for as I would describe it, heads on sticks, that approach surely cannot encourage people working in the health system to come forward, disclose their errors and improve the system.

I hope, and I believe that nurses have had a long history of incident reporting, of coming forward with issues and then obviously relying on the system to be improved so that those errors will have less likelihood of occurring again. But if we are to continue with a continual attack on individuals trying their hardest to work within the health system, then surely there is an impact on those individuals in terms of their willingness or their ability to disclose without becoming the subject of people media pillory for what are errors of clinical judgment and at times omissions or mistakes.

We believe that the system has, in the main, the most to answer for in terms of a lot of the errors that are occurring. A system that is under-funded, a system that is under-resourced in terms of staff and the responsibility for that goes all the way to the top. It goes to our State Government, it goes to our Federal

Government in terms of their responsibility to properly fund our public health system here in Australia.

But at the end of the day, it is often the case that it is the individual at the bedside, often nurses, who are left with the blame on their hands for what is ultimately a system error, an inadequate provision of resources and staff.

I will conclude my remarks and recommend our submission.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Mr Holmes, you have said that public confidence has been similarly eroded by sensationalist media reporting of the crisis at Macarthur Area Health Service. Do you believe that that reporting of his has blown the crisis out of proportion?

Mr HOLMES: I do believe that. No-one denies that we have errors and problems occurring in our health system but each of those issues needs to be dealt with in the proper environment and not by judgment by the media.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Do you believe the cases that have been brought up by the whistle blowing nurses, so-called, are correct, do you believe that the assessment of the whistle blower nurses are correct?

Mr HOLMES: I am not here to be in judgment of the whistle blower nurses or the cases they have identified. Those matters have been investigated by the Health Care Complaints Commission and as I understand it, some of my members may still be the subject of Health Care Complaints Commission investigations as a result of that. So I am not in a position to make judgment about what has already been put forward there by the Health Care Complaints Commission.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: It would seem that the HCCC has vindicated some of those complaints, would it not?

Mr HOLMES: Well, the Health Care Complaints Commission has identified problems. The problem with the Health Care Complaints Commission report so far is that individuals involved in those issues have not had the opportunity to make comment about those issues. The response from the Macarthur Health Service was a generalized response co-ordinated by the Macarthur Health Service management. The Health Care Complaints Commission obviously took a systemic review of the problems at Macarthur and identified individual examples that they could where problems had occurred. We are not in a position to deny that they occurred or suggest they did not occur. What needs to happen is that the second part of the Health Care Complaints Commission responsibility needs to be allowed to proceed without excessive interference from people who are not involved in the matter and without the media sensationalizing each and every case, without the full facts.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Would you not concede that the media has sensationalized this because it was not dealt with in house?

Mr HOLMES: I am not in a position to be able to make that judgment.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: If it had been dealt with in house, the whistle blower nurses who were here this morning stated they had no desire to go to the media, they did not go to the media for, I think it was ten months after they had initially – it might have been longer than that – after they had initially put in their complaints to the management of South Sydney Area Health Service. The internal procedures had not been working.

Mr HOLMES: I do not believe that I am here to make judgment of South Western Sydney Area Health Service or any of the complaints made.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Would you agree that it is your job to back your

members when they have dealings with their superiors in the workplace?

Mr HOLMES: We provide assistance to members who are financial and who seek our assistance. If people who are our members undertake activities on their own, then we do not seek to interfere with their right to do so.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Sure. But if they put in an incident report, which is in their workplace and relates to their job, it has nothing to do with their private lives, they are nurses, they are involved in nursing and they put in a report to management of an incident which is quality control in terms of your report, is it not your job to back them?

Mr HOLMES: If they seek our assistance in that.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: And if they get into trouble with management, being suspended, stood down or disciplined, is it your job to back them up?

Mr HOLMES: We do that, where they seek our assistance.

The Hon. PATRICIA FORSYTHE: Always?

Mr HOLMES: That is our attempt. I know that some members are not always satisfied with the service we provide.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: In this case my understanding is that the negotiation of a deed of release was made with South Western Sydney Area Health Service, in which the employees were paid a sum –

The Hon. AMANDA FAZIO: Offered a sum.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Offered a sum provided they did not criticize the management there. In other words, it was almost a hush agreement both ways, the management would not criticize them as being bad nurses and they would not criticize the system as being bad managers and they were offered a sum of money and given that deed of release as it was called.

Mr HOLMES: There was no attempt to quash any persons' right to raise complaints about clinical care. The deed of release you talk about related to the payment of a sum of money which was equivalent to the shift penalties that two nurses who we were dealing with would have received had they not been suspended.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: So effectively they were resigning for no money –

Mr HOLMES: No, they were not.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: They were resigning for no money and a deal to say nothing and that was the best the union could do for them after 26 years.

The Hon. PETER PRIMROSE: Mr Chairman, I spent all week listening to the Hon. Dr Arthur Chesterfield-Evans, if he is going to ask a question, I would be very happy for him to continue with this line of questioning, but please let the witness conclude the answer before asking another question.

CHAIR: It is not a point of order, it is some good advice.

Mr HOLMES: It was a standard deed of release drawn up, the standard wording that people have, and it relates to trying to preserve everyone's dignity in a situation where there has come to a point whether either an employer no longer wishes to continue with the employment of a person or that there is some resolution to a

matter and it is intended for the participants in that not to disclose sums or figures that they have been paid or to disparage each other in a public way about that matter. So, it had no affect on their rights to disclose or to complain about other matters with regard to patient care or their own self. They still would have maintained those rights.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: It facilitated resignation, did it not?

Mr HOLMES: These people were offered a placement in another hospital as a result of their management's decision that it was not in the best interests of all staff for them to return to that particular workplace they had been suspended from.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Surely they could have resigned and gone and found another job without any help from the union?

The Hon. AMANDA FAZIO: No, look –

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Just let him answer the question.

CHAIR: I will take it in order. Would you finish up your questioning?

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: I have finished. I am asking if this facilitated resignation and wouldn't it have the same result if they had simply resigned and went and found a job elsewhere? What has the union actually done for them is what I am really coming to.

Mr HOLMES: The union deals with its members in a private manner. We have had discussions with those members. They have not been happy and they have made it publicly clear that they have not been happy with the resolution that we obtained. I cannot say anything more about that at this point.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Are you happy that that is a good deal to offer your members after 26 years of membership?

Mr HOLMES: The service that somebody gets is not reliant on whether they have had 26 years or six months.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Okay, if they have had six months, is that a satisfactory level of service?

CHAIR: That is sufficient on that issue for the moment.

The Hon. PATRICIA FORSYTHE: Mr Holmes, amongst these submissions that we have received there is one, and it goes to the issues that we talked about this morning with witnesses, about the Association's dealings with the nurses and there is a suggestion in there that you received an amount of money, in one of the submissions, from Craig Knowles towards your last campaign. Could you outline about that please?

Mr HOLMES: With due respect to the Chair, can you tell me how that fits into the terms of reference?

CHAIR: It has been raised in a submission.

The Hon. PATRICIA FORSYTHE: It has been raised in a submission.

The Hon. PETER PRIMROSE: But how does it relate to the terms of reference?

The Hon. PATRICIA FORSYTHE: I think we are entitled – there has been various comments made, surely we have a right to test some of the submissions that we received.

The Hon. PETER PRIMROSE: If it relates to the terms of reference, then it is a lawful question.

CHAIR: A point of order?

The Hon. PETER PRIMROSE: A point of order. The question has been asked, Mr Chairman, I would suggest that we seek advice. If a matter does not relate to the terms of reference it is not a lawful question.

The Hon. AMANDA FAZIO: Well, I would like to ask a question.

CHAIR: To the point of order –

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: If it is a factor impinging on the way a complaint is handled, the way a complaint is or is not handled, then surely it is within the terms of reference of this inquiry?

CHAIR: I rule that you should answer the question to the best of your ability.

Mr HOLMES: Mr Knowles attended a fundraiser dinner. Mr Knowles participated in an auction. Each and every one of the members of a political party would have been at such fundraising events and possibly participated in auctions. It has no impact on how I deal with the government or how I might have dealt with Mr Knowles before or after the event.

The Hon. AMANDA FAZIO: I actually wanted to ask you a question about your submission that relates to the terms of reference. In your submission you note that clinicians cannot identify concerns regarding performance of senior clinicians without the fear of retribution. Can you explain that in a little bit more detail to us and tell us how you think that really impinges on the ability of the complaint to ensure better quality outcomes for both staff and patients?

Mr HOLMES: The Department of Health has produced a large number of documents about complaints handling and about processes that need to be put in place on incident reporting. I am sure the Committee will be made aware of all of those by the Department, should it appear, but one of the problems is of course, is not just about the fact that there is a policy there, there is a procedure there, sometimes it comes down to culture and fear and without doubt if you are going to challenge a more senior clinician than yourself about their clinical practice, then you have to have sufficient evidence and you would need support from either your peers or another person because at the end of the day there is going to be a judgment made by management as to whether what you have said is right, or what the senior clinician has said is right.

So people need to think twice, and they do think twice, about coming forward and making those allegations. But there is no doubt that nurses do that. They fill out, I would say, a large number of the incident reports that occur in our public health system and they note when things have gone wrong, where they have identified that problem, but it is our experience that there needs to be a culture within the health system that says that it is okay to challenge your clinical superior and for that to be dealt with appropriately.

Now there is mechanisms in place, there are mechanisms in place but it comes down to what the individual has to deal with.

The Hon. AMANDA FAZIO: Just in relation to that, did you have more complaints about the response when your members lodged those incident forms in the South West Sydney Area Health Service than you had from other Area Health Services in the State? Did it seem to be more of a problem there than elsewhere?

Mr HOLMES: Not that I am aware of.

The Hon. PATRICIA FORSYTHE: If I could return to my line of questioning and that is that you referred to an auction. I did not raise an issue of an auction. Can you tell me about that auction? Does that imply that MR Knowles was the bidder at the auction, the successful bidder?

The Hon. AMANDA FAZIO: A point of order Mr Chair. I think this is really stretching the boundaries of the terms of reference to an extent that is unacceptable.

CHAIR: It is a question of clarification on something which was volunteered by the witness.

The Hon. PETER PRIMROSE: Further to the point of order, you in fact directed the witness to the best of his ability, so it was not volunteered.

CHAIR: It was. I did not direct him to say anything about an auction. He volunteered that. I will allow the question on whether, along the lines of what his auction was about. Who were the people involved, what was Mr Knowles' role?

The Hon. AMANDA FAZIO: In view of your response Mr Chair, if you recall some of the earlier witnesses from this morning, I had extensive questions to ask them about issues they raised in their submissions, and issues relating to public knowledge, I think basically if all bets are off in terms of what is on the table and what is off the table here, then so be it on Patricia Forsythe's head for starting this line of questioning.

The Hon. PATRICIA FORSYTHE: I would still like the answer.

Mr HOLMES: I believe I provided an answer that was clear enough. The implication of your question –

The Hon. PATRICIA FORSYTHE: Was Mr Knowles the highest bidder?

Mr HOLMES: Yes, and if you read your Sunday newspaper you would have read that twelve months ago.

The Hon. PATRICIA FORSYTHE: But I am entitled to ask you on this point because you were the one who raised it. Is Craig Knowles a friend?

Mr HOLMES: No, I have not seen him since he stopped being the Minister. I have respect for Mr Knowles. He was a good health minister. He made good improvements to our health system and we had a very professional and efficient working relationship.

The Hon. PATRICIA FORSYTHE: Did you take the opportunity at any stage to discuss the allegations of Camden and Campbelltown Hospital with Craig Knowles?

Mr HOLMES: No, I have not. I have not seen Mr Knowles or had conversations with him since this matter was raised or before this matter was raised.

The Hon. PATRICIA FORSYTHE: And in relation to the current minister, have you had discussions with him or his office about the allegations of the whistle blower nurses?

Mr HOLMES: Obviously we have raised our concern about the health system and what is happening. The Minister has not discussed the individual complaints with me and nor have I sought to try and discuss them with him. I respect the fact that there are inquiries underway and those inquiries should be allowed to establish the facts.

The Hon. PATRICIA FORSYTHE: So when you say you have raised concerns with him, does it go to the sort of issues that the whistle blower nurses raised or were your concerns about the way in which the

issue was being dealt with in the media? Was it about the problems or the perception?

Mr HOLMES: I raised my concerns about the perceptions that are occurring in the community and the impact upon those perceptions upon my members.

CHAIR: Any questions from the Party?

The Hon. CHRISTINE ROBERTSON: I do have a question. I am particularly interested in this line of questioning of the union's activity. Can you please tell me when your elections are due?

Mr HOLMES: The election was held in July of last year.

CHAIR: For the sake of the record, I just remind members that I allowed that question, even though it is not relevant.

The Hon. CHRISTINE ROBERTSON: I think it is incredibly relevant, Mr Chair. The relevance is that at no time did we discuss or expect or even come across our minds that the union was in some way to be attacked here. It has got nothing to do with our inquiries so I am very interested, because during this day I have seen some very interesting people who have had a long history with the Nurses' Association in this room and I just wondered why there was so much activity coming from a faction of the Nurses' Association which has been in competition with the current faction for a long time and I cannot say because it is outside the terms of reference for me to name someone who is in the gallery, but I just was very interested and wondered if you were having some sort of trouble within the union?

CHAIR: The question was when was the date of the last election.

The Hon. CHRISTINE ROBERTSON: Yes, I have been told when the last one was, I am satisfied. I think this is a strange line of questioning from the union who gave us the most superb submission in relation to terms of reference with some excellent recommendations.

CHAIR: If I might ask you a question, I noted that you said there was a need to alter unrealistic expectations of perfection from nurses. Could you give me an example of expectations of perfection?

Mr HOLMES: There is an expectation that every mother and child that gets delivered in our hospital system is going to come out with a perfect baby and a perfect delivery. It is very tragic but two percent of those occasions result in a tragedy. As a midwife it was one of the most pleasant places to work but when tragedy occurred it was one of the most painful events in nursing to see a baby die or to have a still birth, and there seems to be a public perception that there is no risk to child birth, and that is wrong. The fact is that tragedy occurs. Nature causes some of these tragedies and that the health system is going to unwind nature and make sure that nothing goes wrong, that is an example. The fact that people go to hospital, they are acutely ill, in years gone by they would have died before they even got to hospital. They now survive for much longer. The expectation of the community is that our health system can save almost everyone. That is a false perception.

The other thing is, of course, that health workers, nurses, doctors, allied health workers alike, are human beings. They suffer the fallibility of human beings, they are put in extraordinarily difficult situations to make clinical decisions at short notice, with sometimes not enough information, information that becomes available to the coroner or upon post mortem that they did not know at the time but they had to make a clinical decision. I am sure Dr Arthur Chesterfield-Evans would have been in that situation of having to make rapid clinical decisions on the information available. Sometimes those decisions do not end up in a positive outcome but there is this perception that you can go to hospital and you are going to be absolutely safe all the time and everything is going to turn out.

CHAIR: What if the set policies and procedures are not followed?

Mr HOLMES: That is where incident reporting is important and the hospital or the health service has

a responsibility for properly investigating those and taking corrective actions to the system, to find out what the systemic problem was, to find out what the deficits of the individual were and provide them with the assistance, the education, the training that is necessary to make sure it does not happen again. If they are identified as having an impairment or an incapacity to do their job, then there are procedures available to report them to their registration body and have those matters dealt with by an expert board.

The Hon. AMANDA FAZIO: Can I just ask you following on from some evidence that we heard just before lunch when a nurse had done her very best to ensure the survival of a mother and her unborn child. She had problems in getting the critical level of that situation across to a CMO. Could you tell us what are the key issues for nurses when they are raising complaints about doctors? Is there still that sort of "I am a doctor" type of attitude?

Mr HOLMES: Amongst some doctors, yes, there is. They have to be permitted and have some belief in their capacity in order to do the work of a medical officer but they have to be able to be challenged and that is what nurses often do. It is often the nurse that steps in on behalf of patients, who is a patient advocate and says, "Look, doctor, I think what you are doing is wrong", but it does take some conviction and being able to know that you are doing the right thing that you are challenging. If the doctor overrides you, then the nurse has an obligation to report further up the nursing chain, that is to the supervisor that is available, or the nursing unit manager if it is during the day, and there are opportunities then to have those matters raised. If the nursing supervisor is unable to intercede and prevent the doctor from taking some course of action, then they have the power to call a more superior person in terms of a medical officer or a manager of the health service should they think it necessary. But there are always time factors in that as to how quickly it can happen and how available those people are to see, but nurses on the whole are there and they try to protect their patients from activities that they believe are not quite right being undertaken by a doctor.

The Hon. CHRISTINE ROBERTSON: This is what should happen but not always.

Mr HOLMES: It happens more times than not in my opinion but there is nothing to say that on occasion there is a breakdown in the system and it may be that the person you are trying to get assistance from is doing the same thing somewhere else in a hospital.

The Hon. PATRICIA FORSYTHE: In addition to the fund raising activities that you have referred to, on what other occasions did you meet with Craig Knowles socially?

Mr HOLMES: I cannot recall any others.

The Hon. PATRICIA FORSYTHE: Did he ever visit your house?

Mr HOLMES: Of course not.

The Hon. PATRICIA FORSYTHE: Of course not?

Mr HOLMES: Of course not. I don't have a relationship with Mr Knowles that I would invite him to my residence.

The Hon. PATRICIA FORSYTHE: So he has never visited your house?

Mr HOLMES: Absolutely not.

The Hon. PATRICIA FORSYTHE: In the context of the existing inquiry, what discussions have you had with the current Minister's office about the nature of this inquiry?

Mr HOLMES: This inquiry?

The Hon. PATRICIA FORSYTHE: Yes.

Mr HOLMES: I have had no discussions with them about this inquiry.

The Hon. PATRICIA FORSYTHE: None at all?

Mr HOLMES: I have not.

The Hon. PATRICIA FORSYTHE: Can you explain to us why you believe there has been the breakdown that has been evidenced to us from the witnesses this morning between the nurses that we have heard from and the Nurses' Association?

Mr HOLMES: No, I cannot explain that.

The Hon. ROBYN PARKER: Do you think that the Nurses' Association has provided quality support for those nurses who have made complaints on issues?

Mr HOLMES: At no time was the Nurses' Association provided with detailed information about patient matters and let me say that as a general rule if one of our members advised us that they had collected an amount of information about patients, then we would advise them that the proper body for investigation is the Health Care Complaints Commission and we would not have sought to see those documents or to interfere in that process. We would have advised our members that they should go to the Health Care Complaints Commission with those matters and that once they had done that they would become complainants in terms of the Health Care Complaints Commission.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Surely, whatever complaint nurses have, it is the Nurses' Association' job to back them up, is it not?

Mr HOLMES: If they seek our assistance.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: If they were at the point of signing deeds of release, that must be the end point of having sought your assistance prior to that?

Mr HOLMES: There was no declaration that those people who we were assisting were, as it were, trying to blow the whistle. At the time that we were dealing with them, which was prior to any disclosure or prior to any meeting with the Minister, we were not aware that they intended or that they had access to large amounts of information about patient care.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: No, they were merely members who had made complaints and were getting themselves into a conflict situation with management, were they not?

Mr HOLMES: They came to us because they had a disciplinary problem that we were trying to assist them with. They came to us after they had spent quite some time with their own legal advisers, because they had been unsatisfied with not being able to talk to someone immediately on a Friday afternoon.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: But it was your job to back them up if they complained about the situation in the workplace, was it not?

Mr HOLMES: Our job was to assist them with their defence against the disciplinary matters that were being undertaken.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: And do you think you did that for them?

Mr HOLMES: We provided them with advice, we provided them with independent legal advice. We wrote to or we had our solicitors on their behalf write to the area health service seeking further information.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: And South Western Sydney was not exceptional in the number of people seeking help, the number of people having difficulty with management in this matter. You did not notice any pattern of quality control problems down there?

Mr HOLMES: No, South Western Sydney would probably rate, along with Western Sydney, as an area health service which we had, I suppose, not infrequent dealings with and we were not always happy with their final decisions. We work within the power of the law and there are some times where management has a prerogative that overrides what we want for our members.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Would you agree that where the manager being complained of is in the union and the complainant is with the union is far more difficult than say an industrial dispute over wages? In this case you have got two union members or one union member complaining about a number of other union members.

Mr HOLMES: It depends in what context. We do not seek to represent our members who are managers when they are acting as managers. We advise those members that in the position of a manager they should seek assistance from their human resources officials from the area health service or from the hospital and we do not seek to represent them when they are acting as a manager. If they are personally the subject of disciplinary action or of some allegation about them personally, then they seek our assistance and they are provided with our assistance.

The Hon. PATRICIA FORSYTHE: Can I ask who provides the legal advice to the Nurses' Association?

Mr HOLMES: A firm of solicitors, Whyburn and Associates.

The Hon. PATRICIA FORSYTHE: Can you just come back to the connection between the Nurses' Association and Jennifer Collins. What is your connection, what is your association with Jennifer Collins?

Mr HOLMES: She is a member of the association.

The Hon. PATRICIA FORSYTHE: Is she a friend?

Mr HOLMES: No, I wouldn't regard Jennifer as a friend. I joined the offices of the association in 1990 and at some point there Jennifer Collins was the president.

The Hon. PATRICIA FORSYTHE: And did you later on--

Mr HOLMES: I was aware of her as a fellow delegate prior to that but that is about it.

The Hon. PATRICIA FORSYTHE: And in the context of the complaints allegations at Camden or Campbelltown hospitals did you or the union have any contact with Jennifer Collins about the allegations that were being made to you by the nurses?

Mr HOLMES: When the interim report was leaked I attended Campbelltown Hospital to talk to our members and on that day I spoke to Jennifer Collins about what it was that they were doing to support our members who felt that the interim report had been unfairly leaked and that it was impinging upon their work and lives.

The Hon. PATRICIA FORSYTHE: When did you speak to the area about various allegations being made by nurses?

Mr HOLMES: I recall that it was when it went to the press.

The Hon. PATRICIA FORSYTHE: What sort of date was that? When are we talking about roughly?

Mr HOLMES: My understanding is that it was somewhere around November.

The Hon. PATRICIA FORSYTHE: Only last year?

Mr HOLMES: November the previous year when it became public knowledge. I was not aware of the allegations prior to then.

The Hon. PATRICIA FORSYTHE: So you had not received any correspondence from any of the nurses in relation to their concerns about the Nurses' Association's treatment of nurses or failure to take action in response to concerns prior to that?

Mr HOLMES: Prior to that, no.

The Hon. PATRICIA FORSYTHE: Mr Holmes, I have got a copy of an email dated July 2002 to you from whistle blower nurses expressing disgust and horror about issues you have put in a previous edition of *The Lamp* about Camden/Campbelltown Hospital, indeed about a number of the issues that were brought to your attention.

The Hon. AMANDA FAZIO: I have raised previously with the Ethics Committee the issue of items of correspondence or whatever, purporting to be emails and the veracity –

CHAIR: I am just going to raise that very issue and ask could I have a copy of that and could I actually show it to you, if you would verify it as an email that was sent to you.

The Hon. AMANDA FAZIO: There is also of course a difference between an email that has been sent and received and actioned, which was raised –

CHAIR: Would you please look at this and say whether you have seen that email previously.

Mr HOLMES: Yes, I do recall this and let me say that the date on it struck me as very strange when it arrived.

CHAIR: Can we have that back?

Mr HOLMES: Yes, you certainly can.

CHAIR: Are you saying there is a disparity?

Mr HOLMES: What struck me was the date on it, that was marked on it was not actually the date that it was received. A very strange event. Either the clock on the sender's computer was wrong–[1]

CHAIR: Are you saying the date was vastly dissimilar, like six months, three months, one month, one day?

Mr HOLMES: Vastly dissimilar.

CHAIR: Like months?

Mr HOLMES: Months, if not more.

The Hon. PATRICIA FORSYTHE: So, when do you recall seeing the email?

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[1] Please refer to correspondence received from Mr Brett Holmes, General Secretary, NSW Nurses' Association, dated 30 March 2004, available as a separate pdf document with this transcript.

Mr HOLMES: Quite sometime after July.

CHAIR: You did say before November was the time you first became aware of it.

Mr HOLMES: That's right, I believe that email arrived sometime after the whole event because we did not start writing about this issue in *The Lamp* until it was obviously disclosed in the public, so that puts the whole context of the timing of that right out. There is no way in the world it could have been sent in July 2002 because the editions of *The Lamp* that contained this certainly did not start being put out prior to that.

The Hon. PATRICIA FORSYTHE: When you spoke to Jennifer Collins about you said at the time of the leaked report, did you attempt to understand the nature of the allegations that had been raised?

Mr HOLMES: The report was not public knowledge, it had been leaked to the newspaper. The only thing that I was able to obtain was what was available in the newspaper. Ms Collins did not disclose to me a copy of that report. Obviously the Nurses' Association sought a copy, seeing that it was now in the public domain from the Health Care Complaints Commission and we were denied that copy because it was not supposed to be released in that form and it was not available to us.

CHAIR: Are there any other members of your party here wishing to make statements?

Mr HOLMES: No, they are here to answer questions if you have specific questions for them.

The Hon. PATRICIA FORSYTHE: Can I ask about the deed of release?

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Were you aware of the problems in South West Sydney in Macarthur in particular as had been raised, you say you were not aware until they blew up in the media, is that correct, you personally were not aware?

Mr HOLMES: I personally was not aware of that, yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You have got two delegates here who were closer to the action than you were, supposedly looking after patches, were they aware of the problems in Camden/Campbelltown nearer to that time? Were they asked for help?

CHAIR: I think it would be appropriate if the delegates themselves reply.

Mr HOLMES: If I could clarify –

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: I don't know whether I should ask the regional organizers or the, I don't know –

The Hon. AMANDA FAZIO: Why don't you let Mr Holmes clarify?

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Well –

Mr HOLMES: If I can clarify the position for you. Jan Grieg on my right is the organizer who was responsible for South Western Sydney. Katherine Sullivan on my far left was the manager of the Organizer Services for the Southern sector of the State at that time. So if you would like to ask your questions on that basis.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: I don't know whoever would be more aware, which ever one would feel that they are more aware and able to answer the question. Were they aware of the difficulties at Campbelltown and the allegations being made by a number of the nurses?

Ms GRIEG: I do not have any recollection of nurses that I spoke to that raised patient care matters and it was not until the media and the newspaper that I became aware of any allegations in relation to patient care at Macarthur.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: The deed of release surely is an end point of a failed negotiation process, is it not, when somebody is resigning the presumably means that they can no longer work with management, so all negotiations should be prior to that, presumably, would they not?

Ms GRIEG: I am not sure that I understand the question. If I could make a point that there are two parts to this scenario which seems to be, I believe, being blurred. One is the issue in relation to the deed of release and the negotiations that officers of the Association were having with the Area Health Service regarding those members and then after the event when nurses now known as whistle blowers raised issues of patient concerns. So there are clearly two different parts to this story, so I am sorry, you will have to repeat –

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: I am asking about prior to any whistle blowing, which I think this is when all else had failed they blew the whistle, at that time they were nurses making a complaint about their management and presumably asking the union to back them in that complaint, were they not, and were you aware of those nurses, their complaints and were you backing them in their negotiations with management, that is what I am asking.

Ms SULLIVAN: If I may, yes, we were. We did support those nurses. We are talking of two nurses who are here today and we supported them. They did not like the outcome and have told us so and this is something that Brett I believe has touched on earlier. Sometimes there are outcomes – we cannot control the outcomes but we do our best, through negotiations as much as we can, and where possible the Industrial Relations Commission. That was not an avenue that was open to us in this particular case. At one time we thought it was, we thought it was – we were going to be able to prevent the transfer of the two nurses to other hospitals through that mechanism. It turns out the only way that you can access the Industrial Relations Commission in like manner is for when you are being terminated and you must go and seek reinstatement or you are being threatened with termination.

Now, neither of those two things were on the agenda. The management were not terminating the staff, the two nurses, nor were they threatening to.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: They had been stood down, however and they felt that they had to resign and you gave them a deed of release so there was certainly termination in the air, was there not? I mean, if it was explicitly stated it was certainly, it was obviously going ahead because –

The Hon. CHRISTINE ROBERTSON: They can still get a job if there is not a formal termination, that is what it is about, it is an industrial issue.

Mr HOLMES: Excuse me Mr Chair, the line of questioning, where are we going with this in terms of the terms of reference?

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: The nurses have a complaint and the union was backing them is where I am going with this.

CHAIR: Judging it on the previous evidence given.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: They had been stood down so they were in an industrial problem situation, were they not?

Ms SULLIVAN: Yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: And you were negotiating so that they would presumably be reinstated with their money and continue or that there would be a resolution to the dispute?

Ms SULLIVAN: Yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: And the outcome of that was a deed of release which was effectively a facilitated resignation?

Ms SULLIVAN: No, no, the nurses had made the decision to resign having considered the options of the hospitals they were then offered to be transferred to, within the same Area Health Service. So the nurses made that decision and then, well, prior to that time, both had asked me to negotiate because they had been financially disadvantaged in the process of their suspension and I did that.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: And that is the $3,000 and something?

Ms SULLIVAN: Precisely.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: And the other nurses did not actually contact you, it was only those two from theatre?

Ms SULLIVAN: Personally, I have had no contact with any other nurses, sorry, who have been-

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Who later became whistle blowers?

Ms SULLIVAN: That is correct.

The Hon. CHRISTINE ROBERTSON: I guess the issue that I would like described by you people, we have two sets of issues in relation to the industrial issues before us this morning. One of them relates to two nurses about which you were just speaking who certainly during the clinical control processes were not getting the endorsement of their management at their Area Health Service and eventually related to the termination. The other issues that we are still being told nurses were not dealt with fairly by their union related to the actual whistle blower nurses who had the larger amount of evidence in relation to a lot of – so what has happened in the questioning over here is there has been quite a bit of confusion about what the function of the union is, your function is to do with industrial relations, not relating to clinical governments, although it is nice to participate in –

CHAIR: Could you come to your question.

The Hon. CHRISTINE ROBERTSON: I asked it at the beginning. I said the industrial relation issues in relation to these two people. Can you recall that?

CHAIR: I think you asked it and you seem to be answering it, that was the problem. Would you like to answer the question?

The Hon. CHRISTINE ROBERTSON: I did not answer it. I will speak as though it is a point of order because you have point of ordered it. There are two issues here, one relates to the industrial relations issue and one relates to the government's issues. This particular session is totally confusing the two issues and I just would like the union please to let us know about the industrial relations issues with the two separate groups.

CHAIR: Can you answer the question?

Mr HOLMES: I think it is clear that there was an issue where two of our nurses had been accused of being bullies in their place of work. That was an issue that management was dealing with and that was what we were trying to assist them with in working through. There was a chain of events prior to that which obviously uncovered those allegations that management tried to move on, but we came in at a point after those nurses had sought some legal advice separate to the Association and that was because they could not speak to

someone on a Friday afternoon. By Monday they had already seen their own legal advisers and took a course of action, which, you know, that is everyone's right. At some point they decided to come back to the Association for assistance and we offered that assistance.

The Hon. PATRICIA FORSYTHE: Did they come back or did you seek to take it over?

Mr HOLMES: They came back. We did not seek to take it over, they came back to us on the basis that it was going to cost them too much to keep going with a lawyer. They sought our assistance and once they had come back and sought our assistance then our advice to them is the same advice that we would give to anyone. If you want our assistance, then you are with us and we provide the advice and we source the legal advice for you but you do not then continue with your other alternate legal advice because there is nothing surer than two lawyers will not agree on the same thing or the same course of action.

The Hon. ROBYN PARKER: I wand some clarification, earlier you mentioned articles in the Nurses' Association's magazine *The Lamp*. I just wondered if you stand by an article which appeared in the magazine entitled *Nurses Who Dare* which discussed the alleged morale problems at Macarthur and the whistle blowers' allegations. Do you stand by that article?

Mr HOLMES: I am not the author of the article. The article I think you are referring to, and I cannot see it – there are many articles in our journal – but it was a journalist interviewed a nurse as far as I understand and reported what the nurse said.

The Hon. ROBYN PARKER: Do you stand by that article?

Mr HOLMES: Well, it was in *The Lamp* but I was not the author of it. I cannot say that the opinions of everyone that are reported in *The Lamp* are my opinions, that is not the case at all. This is a union journal that allows people to express different opinions.

The Hon. ROBYN PARKER: Do you think the article addressed concerns of patient care?

Mr HOLMES: I cannot recall - what specific line are you talking about?

The Hon. ROBYN PARKER: Do you think it addressed those concerns of patient care?

Mr HOLMES: I don't know what you are referring to.

The Hon. ROBYN PARKER: Do you think they are adequately explained, the issues concerning patient care?

Mr HOLMES: As I said, I am not the author of the article. I am the editor of *The Lamp* officially. I do not direct the words in every article.

The Hon. ROBYN PARKER: Do you have the same reporters currently in articles of *The Lamp* as you had at that stage? Is that same reporter still reporting for *The Lamp*?

Mr HOLMES: It depends who did it. We contract out to some independent journalists at times to do our work.

The Hon. ROBYN PARKER: Who determines who are the reporters you employ?

Mr HOLMES: The person responsible for compiling *The Lamp* engages those journalists on a needs basis.

The Hon. ROBYN PARKER: And who is that?

Mr HOLMES: That is Julie Venamore.

The Hon. ROBYN PARKER: So you have different reporters now from what you have had in the past then?

Mr HOLMES: No, we may still use the same one. I don't know which reporter you are referring to.

CHAIR: I think we have gone down that path.

The Hon. PATRICIA FORSYTHE: Can I just go to the issue of the deed of release. We were told this morning that the nurses were asked to sign, that it was a condition that they said nothing more against the Macarthur health service. Did you endorse that restriction on the signing of the deed of release?

Mr HOLMES: I have already explained it is a standard deed of release that occurs in any of these situations. It is not meant to take away anyone's right and it cannot. It cannot take someone's statutory rights to report a complaint about patient care. No deed of release prevents people from undertaking their professional duty to report. So if it has been interpreted in that way by our members, that is unfortunate. They should have sought clarification before coming to some conclusion that it was some alleged hush money, and let me say that when the Sunday newspaper published that we were able to have that Sunday newspaper withdraw that comment because it was libelous, totally untrue and out of context with the whole exposé of the patient care matters. It was not relevant to the patient care matter.

The Hon. AMANDA FAZIO: Mr Holmes, you have stated in this submission that programs to educate clinicians and managers in quality initiatives, which is where I think most reasonable people would think a complaints process would feed into, that they are not a real priority in the health system. Could you elaborate on that and tell us what you think needs to be done to ensure that these these things are given a higher level of priority?

Mr HOLMES: Currently the priority of our health system is actually front line care. In my opinion we do not have enough nurses at the bed side. Our members tell us that that is a frequent reason for nurses leaving the profession, that there are not enough nurses at the bed side. So it is often very difficult for extensive training to be provided on a generalised basis with some expectation that nurses at the end of a shift or a double shift will be able to take home the policies that have been dutifully written by the departmental officers and learn them. I believe that there needs to be time made available in work time, reasonable time, to provide all that education.

Currently, there is a large amount of compulsory education that must be undertaken by nurses and other health workers, and I think you will see that in the Health Care Complaints Commission report into Macarthur, they were struggling with staffing levels and they were struggling to be able to meet the requirements for the compulsory education. So I believe that there is a problem with our system in having the resources available to free up nurses in work time to be able to undertake the level of education that is necessary on these sorts of matters. Managers and other people may well be provided information. It is ultimately necessary to bring that down to each and every nurse and each and every health worker.

The Hon. ROBYN PARKER: Mr Holmes, what has been in the past your relationship with Amanda Adrian?

Mr HOLMES: Amanda Adrian I think I probably met in the 1990s when she was an officer of the Department of Health, and I have sat on a committee with her, and that is about it.

The Hon. ROBYN PARKER: I wonder if you could just tell me Deborah Piccone, has she formerly held positions with the Nurses' Association?

Mr HOLMES: Yes, I think it is on record that Deborah Piccone was at one stage a delegate for the association from the Prince of Wales Hospital and was elected as the president in some years gone past.

The Hon. ROBYN PARKER: And do you know her personally?

Mr HOLMES: I have met with Ms Piccone on quite a number of occasions. She was a delegate to a conference which I attended when I was a delegate. She was a councillor when I became an officer of the association in 1990 and she was also a director of nursing at Concord Hospital when I was an organiser. So I have had professional dealings with Ms Piccone for quite some time, none other.

The Hon. PATRICIA FORSYTHE: Can I just ask about deeds of release? How common is their use?

Mr HOLMES: On just about every occasion where an employer agrees to pay some money to an employee where the matter is resolved without the employee returning to work.

The Hon. PATRICIA FORSYTHE: Does the Nurses' Association support unfair dismissal?

Mr HOLMES: I will answer that respectfully, but I think it is a disrespectful question. Of course the Nurses' Association does not support unfair dismissal. We spend a lot of time and effort defending our members in such cases.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Could I just ask the deed of release, isn't it very convenient to management to say there is no criticism of management out of that?

Mr HOLMES: It is convenient for nurses who wish to get another job and every time they try and get a job they have a reference check and the employer at the other end says, "No, I wouldn't employ her. I got rid of her." That is there to protect the employee as much as the employer.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Even if the employee has been dismissed for incompetence or unconscionable conduct?

Mr HOLMES: Well, if that is the case, the employer makes a decision as to whether they will agree to a deed of release. If they believe that this person is incompetent, then they have got an obligation to refer to the Nurses Registration Board and to refuse to take this approach. They can then fight the matter out in the Industrial Commission. If they believe that it is so serious that there is a risk to future patient safety, they have got obligations.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: It is the easier path though, isn't it?

Mr HOLMES: It is an easier path, but they have got to make their moral judgments about whether they have performed their role appropriately, and we find that there are instances where in fact they do that.

(The witnesses withdrew)

(Short adjournment)

KATE DYER, Deputy President, Nurses Registration Board of New South Wales, and

IRVING WALLACH, Barrister, Chairman, New South Wales Nurses Tribunal, affirmed and examined:

CHAIR: Do either of you wish to make a statement first of all?

Mr WALLACH: No, I think I would probably best assist the Committee by taking questions and then possibly summing up or addressing you at the end.

CHAIR: Ms Dyer?

Ms DYER: I am aware that the board has actually made a written submission or written response to the questions. I am just happy to talk to that and take questions as they come.

CHAIR: We have a copy of the submission, number 54.

The Hon. ROBYN PARKER: Could I ask the witnesses perhaps what they see as their responsibilities?

CHAIR: Would you like to make any comment on that?

Ms DYER: Certainly, I would like to respond to that. The board certainly plays a role in looking at conduct. Its primary role, of course, though is that of protecting the public and providing nurses who are hopefully safe in caring for the public. We are constituted under the Nurses Act at present, which is 1991, and hopefully soon to be a new Act, and our role and responsibilities are responsibilities are obviously in accord with our function. With response to complaints handling, we have no jurisdiction whatsoever with regards to investigation. What we do have is a consultation process that works hand in hand with the Health Care Complaints Commission. So no matter where a complaint may come from and end up at our conduct committee meeting, that is done in consultation with the Health Care Complaints Commission.

CHAIR: Do you have anything to say at all about how you observe the systems operating within the Department of New South Wales Health concerning complaints?

Ms DYER: I think that that is a difficult question for me to answer on behalf of the board, given that most of the information that we look at or the complaints we deal with are about individuals. If, in fact, there were information or allegations or just something that arose about the system in which the complaint had been dealt with or about system errors, that there was something we were notified about, then clearly through whatever process or pathway that has taken, we would normally notify the director general of areas of concern if it were about system issues, either within that complaint itself or the process by which that was being undertaken.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: One of the previous incumbents of the Medical Board said that his main job was to deal with "the mad, the bad and the sad". Would you see your job at the Nurses Registration Board being something similar to that?

Ms DYER: No, actually I would not. I do not believe that the board would perceive that. We have mechanisms through our health committee, our impaired nurses tribunals and panels, where we are able to provide support which is not disciplinary and not punitive for clinicians who, for whatever reason, may need that extra area of support. Our disciplinary procedures are through the tribunal following investigation through the Health Care Complaints Commission. So I would not perceive it that way, no.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: So you would get a panel basically to deal with "the bad, the sad and the mad". The bad is presumably dealt with by the disciplinary tribunal, but the mad and the sad, or those with alcohol addiction or mental illness problems, to put it perhaps more professionally, they

would be dealt with by the impairment panel and would their registration be impaired or would they be tied to a mentor or something for a period--

Ms DYER: Yes, they may have--

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: --and then released after a period?

Ms DYER: The impairment panel has the ability to put restrictions on practice. That may be monitoring, simply monitoring somebody's medications or their ability. That would be the impairment panel.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: So you do actually have a similar function to the Medical Board in looking at impaired practitioners and trying to get them back to work and trying to not have them deteriorate into a disciplinary or a bad situation?

Ms DYER: Yes, absolutely, and we very much aim not to have that happen.

The Hon. PATRICIA FORSYTHE: Can we just cut to the chase on Camden and Cambelltown about which we have been hearing today. This morning there was a suggestion that nurses had gone to the Nurses Registration Board seeking to take their concerns about practices that they had seen and had not been adequately dealt with.

Ms DYER: I would have to take that on notice and get back to you. I am not in a position to actually know whether that is the case. I am unaware of it as the deputy president of the board and as a member of the conduct committee. So I will take that on notice but I am unaware of that that has actually been the case.

The Hon. ROBYN PARKER: What is your understanding of what nurses are saying in such a situation?

Ms DYER: There are ways in which anybody can make a complaint to the board, whether that be a member of our general public or a registered nurse, an enrolled nurse or a registered nurse authorised to practice. That is usually is within a written submission, notifying the board that is there is an area of complaint or concern. From that point it goes through to the conduct committee which, with the HCCC, would look at that and decide on where that would go from there or via the HCCC to the board.

The Hon. PATRICIA FORSYTHE: Over the years there have been various allegations made about medical practice at Camden and Campbelltown which have from time to time raised issues about standards of care by nurses. Has the Nurses' Registration Board done anything, taken any action, got involved since they became aware of concerns about standards of practice in hospitals?

Ms DYER: I am not actually – sorry, can I just get you to clarify that – I am not actually sure what it is that you are asking?

The Hon. PATRICIA FORSYTHE: Well, there has been a suggestion that some of the nurses lacked, were not interested in following up on education, training that was being offered, that their stand of provision of care was less than adequate, by other nurses, and that is part of the nature of the complaints.

Ms DYER: And the question is?

The Hon. PATRICIA FORSYTHE: I am interested to know, does the Nurses' Registration Board have a role in helping to correct some of those issues of professional standards at a hospital where it is being alleged that there is a concern about professional standards.

Ms DYER: Can I actually answer that in part A and part B and the reason I would like to do that is that if there are specific complaints about specific individuals, then they will come through the Board, either via an individual complaint or through the Health Care Complaints Commission. I am unable to talk about

those individual cases or whatever because I believe that a lot of those are probably already with, you know, the Health Care Complaints Commission, but certainly on a much more sort of overall thing, the Board works very hard at actually getting information out and about about standards of practice and we have brought in some things that you may find useful at a later point. Things like professional conduct books that talk about some of the cases that Irving has been intimately involved we.

We put out something called Board Works which has code of conduct, professional practice guidelines, it talks about cases that have come up and have not, the sorts of things that provide people with avenues about information, where to go, who to speak to and what the process is and where they might actually go to get support if in fact, you know, standards were falling down in an area and how to go about that.

Every new clinician, every new registered nurse on registration is actually given a Nurses' Registration Board port folio that contains all of that kind of information about notifying complaints. The NSW Nurses' Registration Board also does accreditation of courses and also does accreditation of hospitals and I apologise to the Board because accreditation might not be quite the right word but we do have hospital inspections that occur where areas where our enrolled nurses are undertaking training, where our undergraduate nurses are undertaking clinical practice and where are student midwives – as they are called at the moment – are undertaking practice.

Those sorts of hospital inspections look at a range of things and make recommendations in a-

The Hon. PATRICIA FORSYTHE: When was Camden and Campbelltown last the subject of such investigation?

Ms DYER: I will have to get back to you about that, I don't know the last time but I am aware that as a result of the recent difficulties in that Area Health Service the Board has brought forward its next run of hospital inspections, so I can certainly provide you with further information about that.

CHAIR: You would normally do a routine inspection say every three years or every five years?

Ms DYER: I am not actually exactly sure that I can give you how many years but I think it is about every three years but I will actually get back to you about that.

CHAIR: If it was three years and you have another one coming up shortly, the last one presumably would have been about two years ago.

Ms DYER: I will have to get back to you about that, I would not be comfortable making –

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Is it only nurses who are currently in training who you do the audit of quality control or do you have update obligations to remain registered, do they have to do a certain amount of training hours –

Ms DYER: So you are talking about credit points?

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Ongoing education.

Ms DYER: At the current time the Act does not require that for the purposes of a practising certificate, ongoing registration, that you provide X amount of assurances that you are competent or that you have attended X amount of -

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: So currently once you are registered you stay registered until you die as long as you pay your duties, is that it?

Ms DYER: Yes, I think that is a fairly broad of putting it because accountability comes back as part of our Code of Practice where it is clearly stated that each clinician, each individual registered nurse or enrolled

nurse is accountable for ensuring that they are both competent –

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You are not actively managing that at an individual that at an individual level?

Ms DYER: No, that is correct.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Nor an obligation for retaining level?

Ms DYER: That is correct.

The Hon. AMANDA FAZIO: I was just going to ask you, we have heard some evidence this morning where after a nurse had had discussions with a doctor about patient treatment, the doctor then put in a complaint about the nurses' behaviour. Are you aware of any cases ever going that far that they have reached the Nurses' Registration Board when the nurse involved then tells you that because of their raising concerns about patient care and making complaint about that, that they in fact have been accused of all sorts of things so that they actually end up in front of your Board?

Ms DYER: The nurse?

The Hon. AMANDA FAZIO: Yes.

Ms DYER: I am aware of that. I have been a Board member and a member of the Conduct Committee Meeting only for three years but I certainly can get back to you with answering, you know, that question. I am personally not aware of any example of that but I would need to get back to you.

CHAIR: You might like to just flick pass that to the Tribunal. Have you been aware of such–

Mr WALLACH: I must say over the years my overall impression is that there has been an increasing preparedness on the part of individual nurses to report and to report on matters that they consider to be important disciplinary issues. I am not aware of any one individual case where it has been alleged that a doctor, a medical practitioner has warned off as it were, a nurse.

The Hon. ROBYN PARKER: Just in your submission, you note any matters that arise concerning systems failures during the course of a hearing regarding conduct of a nurse that may be referred to the Director General. I just wonder what determines what is referred and what is not?

Mr WALLACH: Sorry, is that addressed to me or Ms Dyer? Look I must say, I am not in a position to do that because the Tribunal acts at the end of the chain when complaints are referred up to it.

CHAIR: I understand you do not refer that one back.

Mr WALLACH: That is right.

Ms DYER: And the time that we might be aware of systems errors would be at then end of the investigation process by the HCCC because the process is notification, investigation through the Health Care Complaints area and then referral back to the Board with their outcome and their recommendation. So where we may identify that there were systems errors, then the Board would do a variety of things, but one of them would include notification of the Director General that there were systems issues identified in part of this complaints process.

The Hon. PATRICIA FORSYTHE: You referred earlier to inspections on a regular basis. You said it was probably about two years ago –

Ms DYER: What I actually said was I would need to get back to you on that.

The Hon. PATRICIA FORSYTHE: In relation to last inspection, obviously it is relevant as to what the date of that is but I would be very interested to know whether there were any adverse comments made about Camden/Campbelltown Hospital?

Ms DYER: As I said, I would need to get back to you about that.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Did you audit the training delivered in hospitals?

Ms DYER: The facilities are audited. With regards to, you know, is there appropriate library area, is there appropriate people around for education of the student.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Do you audit how many hours are delivered and when? I gather some of them in the hospitals the only formal training is hospital placements of nurses enrolled in courses, is that right?'

Ms DYER: That is correct. It is university training and the curriculum for the university courses is accredited by a committee through the Nurses' Registration Board. The hospital investigations or hospital, you know, our nursing officers go out and look at the environment. Is it a suitable area? Is it going to be able to meet student needs? So it is much more about looking at the process by which the environment will provide a learning environment and that there is the appropriate facilities rather than the care that may be being provided for a range of patients at that time.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: But, do you look at whether those courses are actually delivered to the nurses, as in if they are so tight on the roster that they don't get to their training session?

Ms DYER: No.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Or if they don't have a mentor who teaches them correctly, you can't control at that level?

Ms DYER: No, and that is very much about university control.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: The universities are in charge of that control but once you have accredited their programs –

Ms DYER: That is correct.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: So who do you think broadly speaking is responsible for the standard of nursing in New South Wales?

Ms DYER: I find that a very difficult one to answer being here on behalf of the Board. Whilst I could tell you if I was Kate Dyer, I find that my answer on behalf of the Board is that each individual clinician is accountable for their practice.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: At some sort of level they are but obviously everyone is responsible for their own actions but at some level in the bureaucracy, be it the hospital, the university, the Nurses' Registration Board or somewhere there must be the person, the institution that has the key responsibility. Which group do you see as having the key responsibility? I mean, universities do presumably have undergraduates, but beyond that, once they have graduated, who then?

Ms DYER: Look, I am not absolutely sure that there is one key person or one key body or one key authority. I believe that our Area Health Services or the employer has a role in ensuring that they are

employing somebody who is able to meet their specific needs in their specific area that they have been employed in. I think that each individual clinician has an accountable - has the role of actually saying Look, I am appropriately prepared to take this role. I think that on behalf of the Nurses' Registration Board, we certainly have a role in accrediting courses to a standard.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: But you don't have the key – you are answering me as in your official position, not as a private citizen?

Ms DYER: That is correct.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: And you are answering me that the Nurses' Registration Board does not have that overall responsibility, is that what you are saying?

Ms DYER: On behalf of the Board I would believe that we have a role to play but not the key role for your specific question.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: In this case I probably should not ask you for your private opinion?

Ms DYER: No.

CHAIR: I think we have canvassed most issues.

The Hon. PATRICIA FORSYTHE: I was going to ask about the nurses and clinical outcomes. In the system they see issues that could be changed. How are they empowered to effect that change?

Ms DYER: I don't know that I can answer that question for you other than to say that as far as the Board is concerned they have an avenue that they can notify the Board that there is areas of change or problems that they have experienced and that would certainly be taken on board but as far as our Act is concerned, it is not something that we have within our Act that can allow us – we have no provision for investigation.

CHAIR: Mr Wallach, you indicated as a barrister you would like to conclude with a summing up. I might just say, you might just like to quit while you are ahead.

Mr WALLACH: I was going to suggest perhaps that I might wait till my solicitor gets here but it is probably not what you want to hear. I suppose I have got nothing to add and I thank the Committee for its time this afternoon.

(The witnesses withdrew)

(Short adjournment)

ANNE SCAHILL, Deputy Registrar, New South Wales Medical Board, and

BRIAN MCCAUGHAN, Cardiothoracic Surgeon, President, New South Wales Medical Board, sworn and examined:

CHAIR: Would you like to make an opening statement about your role at the board and how you see your function in the light of the whole work of New South Wales Health?

Professor McCAUGHAN: I will be brief but just to ensure that the Committee members are aware what the New South Wales Medical Board is. We are there and our sole role is the protection of the public. We are not the AMA and we have to emphasise that often to our practitioners. We are not the AMA we do not represent doctors but we are there to protect the public of New South Wales and to maintain standards of care. We do that through four essential functions, that is the registering of medical practitioners and pathways resolved around conduct, which are bad doctors, impairment mental health program, which is about sick doctors, and, lastly, since the year 2000, amendments to the Medical Practice Act, the performance pathways which is about doctors who are not performing to an adequate standard. So we are there in those pathways and we are happy to answer questions related to our specific role.

CHAIR: Anne, do you wish to say something?

Ms SCAHILL: No I have got nothing to add to that.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Do you deal with complaints against individual doctors and could you give details of the procedures in that case?

Professor McCAUGHAN: Yes, all complaints or notifications about individual medical practitioners in New South Wales are dealt as according to the law in conjunction the Health Care Complaints Commission. So any complaint that comes to us about a medical practitioner in New South Wales or goes to the Health Care Complaints Commission directly is shared at a weekly meeting. At that weekly meeting all complaints from the previous weeks are assessed as to how they will be handled and there is a number of different ways they can be handled. They can go to formal investigation or they can go through about eight different processes, the bottom one being that that assessment committee, which consists of the medical director of the Medical Board, plus representatives from the Health Care Complaints Commission, plus the conciliation commissioner, might say no further action. They might be referred to other--

CHAIR: Could I just ask a clarifying point?

Professor McCAUGHAN: Certainly.

CHAIR: Did you say say all complaints that go to the HCCC come before a joint meeting?

Professor McCAUGHAN: All complaints concerning medical practitioners. I can refer to you our annual report, of which I believe you have a copy. There are roughly 1200 individual complaints about medical practitioners annually. Given the profile of the Health Care Complaints Commission in the past, the majority go directly there. We see those and they see all the ones we see and a decision is made at that weekly assessment committee as to the process. The New South Wales Medical Board has no powers of investigation. So if it is decided a formal investigation is required, that must be done by law by the Health Care Complaints Commission.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Is the Medical Investigation Tribunal's function now taken over by the Health Care Complaints Commission?

Professor McCAUGHAN: No, the Medical Tribunal is part of the District Court of New South Wales.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: The Medical Investigation Tribunal?

Professor McCAUGHAN: I am unaware of the Medical Investigation Tribunal.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Years ago there was a Medical Investigation Tribunal and a Medical Disciplinary Tribunal in the old days.

Professor McCAUGHAN: There is a Medical Tribunal which is part of the District Court of New South Wales. Reg Blanche is in charge of that and that is part of the District Court and we fund it, and your fees as well, Dr Chesterfield-Evans, we fund it but we have no particular influence over it at all. When there is a case goes before it, the Health Care Complaints Commission acts as the prosecutor, not the Medical Board.

The Hon. PATRICIA FORSYTHE: Does the Health Care Complaints Commission have any bearing on your decisions about how the complaints should be dealt with?

Professor McCAUGHAN: No, it is the nature of the complaint and the severity of - it is assumed that everything in the complaint at first part is true. Therefore, we have a threshold for that. We do not say "This can't be true"; we assume it is true on anything we are told, from any source. It cannot be anonymous, although if we received an anonymous complaint of such serious moment, we may act as the complainant, the Medical Board.

CHAIR: Have you succeeded over the years in breaking down the old boys' club network that we have had complaints about in the past?

Professor McCAUGHAN: Not as successfully as I would like. I guess a measure of it is that I am the president and I would hardly be described as one of the old boy network, although I have got a dark suit on, which was probably a mistake.

CHAIR: And you probably went to the right school?

Professor McCAUGHAN: No, I went to Cronulla High School and I am very proud to say I am the last doctor to have come from there. So no, I did not go to the right school. Well, I thought I did. So we haven't got it as much. It is much more open and one of the ways we have done that is through our impairment program, where we have got people to identify, again, not as much as we would like, and there is an interest in whether it should be mandatory reporting if you know about an impaired practitioner and the board keeps revisiting that.

The Hon. PATRICIA FORSYTHE: You meet with the HCCC. Does the Nurses Registration Board also meet with the HCCC?

Professor McCAUGHAN: I have no idea. I presume so. We have a bi-annual meeting with my equivalents in the physio board, chiropracty, pharmacy, nursing, and it sounds as if the same process occurs. I cannot attest to the exact measure.

The Hon. ROBYN PARKER: With the reports that come to you. Do you have it chartered where those reports come from, what area the complaints come from?

Professor McCAUGHAN: Anne might be able to tell you. I cannot tell you in percentage terms. The vast majority come from individual complainants, patients.

The Hon. ROBYN PARKER: Are they patients or are they working within the system?

Professor McCAUGHAN: No, the majority of them are from patients but we have some from CEOs of organisations, from general managers. Part of our performance pathway, which is a key way we are moving ahead on the under-performing doctor, is not trying to allocate blame for something that may happen. It may

be a performance issue has come particularly from medical administrators who have had long-term problems with performance. The majority come from individual complainants who are patients or relatives or carers of patients and they are dealt with exactly the same way, provided we have approval from the patient for that person complaining on their behalf.

CHAIR: Ms Scahill, do you find that you have a greater percentage of complaints coming from any particular area health service?

Ms SCAHILL: I could not comment on that without specifically looking at the statistics.

The Hon. PATRICIA FORSYTHE: Do you look up the statistics, do you make yourself aware as to whether there is a systemic problem in an area?

Professor McCAUGHAN: Yes, we do. One of the things we have done with the previous Health Care Complaints Commissioner specifically was to address system wide issues. Our main responsibility, we accept, is about the bad apples, no doubt at all, but we have taken action together, although I have no legislative framework to do it, but I have informal networks, and we also have through the HCCC took - and correct me if I am wrong - section 59 or somewhere in the legislation we can do to say here are some system problems we are worried about. Can I give you some examples?

Sometimes we get an individual complaint which may go down a conduct arm or a performance arm. One matter went down a performance arm. It would appear that an anaesthetist was not performing adequately. The assessment of performance is on site. We don't do an airy fairy paper thing; we go and look at them. It was quite clear that the hospital at which he worked had issues around the system. So that was taken up with the department. So we don't buck from system issues, but we similarly quite firmly believe you cannot use that as an excuse if their are personal issues. So we do identify system issues.

The Hon. AMANDA FAZIO: The focus of our inquiry is on complaint handling procedures and whether the system that we have got in New South Wales in the health care system is actually doing what we want it to do. We have been looking at systems used elsewhere and it seems that this no blame model within complaints of standards of care that aren't adequate seems to actually result in more incidents coming to light and less adverse action for the patients. So the New South Wales system seems to be pursuing a system of blame where we punish people.

Professor McCAUGHAN: Yes, clearly, and maybe if you give me a little bit of space I think I will get to the answer, I will not obfuscate, but when I first became president of the board 30 percent of complaints at the weekly meeting, over 30 percent, went for formal investigation. That meant they were put in a process that that the Health Care Complaints Commission investigate. Some of those went for five years and at the end of it, even if everything was right, there was nothing to be done. There was no formal action. We took the view that the best time to get a good result for everyone, the complainant, the practitioner and the system, was to deal with it upfront and in a short timeframe.

CHAIR: Within five weeks?

Professor McCAUGHAN: Yes. So we set up as part of under performance arm, previously under conduct before we had the performance arm, a thing called a section 26 - again, it is just words - where we got the doctor's response to the complaint. Now, often it is about communication. 80 percent of our complaints revolve around communication problems and the perception of the patient, or their carer's frequently, of how they were treated. So by doing that, we have involved ourselves in the no blame idea, that the doctor apologises and says, "If it was perceived that I had a bad day, I might have", and that goes to the complainant. On the other hand, we cannot let the reckless, the unethical, the wilful or the criminal go in a no blame culture. There are some doctors who have to be dealt with through a strict conduct arm. You cannot sleep with your patients. We cannot go into a no blame culture and sing Kumbaya or something, they have to be dealt with down the conduct pathway. But we have taken the complaints for investigation out of the low 10 percent. Not that the 20 percent is not being dealt with, but it is being dealt with in a timely, relevant way.

Other commissions of inquiry are on at the moment and they see that we have said there should be more of this alternative resolution in a timely way to avoid those problems. So we are part of the general quality movement, but recognising we have to direct those serious issues.

The Hon. AMANDA FAZIO: Thank you, professor. From what I was aware of, I did not understand you were doing that much of that sort of negotiating and alternative dispute resolution.

Professor McCAUGHAN: I have had the pleasure myself of undergoing conciliation of an issue where I went through it with a son and daughter of a patient of mine who had an unfortunate outcome and learnt a hell of a lot. That in fact it was dealt with near the time of the incident. We all had good memories of it, so that it was not five years when you just could not possibly remember actually what happened that day.

CHAIR: We had evidence earlier from some nurse practitioners that when that had taken matters of clinical practice up with medicos they were treated very harshly and they were treated as if they were ignorant and as if they were only "nurses".

Professor McCAUGHAN: We do not have a lot of direct complaints from nurses. We have had a number that stick clearly in my mind. One of which was a nurse who had gone to a hospital as a agency nurse in the theatres and identified an eye surgeon with a tremor. Now, he did not develop the tremor that day but she raised the complaint. That doctor is no longer practising intraocular surgery. If a nurse brought us a complaint a doctor, that is dealt with as is any other complaint. We do not have that belief, what you said they said about nurses, we think they are actually totally integral to the system and when we have done our performance reviews, we go to the hospitals, we don't just interview the doctor's mates, we interview the nurses he or she works with and we interview the administration as well, and their patients.

CHAIR: Do you consider there is a culture of openness on issues of complaints within New South Wales Health?

Professor McCAUGHAN: No.

CHAIR: Do you want to elaborate?

Professor McCAUGHAN: Well, I think it could be improved is what I suppose I mean. I think we have to move on. There has been great interest in open disclosure, as you may or may not know, in conjunction with Standards Australia, Professor Baraclough's quality committee put together standards about open disclosure, ranging from the whole gambit of things, you know, from getting a urinary tract infection from putting a catheter in, all the way through to death, so we can do a whole lot more. You have got to be very careful with open disclosure, with who does the open disclosure the people themselves have to be very well informed to know what it means.

Unfortunately sometimes the complaints that come across our desk is still someone openly disclosed about something they have no knowledge of and that just causes problems right the way down the track. So open disclosure set as a standard, and there are standards now, it was voted on at Standards Australia of how open disclosure should work. It could always be improved.

The Hon. CHRISTINE ROBERTSON: Can I just ask, no knowledge of the issue or second hand knowledge?

Professor McCAUGHAN: No specific knowledge on the action, of what should have happened if we had perfection in the medical care. You must have a certain level of knowledge to be able to speak openly. You also need what many of us lack, medical practitioners, the communicative skills to impart that. So, you are often helped if you have an issue you want to talk to the relative about, by having someone else with you who may be able to interpret for them some of the nonsense we talk.

The Hon. PATRICIA FORSYTHE: Amongst one of these submissions that we have received, there

was a suggestion from one of the nurses that she was sufficiently concerned about the whole system, a lot of problems within the hospital and attempted to take that to the HCCC but they suggested they would only deal with individual cases, they cold not look at a system problem. Is that still the situation and is there any scope for someone to come forward in any way about a broader issue system problem?

Professor McCAUGHAN: I cannot answer what the HCCC can or cannot do. We can only take individual complaints. One of the great advantages of the performance arm is then we can look at the doctor's whole practice. Previously you could only look at that one complaint.

In terms of systems issues, generally, you certainly would be more aware of than I, of what has been going on with the review of the Health Care Complaints Commission, what has been in the newspapers, what the Acting Commissioner has put forward and presumably what we will hear subsequently from Brett Walker SC. So, clearly there is a plan to have a separate group which the Board supports, to have a look at the system problems, to separate those processes, so all of us focus our skills on what we are meant to do.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Presumably your performance plans for individuals will be slotted in to some sort of relationship with ICE or the new revamped ICE which is presumably going to be another wing of the HCCC?

Professor McCAUGHAN: No, super ICE as some people are calling it, which I think is a wrong thing to do, will not be linked to the HCCC. It will be, in what I am reading, and this is as an individual, not as the President, I am reading it will be a separate commission and I will have the opportunity as anyone else will, to refer an issue to them, as you said, the nurses could have done about a system problem. I welcome it, because in our dealings the secretariat and the members of the Board, we do identify issues that are system issues and we welcome the opportunity to have a body separate to the Department of Health, separate to the Department of Health, that will be able to take system issues and make a notification. So we welcome that, if it does proceed, we will look forward to Walker's report.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You said that you were responsible for the standard of doctors, do you foresee the day in which doctors have to have certain mandatory ongoing training? If so, who would supervise that, the colleges, the universities or yourselves?

Professor McCAUGHAN: We have put our toe in the water. It would not have been the legislation, with due respect to those who write the legislation, but the year 2000 Amendments to Medical Practice Act made it mandatory for doctors to report to us on an annual basis, whether they did continuing professional development of CME – continuing medical education. It was otherwise silent on it in terms of – they only had to tell us they did not do it. There was no action that followed. So it would not have been quite our perspective it but there are other competing forces lobbying Government in how it was written. So we have a requirement every year that the doctors tell us whether they are doing continuing professional development. They have the opportunity of using an approved college program and the only reason we would accept that is because the Australian Medical Council now is in the process of accrediting all colleges. Part of that accreditation is the adequacy of the CPD programs.

So we do not want a CPD program that consists of going up having a good feed and a sleep in the corner and signing a book as you leave Dr Evans. We support that and we wish that would go further and if you look at the New Zealand model, they actually have gone a step further and so are other jurisdictions. We believe it is our responsibility to monitor it. It is not our responsibility as a Board to know what standards each and every practitioner in different specialties are and we will rely, in the absence of any other evidence, that the colleges are doing that.

If it became apparent to us that colleges did not have successful CPD, we would not accept it. An individual now who does not believe his or her college has an appropriate program, can give us a one pager of the things they have done for CPD next year. In the last two years, 4 per cent of medical practitioners have indicated that they do not do continuing professional development in the preceding twelve months and they plan to stay in active practice for the next twelve months. If this occurs currently over three years we write to

them and ask them why. We have no legislation to back that but we believe that is part of our responsibility. In fact we believe we should be on the front foot of that.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Are you saying then that you assume the colleges are doing adequate continuing professional development – I think that is what CPD stands for?

Professor McCAUGHAN: Yes, continuing professional development.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Are you assuming that the colleges are doing that or do you have some way of monitoring the colleges are doing it?

Professor McCAUGHAN: We are a member of the Australian Medical Council, that is the New South Wales Medical Board, I am on the executive of that, we are part of the accreditation program. Four of the colleges have been through it and one of the specific parts – they are looking at their whole training program – and one of the specific elements they are looking at is the adequacy of continuing professional development, whether it is mandatory, the nature of it, how it relates to your ongoing clinical performance, your competency as well as your knowledge base.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: As far as doctor numbers are concerned, there is a short of doctors in some areas of the State and the evidence we have had from Campbelltown was the number of specialists per head of population, which presumably means per head of patient population, is much lower. Does the Medical Board take an interest in this and if so, what is that interest and so successful, what has it done about it?

Professor McCAUGHAN: I have just come from a meeting all day with 150 people around Australia looking at areas of need and how to more rapidly get appropriately more qualified practitioners into areas of need. Area of needs, different things to different people. Queensland Rural Health Service, all of Queensland rural health, bigger than Texas, runs on overseas trained doctors of all different forms.

In New South Wales, in major teaching hospitals there are areas of need in some disciplines like intensive care. We are not just talking about outer peripheral areas, out of metropolitan areas or country. The Board of course has an issue in workforce, although it is beyond our unique control unfortunately because of its impact on the standards of care and the protection of the public. So we take a very active role in the workforce issues. As part of the yearly subscription and form you fill in, we ask the members, it is not compulsory but we get a very high yield, to fill in how their practicing, how many hours, how long they are going to practice and all that information is collated in a de-identified way so that we can make plans about it. The Board is vitally concerned as it impacts on practice and the quality of care to the patients.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Can you influence the colleges in the number of graduates they produce?

Professor McCAUGHAN: Not directly. ANC –

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Do you try to?

Professor McCAUGHAN: Yes. Through the ANC – colleges are a national program. The Australian Medical Council is national. There is a joint meeting on specialist training between the CPNC, which is the Council of Presidents of Medical Colleges and the ANC. That is how we work.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: And with doctors trained overseas, there has been quite, well controversial I suppose in the sense that Australian doctors trained overseas would like to take some of these areas of need positions and convinced that they have had more training and feel that the Australian colleges are obstructing their efforts, it would rather simply recruit overseas. Do you take any position on that?

Professor McCAUGHAN: I think they all have to be assessed, that the program is in place. The assessment I would hope following today's workshop, which is continuing at the moment, in terms of solutions, may make it more straight forward for all overseas trained doctors, whether they are Australians here who are trained overseas or ones currently overseas, to identify the pathway, to facilitate, particularly in area of need. We have to be careful, it is the political issues that occur at times, there used to be a favoured nation policy for doctors and they used to fly over on jumbo jets from South Africa and register when activity was over there. They are not the sort of doctors we want. We want doctors who want to come and live here, work in the community and unfortunately most of the areas where the major area of need is, Australian graduates, Australians who have graduated from Australian and New Zealand universities would appear not to wish to work there. That is the major problem.

CHAIR: A senior pediatrician has commented that the HCCC is so politicized that he despairs of its ability to deliver remedies. What is your thought about the HCCC?

Professor McCAUGHAN: Well, it depends which HCCC we are talking about.

CHAIR: The Health Care Complaints Commission.

Professor McCAUGHAN: I am sorry, I meant, there has been announcements made recently which is quite clearly – by the Minister last week – quite clearly indicating a change in the role of the Health Care Complaints Commission. There are no doubt the Board – it is very well documented – that the Board was concerned with the length of time taking for resolution of two sets of matters. One was minor matters that sat on the books for five years on occasion and there was no resolution for anybody. It was on the doctor's minds, it was particularly on the complainant's mind and by the time it came to resolution there could never be resolution.

The second group that we were worried about as well, because we are there to protect the public, were a group of doctors who we had identified were a risk to the public, so much so that we called a s66 and with two Board members, may well have suspended them and continued to suspend them in the absence of any other evidence and that was a formal process but it is a very informal meeting in terms of the evidence.

We were concerned that some of those were either innocent and should have been out or some in fact were guilty and needed to be dealt with properly. So, we did have concerns with the time lines the Health Care Complaints Commission had. I don't know –

CHAIR: The question was about the politisation?

Professor McCAUGHAN: I have no evidence of the politisation of the HCCC. I don't know if he meant big P or little P.

The Hon. ROBYN PARKER: Currently the board, as I understand it, is inquiring into the problems in Macarthur area mentioned in the HCCC report. I am just wondering how your inquiry is going into that?

Professor McCAUGHAN: The board is not investigating that. As I understand it, a commission with the powers of royal commission is currently doing it. Brett Walker's commission is doing that.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: They are currently suspended from work but they are not suspended by the board, is that right?

Professor McCAUGHAN: Apart from the initial assessment and then it went to the royal commission, they are currently not at the board. They will come back, they have to come back depending what new process has been set up. As I understand it from what the Minister announced last week, and you would all know it as well, a separate group has been set up to deal with the Macarthur issues, a separate group of investigators, clinical staff who have not been involved before, but at some stage, if there is any disciplinary action or performance action, it has to be brought back to a joint meeting of the newly constituted Health Care

Complaints Commission and the board. We will then be involved.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: So it is pending?

Professor McCAUGHAN: Well, it is pending.

The Hon. ROBYN PARKER: Are you aware of any others in that situation as well?

Professor McCAUGHAN: You mean other than Macarthur?

The Hon. ROBYN PARKER: Others that are subject to a performance review?

Professor McCAUGHAN: Than Macarthur?

The Hon. ROBYN PARKER: Yes.

Professor McCAUGHAN: No.

The Hon. AMANDA FAZIO: I do not have much involvement in the health care system apart from being a consumer, but my understanding is that one of the consequences of the delays in the HCCC investigating cases where doctors have been involved in some sort of critical incident and there has been a bad patient outcome, is that during the years it takes the investigation to go on they continue practising. If they have not had another critical incident in that period of time, then that almost wipes the slate clean for that incident, and, therefore, even if it was fairly serious, that no action can be taken by the Medical Board because they have for the last three years, for example, been out there operating as a clinician satisfactorily. Is that the case?

Professor McCAUGHAN: No. But it is the case that the length of time makes problems and I support fully, and I was pleased to see that the acting commissioner has indicated that it is his wish that they will have the Macarthur team, a backlog reduction strategy team which will get rid of the long waits, and moving on all new complaints a 12 month timeframe maximum that they will be dealt with. We have taken long-term cases to a tribunal and I have to tell you that in one case, I believe appropriately, the judge said this would have been of consequence if it had been brought to my attention in a timely way and took action all to do with natural justice and things above my head.

So the thrust of what you are saying is exactly what concerned us in terms of how long it was taking to investigate practitioners, but the fact that he or she has had a clean slate for three years would not alter, it is on the strength of the case and the severity that we would act. We were used to dealing with them at three years to be quite honest, because the period had gone out so far.

The Hon. PATRICIA FORSYTHE: In relation to your own position, how long have you been president of the board?

Professor McCAUGHAN: I think she said two long. Four years.

The Hon. PATRICIA FORSYTHE: Do you attend the weekly meetings?

Professor McCAUGHAN: No. The first thing I did in becoming president was appoint a full-time medical director, who is a medical practitioner with experience in administrative issues as well, and what she has brought to that position is, rather than a rotating person, a consistency to assessment and that has been the successful of it. Behind her we have our secretariat which is clearly moving in this direction about the reckless, the wilful, criminal and unethical people. But we are moving, as you have suggested, on the broad front of the system issues as well, but we have no legislative framework to do that. We can only do that because we take that to Government, whereas we are the Medical Board of the Ministers of Health. My appointment is through the Minister. We report to the Minister.

The Hon. ROBYN PARKER: You mentioned at the start the practice in New Zealand and others. I am aware that there is a different registration system in each State. I just wanted you to make a comment on the registration of doctors in New South Wales as opposed to other States and whether that could be improved in your view?

Professor McCAUGHAN: We believe that there should not be different systems. New South Wales has led the charge for national registration. That is on AHMAC's agenda, the Health Ministers of Australia. There are subtle differences, many of which have been ironed out, some of the creases anyway, over the last two years since mutual recognition was brought in, despite some of the other States. Some of the other States are incredibly protective of their miniscule medical boards, something we don't understand. We have 25,000 registrants here. Some of them have hundreds or thousands at the most. So we believe it should be a national registration. We do believe there are elements of ours that are better than others and we have led the way in performance and other States are now monitoring it. We do believe that doctors should not investigate doctors. In Victoria the medical board members investigate the doctors. We do not believe that is appropriate. We clearly wanted a new model at the commission but we do not believe doctors should investigate doctors.

The Hon. AMANDA FAZIO: Can I ask you following on from that, seeing that we do have State by State registration, is there adequate information sharing from State to State in terms of any disciplinary proceedings that are pending or finalised against doctors?

Ms SCAHILL: There is a national computer system which is referred to as the MCMR and all the States have access to it. All the States have input into that, flagging practitioners who are subject to disciplinary proceedings, showing up conditions that are presently on a practitioner's practice. That information is shared and the AMC at the moment is managing a process to improve that information sharing, I guess as a prelude to a national system of registration.

Professor McCAUGHAN: And when anyone would apply to come by mutual recognition to us from another State, they may have a flag, well, we would ask and all we would do with the flag is identify if they fit in with the conditions we would put on them in New South Wales. This particularly relates to impairment.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: If doctors shouldn't investigate doctors, who should? Surely the people investigating should have knowledge of what good practice is.

Professor McCAUGHAN: No, that is a different issue and that is a matter of having appropriate peers to go out and look at the clinical issues. We certainly shouldn't have people looking at clinical issues, but most of the issues are not actually clinical. They are about communication, they are about how things were handled, and doctors are probably not the best people to do that. There is a few of us, Arthur, I agree, but overall doctors are probably not the best people to do that.

(The witnesses withdrew)

(The Committee adjourned at 4.30 pm)

REPORT OF PROCEEDINGS BEFORE

GENERAL PURPOSE STANDING COMMITTEE NO. 2

INQUIRY INTO COMPLAINTS HANDLING WITHIN NSW HEALTH

At Sydney on Friday, 12 March 2004

The Committee met at 9.30 a.m.

[Published by resolution of the Committee, 12 March 2004]

PRESENT

Reverend the Hon. Gordon Moyes (Chair)

The Hon. Dr Arthur Chesterfield-Evans
The Hon. Amanda Fazio
The Hon. Patricia Forsythe
The Hon. Robyn Parker
The Hon. Peter Primrose
The Hon. Christine Robertson

Evidence in Camera by **YVONNE QUINN**, Registered Nurse, affirmed and examined, and

MARY VALERIE OWEN, Registered Nurse, sworn and examined;

CHAIR: I will give opportunities for you each to make a statement and then we will question you. You understand that although there are no media present here we may publicise your comments later?

Ms OWEN: Yes.

CHAIR: Would you like to make an opening statement?

Ms OWEN: I will start, if that is all right. This statement I am about to make refers to my experiences surrounding the concerns I expressed about the risk to patient care at Campbelltown Hospital which was part of the Macarthur Health Service and part of Sydney South West Area Health Service. Without re-entering the details of the particular case in January 2002 in my endeavours to protect the health of a patient about to go to theatre I had allegations of bullying, harassment and intimidation laid against me by an anaesthetic CMO.

There was an investigation into this matter which was proven to be fundamentally flawed, in that it lacked procedural fairness.

I submitted a written complaint following two verbal complaints expressed by me to Katherine Gibson, the Quality Coordinator, regarding the anaesthetic CMO's canvassing support for her own interpretation of the situation. In the report I named staff who had been approached for support in this matter by the CMO.

On the Friday of that week, 19 April 2002, I was called to the General Manager's office, Ms Jennifer Collins.

On the previous day, 18 April 2002, Yvonne Quinn, submitted an incident report expressing her concerns about the clinical competence and behaviour of the doctor, the same anaesthetic CMO. She was also treated to the same experiences on 19 April. We were told that we were being stood down, given that there were serious allegations made against us. We were not to report to duty. We were not to contact our colleagues either socially or with regard to work related matters. We were to remain on full pay while the matter was being investigated. Macarthur Health was not forthcoming in relation to requests for basic information about the nature of the charges laid against us.

The time frame of any alleged incidents so that we could interpret and respond in accordance with our basic fundamental right to do so. At the time we were stood down no investigation had been made into the allegations against us. On the day of our suspension a team of senior management, comprising of Jennifer Collins, Robert Mills, Greer Jones, John Kensley and Vicky Weston presented in theatre to inform the staff that we were stood down because allegations were made against me and Yvonne that were so serious as to warrant such action. Neither myself nor my colleagues had any clue about the detail of the allegations made against us or the precise origin of such allegations.

We were prohibited from contacting our colleagues and we learned over time that in the absence of any accurate and concrete statements from management we had been regarded within the rumour mill of the work place as drug dealers, drug addicts, fraudsters, alcoholics, indeed very undesirability personalities; why else would we have been marched off the premises.

We had written complaints against us made and recorded on 30 April and 27 May, bearing in mind that we had been stood down on 19 April. There was a review and investigation of bullying and harassment by a Ms Jan Stowe after we had been suspended. Staff were not appraised of its full purpose and that myself or my colleague were not interviewed nor evidence sought to bring substance to the issues rather than hearsay. Staff were not informed that Jan Stowe, the consultant, whom we were to learn was a personal friend of the general manager would be imparting information about particular individuals to management in the course of this investigation. This review has been found to be flawed by the New South Wales Nurses' Association as well as the HCCC report.

Following the Jan Stowe experience another investigation was undertaken, its terms of reference were as

follows, and I quote from Katherine Gibson "To investigate what need to be investigated".

On May 31, 2002, Katherine Gibson repeatedly informed me that I had no choice but to do as instructed because I was being paid. I had no information about the nature of the allegations, the options available to me, and in fact I felt bullied and intimidated myself. I had no opportunity to discern the realities from the pressure to proceed in a certain direction. I was not made aware of my rights.

This additional investigation took place on 24 June 2002 and was undertaken by Margaret Thorpe, Director of Aged Care, and Vicky Western from Human Resources. The outcome of this report was punitive without justice. My clinical nurse specialist status was removed. I was informed that it was untenable, according to Ms Collins, for me to work in theatre any more. I was offered alternative positions in A and E, maternity, or indeed any area where I had little or no experience.

At a later meeting with Jennifer Collins and the union representatives, Jan Greg and Katherine Sullivan, an offer was made for me to work in Bankstown Hospital. However, this was truly an untenable situation as by now word had spread to many hospitals in the area about the events occurring in Campbelltown and, indeed, both Yvonne and I had been named in meetings in Liverpool Hospital as the nurses involved in the disciplinary hearings.

It was very clear by now that no one in the Macarthur Health Service was interested in following clearly stated guidelines set down by the health department for dealing with matters such as these. There seemed to be nobody prepared to ensure that the policies in place in the Macarthur Health Service were followed. Why have policies, one would ask, given that even our nurses' union were not in a position to protect its members from wayward management teams.

I was by now in poor health and was informed by Katherine Sullivan, union representative, that Jennifer Collins would not allow me to take sick leave and it would be in my best interests to resign or I would be sacked. Left with no alternative I submitted my resignation to Greer Jones on 9 October 2002.

It was at this stage that the union said that if I was willing to sign a deed of release a sum of money would be paid to me by Macarthur Health Service on the understanding that I would not say anything disparaging about Macarthur Health Service or take legal action against them. This was something I would take no part in.

Following nonpayment of my long service leave. I was yet again informed by my union representative, Katherine Sullivan and Jan Greg, that Jennifer Collins had withheld this payment because I had upset her by either writing to or talking to the then Minister for Health, Craig Knowles. As a result of this accusation, which yet again is not based in reality, I did go to meet Mr Knowles in his office on 5 November 2002.

Issues raised at this meeting would later draw concerns about patient care and adverse events which were being ignored by Macarthur Health Service. While policies were in place at this time no one was ensuring their implementation. I took this opportunity to relate my own story to Mr Knowles and my belief that I was being punished for being a patient advocate. Within one week of talking to Mr Knowles all moneys owing to me by Macarthur Health Service were paid in full.

Our struggle to be heard has taken to us many doors and today, 12 March 2004, gets me within the third year of my struggle for justice.

I find it very hard to report to this committee that after all we have been through no protection from malicious and vexatious complaints, misuse of the bullying and harassment policy, that is if you perceive you are bullied then you are, failure to be provided with natural justice, failure to have a fair, impartial and complete investigation and total lack of procedural fairness. That it has left many of the remaining staff in Campbelltown theatre afraid to document or submit incident reports out of fear of meeting the same fate as Yvonne and myself.

It has been a common occurrence for both of us over the last two years to receive distressed calls from staff in relation to events that have occurred that staff need to debrief on and are too afraid to report lest they travel the same road as us. Stories such as continued shortage of staff, which prevents these nurses providing

safe care for their patients, misuse of the bullying and harassment policy, and the filling of senior positions on short term contracts to enable accreditation.

We worked under a management system that was a law unto themselves and was not open to a culture of learning or had any willingness to share information about errors and failures of system. If you drew attention to such issues your days were numbered. Whatever is needed in Campbelltown has not been found yet. The workers on the coal face are still fearful of their position. Compulsory cancelling is now in force, which reinforces a sense of fear and inability to know who to trust.

It is ironic, to say the least, that Yvonne and myself are the two people that are being contacted by the staff in Campbelltown Hospital for advice.

CHAIR: Yvonne, do you wish to make a statement before questioning?

Ms QUINN: I do wish to make just a brief statement. I feel compelled to convey to you people the overwhelming sadness and despair that we feel. We experience this and we continue to on an ongoing basis.

I never set out to a whistle blower. I am just a nurse, and I have been a nurse since I was 17. When I started my training at Royal Prince Alfred Hospital in 1975 I believed, with stars in my eyes, that I was being educated within a system which had a culture of learning and willingness to share and I continued my education. I did an operating theatre certificate, I did a masters degree. I was working on my second masters degree when I was thrown out of the system. Unfortunately I came to realise the academic world was very different from the real world.

It was with those beliefs that led me to have the passion and commitment to pursue what I believed was right. Unfortunately, the pursuit of my concerns led me to being shackled by management and thrown on the scrap heap.

My expectations of the New South Wales Nurses' Association, which I had been a member of since one week after my seventeenth birthday, was that they would be my advocate when I needed them. That they would be my voice when I had no voice of my own. I was to discover that they were, self admitted, a conduit of management. It was very distressing for me and from that point on my experience with complaints handling within the New South Wales health system began and has led me here today.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: This deed of release, you have a deed of release?

Ms QUINN: Yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Which was done between the union and yourselves, I think?

Ms QUINN: No, it was done between the union and Greg Driver of the South West Sydney Area Health Service and offered to us.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You would say that this was fundamentally the union being complicit in giving you the obligation to shut up and a very small amount of money relative to your employment and future prospects?

Ms OWEN: The moneys offered was a figure that the unions informed us could be hidden from the auditors in Campbelltown Hospital.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: It was the maximum that could be given as an ex gratia payment without needing further accountability, is that what you are saying?

Ms QUINN: It was explained to us that the amount represented shift penalties and allowances that we would have been paid had we not been on suspension. Because we were on suspension we were not paid these allowances.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You went back to base rate?

Ms QUINN: However for ten weeks we were left on the roster as if we were present within the work place.

Katherine Sullivan of the New South Wales Nurses' Association made this offer to me on the occasion that I informed her of my resignation. Her advice to me was, "Well, that is a good idea, move on with my life". I said, "Do not misunderstand me, Katherine, I am still going to pursue this". That is when the offer was made.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: There was to extra money apart from what you would have had if you had not been effectively terminated?

Ms QUINN: That's right.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You had no upside in the sense that you were merely signing a hush agreement?

Ms QUINN: We were. We did not sign and we did not get the money.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: This deed of release has been never been signed?

Ms QUINN: No.

Ms OWEN: No.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: It was put to you by the union and management to get that $3241.20?

Ms OWEN: On the basis that we probably would do with some money at this stage.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Yours was the same option?

Ms OWEN: Yes.

The Hon. CHRISTINE ROBERTSON: Your original incident report was in relation to the activity of a career medical officer, is that correct?

Ms OWEN: Yes. She initially submitted a complaint about me because I had intervened with how she was dealing with a patient. I took her quietly aside and expressed my concerns about her inappropriate behaviour.

The Hon. CHRISTINE ROBERTSON: Okay. She actually got the incident report in first, did she?

Ms OWEN: She reported me and accused me of harassment and bullying. I submitted a report, many months later, when she was openly canvassing for support of her position. We were both asked not to discuss this in the operating room.

The Hon. CHRISTINE ROBERTSON: There was actually a conflict in relation to an incident and the institution would have appeared to have only supported the CMO's stance in this issue?

Ms OWEN: Yes. This is where the union represented me and they, in fact, ended up getting legal advice from their lawyers advising Campbelltown Hospital that they had to be seen to be fair.

The Hon. CHRISTINE ROBERTSON: In your professional role you recognises there have an issue with the patient and you went to the CMO, which you would think would be an appropriate way to behave?

Ms OWEN: I think it is the only way to behave.

The Hon. CHRISTINE ROBERTSON: And the CMO decided that that was something they were going to get you for?

Ms OWEN: Yes.

The Hon. CHRISTINE ROBERTSON: And your management did not deal with that issue very well at all?

Ms OWEN: Absolutely not.

The Hon. ROBYN PARKER: I wanted to ask, before we move on from the discussion we were having about the deed of release, if it could be tabled as document to be incorporated please.

CHAIR: Certainly.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Can I ask the nature of the dispute?

The Hon. AMANDA FAZIO: Why have we got it?

The Hon. ROBYN PARKER: It is here on the table, it has been passed around but I don't have it.

The Hon. AMANDA FAZIO: Did you provide the deed of release?

Ms QUINN: No.

Ms OWEN: No. We have provided it to our legal representatives.

The Hon. AMANDA FAZIO: In that case I am not prepared to support tabling a document, we don't know if it is the deed of release. We have had this issue raised in privileges and ethics.

The Hon. ROBYN PARKER: Can we ask the deed of release, if a copy of it could be tabled.

The Hon. AMANDA FAZIO: If you can explain where you got it from. I would be very interested to know.

CHAIR: We can do that outside of this meeting.

The Hon. ROBYN PARKER: It appeared on the table.

The Hon. AMANDA FAZIO: I did not see any paper fluttering down through the stain glass windows.

The Hon. ROBYN PARKER: I don't know. I have asked for the deed of release to be incorporated as a document and I think that is a reasonable expectation. If the nurses have a copy of that perhaps they could table that today or we could have it tabled.

CHAIR: We will not go into where it came from or how it appeared. Would that deed of release be passed around. Would the witnesses look at it and see if that was the deed of release that you have previously seen and I will ask you, if it is the deed of release, would you make it available to be tabled in this committee. If you are not sure about that we can leave this for some time.

The Hon. CHRISTINE ROBERTSON: How long since you have seen it?

Ms QUINN: I have my own copy and regularly I am going through my papers. I recognise it and it has my name on. Yes, that is the deed of release.

CHAIR: Do you wish it to be tabled here in which case it will be made public?

Ms QUINN: Yes, I am happy for it to be tabled.

The Hon. PETER PRIMROSE: Just one question; in relation to that document, is that the original document, or is that a typed out? I have not seen it.

CHAIR: I will pass it around to you. It looks like a copy.

The Hon. PETER PRIMROSE: Can we table what the nurses advise is a copy.

CHAIR: Yes.

The Hon. PATRICIA FORSYTHE: Can I return to the meeting you had with Craig Knowles. Could you outline the mood at the meeting, how the Minister treated you, your impressions of that meeting?

Ms QUINN: Are you speaking to both of us?

The Hon. PATRICIA FORSYTHE: Both of you.

Ms QUINN: Yes. Our meeting with Mr Knowles was on Melbourne Cup day in the year 2002. We all came together in his Ingleburn office. From my recollection Val and I were the first people to actually speak as to what our concerns were. We raised concerns with him relating to how management had dealt with us and the subsequent impact that we felt this had on patient care. We also raised our concerns about the relationship between Jennifer Collins and the New South Wales Nurses' Association and we had a little bit of discussion with him about this.

He then moved to Nola and Sheree and Nola's brother was there. I had never met him before and I had never met Sheree but I had a vague relationship with Nola.

Val and I were astounded at the issues that were being raised about patient care. Astounded because to me they were shocking and I was also astounded because I had little or no knowledge that this was what was going on. Being in the operating theatre I felt we must have been behind closed doors and protected from a lot of what was going on within the rest of the hospital. We sort of sat there stunned.

The mood of the meeting changed. It was a definite shift in the mood, I would say. Mr Knowles appeared to be taking our concerns very seriously. He informed us that he was going to contact the Director General that afternoon. He asked if we were happy for him to convey to her our names and contact details and we all said 'yes'. He told us that we needed to have evidence. He asked do we have evidence and we said, yes, we were confident we did. He said, again, it is a very serious matter, he was going to have an investigation. We would be involved in that investigation and that it could be long and we could be in for a rough ride. We nodded that, yes, we understood. Looking back I don't know that we actually did understand how long and rough it was going to be. He did say, "Once the train leaves the station it is going all the way through and once you are on it you are on it". That seemed perfectly reasonable in my mind. The meeting was then ended and we all went off in separate directions until we were contacted by New South Wales Health a couple of weeks later.

The Hon. AMANDA FAZIO: Were you then interviewed? The evidence we heard earlier, were you then interviewed by this audit section?

Ms QUINN: Victoria Walker and Steve McGucken came to my house.

The Hon. CHRISTINE ROBERTSON: Even though your issues were quite different. Your issues were the way a complaint was dealt with, weren't they?

Ms QUINN: Management, human resource issues.

The Hon. CHRISTINE ROBERTSON: Although it was about a patient.

Ms QUINN: Our issues kept getting side lined as purely industrial.

The Hon. CHRISTINE ROBERTSON: They are management quality?

Ms QUINN: We continued to argue that. In the very early stages we were often finding that.

The Hon. CHRISTINE ROBERTSON: It looks black and white, but it is not?

Ms OWEN: One of the things I should say here is that I, on previous occasions, had submitted complaints, incident reports about patient care, about inadequate procedures. I was in the hospital a short while, I came from Ireland and it was quite proper for you to submit a complaint so that issues could be dealt with, not so that individuals could be punished. This was about improving our system, improving our health care.

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

The Hon. PATRICIA FORSYTHE: Can I ask who said that?

CHAIR: The NUM.

Ms OWEN: Nurse Unit Manager.

The Hon. AMANDA FAZIO: In your submission you have gone through and talked quite a bit about the culture and the complaint handling mechanisms in the Macarthur Area Health Service; given your experience within the New South Wales Health Service do you think the system is wrong or managerial problems at Macarthur that were the impediment, in terms of getting complaints handling dealt with properly? Do you think the system is basically okay and it was the personalities and the management there?

Ms QUINN: By "the system" are you referring to the policies and procedures and guidelines that have been put in place by New South Wales health?

The Hon. AMANDA FAZIO: Yes. And in terms of your experience in other hospitals and other area health services?

Ms QUINN: Yes, I feel, and my opinion on this has never wavered, that the policies and procedures and guidelines that New South Wales health have in place are very appropriate. The problem was the management at the South West Sydney Area Health Service chose not to follow them. They chose not to follow the guidelines. They chose to do whatever they wished to do. Now, the problem with that is that there was nowhere else to go. They were not accountable to anybody, it would appear.

I wrote to the Minister some weeks before I saw him. A Ministerial was put in to South West Sydney Area Health Service. I get the letter this is been investigated, all policies were followed. They weren't. They seriously breached their own policies and mandatory New South Wales health guidelines. They seriously breached them. Blind Freddy could see that they were being breached. However, the response from the CEO of the South West Sydney Area Health Service is, "Everything is fine here. Nothing to see here."

CHAIR: Can I just follow that up? You were saying that the general manager or CEO made statements ---- any accountability beyond that level?

Ms QUINN: Yes.

CHAIR: In your opinion does the hospital board or the area health service have any responsibility in that?

Ms QUINN: Yes, I think, given information, individuals have a responsibility.

CHAIR: How did would they get that information?

Ms QUINN: Within my--

CHAIR: Wouldn't that information normally come from the CEO?

Ms QUINN: Well, yes.

CHAIR: So if it doesn't come from the CEO because of a ---- on them the board wouldn't know?

Ms QUINN: I guess where I am coming from is within my personal situation I was aware that a lot of administrative personnel, a lot, up to area level, knew the details, they knew the details. They had reviewed - Greg Driver, Area Human Services Manager, had reviewed it and his response was "everything was done in an appropriate manner". Everything wasn't done, but he chose, rather than to do what was right, he chose to support his fellow administrative officers, he chose to support the general manager of Campbelltown Hospital rather than do what was right for me.

The Hon. AMANDA FAZIO: Can I just ask when you have put incident reports to area health services, that they have been responded to appropriately?

Ms QUINN: Most of my career was spent within the one area health service. I had a one year period at Westmead Hospital doing a theatre course. I cannot remember actually submitting any incident reports there but most of my experience and my work life was spent within that area health service.

The Hon. AMANDA FAZIO: And say ten years ago, was there a different culture then than there is now?

Ms QUINN: Yes, it was.

The Hon. AMANDA FAZIO: What would it take for you to go back and work in that area health service again?

Ms QUINN: I planned my career in that area health service. I had goals. I wanted to be the clinical nurse consultant for peri-operative nursing for the area. I was driven by those goals. That is what I was working towards, working very hard, and all I wanted for months and months and months was to go back, even up until half way through last year, that was why, that was one of the reasons the Health Care Complaints Commission, to try and help Val and I, separated our issues out and sent them off to the director general so that she could deal with them so we could get back. The director general ignored us. I wrote to her; she did not even respond. Val wrote to her, sent a registered letter; it got sent back unopened.

Now I still wanted to go back and work there. We were finally offered our jobs back this year. I have had an ongoing complaints process happening with the association over their handling of that matter and I had a meeting with Brett Holmes in January this year, and you know what Mr Holmes advised me? What is her name the director of clinical services now? The new lady. Sorry, I cannot remember her name. The South West Sydney Area Health, Deborah Piccone. He said, "Debbie Piccone will give you your job back but my advice to you is not to go back there. I caution you against it."

Brett Holmes cautioned me against going back to that area health service because I am still being villified out there. Would you like to discuss the Sunday program? Val and I had nothing to do with that program and yet we were defamed seriously on that program. We have got the Minister apologising. We have got the area director offering us our jobs and we have got the New South Wales Nurses Associations saying, "I wouldn't go back there if I were you. They don't like you out there. You are trouble makers", and we have got Channel 9 nationally defaming us, which completely negates any apology we have ever been given. So going back, even though that is all I have ever wanted, I have had to accept for my own sanity that it just isn't going

to ever be a reality. My career is finished.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Can I come back a little to your questions, Valery. You said that you complained about the CMO in anaesthetics. Now, you were making a complaint - that was wasn't a compliant that was a dispute at the time about what she was doing, is that correct?

Ms OWEN: I didn't make a complaint about the CMO.

The Hon. CHRISTINE ROBERTSON: The other way around, the CMO did?

Ms QUINN: Yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: The origin of the complaint was you were not happy with the CMO's treatment and management of that case?

Ms OWEN: I was not.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: And you made that clear to the CMO at the time and the CMO complained that you were obstructing her or not--

Ms OWEN: That is right.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: --behaviour that you regarded as incorrect?

Ms OWEN: Yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: And, Yvonne, they actually got in trouble for backing you, is that right?

Ms QUINN: No, it was a separate issue.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: It was a separate issue?

Ms QUINN: Yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You knew that they were separate issues at different times?

Ms QUINN: I did. 18 April I submitted a incident report complaining about the CMO.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: The same one?

Ms QUINN: The same CMO. The next day, 24 hours later we were both escorted off the premises. I was called in from my home.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: They called you in?

Ms OWEN: Yes, she did.

Ms QUINN: Yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You said, Valery, that you when you worked in the country, for three months I think you said, you put in a complaint about a serious other matter. That was not the same CMO, it was a separate issue in the department?

Ms OWEN: Yes, it was a separate issue.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: So there was a number of times you thought the standard of care or treatment wasn't up to scratch?

Ms OWEN: Yes, I submitted several reports expressing my concerns at the practices in the operation theatre -- --

The Hon. CHRISTINE ROBERTSON: And of course the aim was corrective action from the incident report?

Ms OWEN: That is the only way of stopping the incidents, because I had come from a system where this is how you improved your patient care, by monitoring practices, by monitoring your own practices by being accountable for your actions, your own ongoing education.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: And do you think there is a problem then, because you obviously put in a number of complaints? Were they addressed at all?

Ms OWEN: No. I had to follow up my complaints originally and the responses I was getting was, "Well, that will be up to the doctor". They are never looking at the actual patient and the consequences of their behaviour towards the patient. It was about protecting the doctor. These practices, yes, they are still going on. I even submitted many many reports about patients not being escorted to the operating theatre and this was based on the fact that there was not enough staff to excort our patients, and where you transfer the care of your patient to another nurse, not hand to your patient a ward plan and say, "Off you go". You take this patient to theatre. You have to accept transfer of your patient with the proper hand over of information, and this was not happening in Campbelltown and we fought hard to get a policy which was eventually put in place, which basically said that patients who could speak English, who had signed their own consent and who were not premedicated, were compis mentis, could come to theatre without a nurse escort.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: And did that commonly happen in practice?

Ms OWEN: No, it didn't.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: It went on the books?

Ms OWEN: It went on the books and I have staff who have complained every patient who came to theatre without a nurse escort I have submitted an incident report, because I have found I wear them down about it and they will do something, but I became the problem because the staff on the ward were stressed, they didn't have the personnel to come down and I was being obstructive by not accepting the patient, and that is what it got down to. I would not accept the patient and they would wait until somebody came down from the ward and made the hand-over. It has been shown since that a patient who has had the wrong procedure done, a patient can not speak English, was not compis mentis, did not sign their own consent form, had the wrong procedure done, no nurse escort, no hand-over of care, even though there is policy to protect our patients.

The Hon. PATRICIA FORSYTHE: What was the effect of that wrong procedure?

Ms OWEN: The patient came for a masectomy, she had the wrong breast removed and it was only when her daughter visited that evening and noticed that the patient had the bandage on the wrong side. The patient was taken to theatre that night and she had to have the other breast removed.

The Hon. PATRICIA FORSYTHE: Has that been the subject of an HCCC report?

Ms OWEN: Yes, it has. I am just using that to highlight the dangers. I worked in a private system. I walked in the doors in the morning with people off the street who would be a patient within an hour and they got a nurse escort to theatre. This is not acceptable.

CHAIR: I want to thank you for what you have said in and the way you have spoken. Would you mind just confirming for the record that you agree that this can be published?

Ms OWEN: Yes, not a problem.

Ms QUINN: Yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Do you want to ask the last question about what they want to see as an outcome?

CHAIR: I can get guess what your answer is. What do you hope will the be the outcome of this presentation?

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Inquiry.

Ms QUINN: The outcome of the inquiry? I have a couple of things in mind that I would like to see. I would like see to see mandatory reporting. I would like to see New South Wales Health bureaucrats all the way down the line have their performance management tied to patient outcomes, not just the bottom line, and I would like to see some independent body, such as a nursing ombudsman, where nurses can go with any concerns about either patient care or about their own treatment, because at this point in time there isn't anybody.

CHAIR: And I would just like to say to members of the Committee that on that deed of release, it does have the private addresses of two employees. We will remove those.

Ms QUINN: Thank you.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Valerie, do you want to say something?

Ms OWEN: I support what Yvonne was saying. I think unfortunately in Australia there is the culture of dobbing people in and I don't know how you are going to get across to your people here that this is the best patient care, never mind dobbing people in.

(The witnesses withdrew)

(Conclusion of evidence in camera)

(Short adjournment)

(Public hearing resumed)