REPORT OF PROCEEDINGS BEFORE

GENERAL PURPOSE STANDING COMMITTEE NO. 2

INQUIRY INTO COMPLAINTS HANDLING WITHIN NSW HEALTH

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At Sydney on Friday 19 March 2004

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The Committee met at 9.30 a.m.

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PRESENT

Reverend the Hon. G. K. M. Moyes (Chair)

The Hon. Dr A. Chesterfield-Evans
The Hon. A. R. Fazio
The Hon. P. Forsythe
The Hon. R. M. Parker
The Hon. P. T. Primrose
The Hon. C. M. Robertson

CHAIR: Good morning, ladies and gentlemen. Welcome to the second public hearing of the inquiry by General Purpose Standing Committee No. 2 into complaints handling procedures within NSW Health. Before we commence, I would like to make some comments about aspects of the Committee's inquiry. This inquiry will raise difficult issues for many participants, as we have already seen: 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 that the media and any other person in the audience demonstrate sensitivity in any approach made to witnesses during this inquiry, particularly immediately after the giving of evidence.

The inquiry's 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 on errors. People's individual experiences of this system will help the Committee to understand how the complaints-handling system works, or does not work. I ask everyone who is interacting with the Committee to reflect on the terms of reference and to assist the Committee to use these difficult experiences to improve our health system. The Committee does not propose to duplicate other inquiries will investigate or conciliate individual complaints.

It should also 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 reflections 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 come here and respond to the criticisms raised, either in writing or as a witness before the Committee. This is not an automatic right but, rather, a decision of the Committee which will depend on the circumstances of the evidence given.

I also ask that witnesses be mindful of the ethical and legal implications of disclosing personal information about patients. Health practitioners and managers should discuss personal information about a client or a patient only if they are specific to the terms of reference and that person has authorised them to do so. I also ask my fellow Committee members to consider the ethical duties owed by practitioners to patients when pursuing lines of questions. It is likely that a number of matters raised during the hearings may be the subject of legal proceedings elsewhere, such as the Industrial Relations Commission, or a disciplinary tribunal or the special inquiry being conducted by Bret Walker, SC.

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 this parliamentary Committee may discuss the matter that is being considered by another inquiry or a court. This would include investigations undertaken by the Independent Commission Against Corruption [ICAC]. Nevertheless, I remind people today that this inquiry is about systemic issues and not the culpability or otherwise of particular individuals. If people have concerns about any of these issues, please raised them at any time with the Committee and we will consider those concerns.

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 at the table by the door. In accordance with the Legislative Council guidelines for the broadcasting of proceedings, a member of the Committee and witnesses may be filmed or recorded. People in the public gallery should not be the primary focus of filming or photographs. In reporting proceedings of this Committee, the media must take responsibility for what they publish or the interpretation that is placed on anything that is said before the Committee.

Witnesses, members and their staff are advised that any message should be delivered through the attendants or 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 that have not yet been tabled in Parliament may not, except with the permission of the Committee, be disclosed or published by any member of such Committee or by any other person. I make a request for people to turn off their mobile phones.

I ask each witness to state their full name and occupation, and in which capacity they appear before this Committee, as a private individual or as a representative of an organisation or a business. I will ask whether any witness wishes to make a brief opening statement prior to questioning. Witnesses will be asked to take an affirmation or an oath and they have copies of those before them. If they should consider at any stage during

their evidence that certain evidence of documents they might wish to present should be heard in private by the Committee, the Committee will consider their request. However, we may also consider, if it is relevant, publishing it later, if it is in the public interest so to do.

DEBORAH GREEN, Chief Executive Officer, South Eastern Sydney Area Health Service, and

LIZ JAKUBOWSKI, Director, Communications, NSW Health, and

ROBYN KRUK, Director General, NSW Health, and

VICTORIA WALKER, Director, Audit, affirmed and examined:

ROBERT McGREGOR, Deputy Director General, NSW Health, and

GREG STEWART, Chief Health Officer, NSW Health, sworn and examined:

Ms KRUK: I appear in my capacity as Director-General of NSW Health.

Mr McGREGOR: I appear in my capacity as Deputy Director-General, NSW Health.

Ms JAKUBOWSKI: I appear in my capacity as Director, Communications, NSW Health.

Dr STEWART: I appear in my capacity as the Chief Health Officer, NSW Health.

Ms WALKER: I appear in my capacity as Director, Audit, NSW Health.

Ms GREEN: I appear in my capacity as the Chief Executive Officer, South Eastern Sydney Area Health Service.

CHAIR: Director-General, do you wish to make an opening statement?

Ms KRUK: I welcome the opportunity to make an opening statement. I will, as previously, keep that short. Chair, I read your opening statements at the hearing last Friday, which you reiterated this morning. I would like to remind the Committee members that I am required to abide by privacy legislation in New South Wales and that there are ethical and legal implications in regard to disclosing personal information without the specific consent of individual patients and where personal information does not relate specifically to the terms of reference.

CHAIR: I think they might have heard me.

Ms KRUK: Thank you. Chair, I acknowledge your reminder that the privilege provided by Parliament is limited to discussion which relates to the terms of reference and that the terms of reference for this inquiry relate to systems not individuals. I welcome your comments in that regard. I thank you for this clarification and in keeping with your comments, it is not my intention to comment on individuals or on individual cases of patient care. I will, however, endeavour to be as helpful to the Committee as possible.

I wish to make my opening statement in two parts. In the first part I wish to comment on NSW Health's current complaints handling procedures and on some aspects of quality and safety in the New South Wales health system. In the second part I would like to respond specifically to issues raised by other witnesses in their evidence before the Committee last Friday. I will try to keep my comments as succinct as possible. The NSW Health Department has provided the Committee with a background paper on complaints handling procedures and its submission. I do not wish to go into the details of these submissions in my opening statement. I am sure members of the Committee have read the documents and will have questions to ask should they wish to at the conclusion of my statement.

I would, however, like to make a couple of important observations. NSW Health has made substantial progress during the last decade in the implementation of system-wide complaints handling guidelines and

quality frameworks and policies. Many of these initiatives are in fact recognised internationally as world-class. Over the last decade NSW Health has moved from a system in which hospitals and health services had individual policies and procedures for complaints handling and clinical governance to a system where there are now standards and policies that apply system-wide. Our experience has not been substantially different to the experience of other health systems, nationally or internationally, either in regard to the time frames in which the NSW Health system has developed system-wide guidelines and policies for complaints handling and quality and safety programs and, secondly, the types and number of adverse events that occur in New South Wales hospitals.

Importantly, the United States, the United Kingdom, New Zealand and Australian studies all reveal that 10 per cent of admissions at hospitals result in an adverse event; 2 per cent of all admissions are associated with an adverse event and 0.3 of these cases the adverse event results in the death of a patient. That is common to all health jurisdictions. I would like to list a few examples of policies, guidelines and initiatives taken in New South Wales over the last five years to introduce system-wide standards for complaints handling, incident management, quality and safety: firstly, in 1998 the "Better Practice Guidelines for Frontline Complaints Handling" and in 1999 a framework for managing the quality of health services in New South Wales. The quality framework made New South Wales the first Australian State to introduce a structure for clinical governance and made us a leader in that regard. At that time we also established the Quality and Safety Branch, a specialist quality unit within the NSW Health Department. In 2000 we introduced the "Managing Performance: a Better Practice Approach for NSW Health" policy. In 2001 the Institute of Clinical Excellence was established. The clinicians' tool kit for improving patient care was introduced and guidelines for the management of complaint or concerns about a clinician were introduced and disseminated across the health system.

In 2002 there was the introduction of standardised procedures for responding to incidents in the health system called "Effective Response Framework for Prevention and Management in the Workplace" and in 2003 the rollout of the safety improvement program across the New South Wales health system. The challenge for NSW Health—and the same could be said for other health systems in Australia and even internationally—is to continue to drive the effective implementation of these initiatives. Significantly, the Institute of Clinical Excellence will have an increasingly important role in its implementation, secondly, to monitor progress and develop better ways to assist services with the implementation of these policies—again, the Institute of Clinical Excellence and the Department of Health will work closely in this regard—and, finally, to increasingly analyse, learn from and apply the information that is now available to Health for our complaints and incident reporting mechanisms.

Our challenge is to ensure we have in place in the near future a fully integrated system, which consistently alerts health care providers to individual errors, to poor clinical practices and to system failures—a system that drives improvement in quality and safety. A good example of a program that is achieving this aim is the improved system for reporting incidents in New South Wales' hospitals that commenced in May 2003. Since its implementation the incident report system has been used successfully to identify where specific statewide policies or changes in practice were needed to prevent adverse events.

Some examples are a change in the purchasing policy for resuscitation bags and, secondly, a change in the method used to calibrate radiotherapy machines. Effective implementation of the incident management system and the safety improvement program and other quality initiatives is reliant on a culture in which clinicians, healthcare workers and patients can report errors or adverse events without fear and with the knowledge that these reports will be analysed and acted upon. The issues that have arisen at Macarthur are a reminder of the importance of a robust system, which protects patients confidentiality yet treats employees fairly. This involves more than policy: it requires a commitment from clinical staff, patients and the community to openness, and to an acceptance that humans err.

I would like to move now to the second part of my statement. As I mentioned earlier, I would like to clarify a couple of the issues raised by other witnesses during their testimony last Friday. In her evidence Ms Quinn suggested that there had been several weeks' delay between the time in which the nurses met with the former Minister and the time it took NSW Health to begin investigating the allegations. This was not the case. When I appeared before this Committee on 25 November last year I provided a chronology of these events. I would like to refer members to the *Hansard* for that hearing.

Ms Fraser also in evidence last week referred to discussions with the director of audit of the NSW Health Department about the recommendation she made to me following her preliminary investigation.

Ms Fraser raised concerns that Ms Walker's recommendations may have been altered after these discussions. The Director of Audit, Ms Victoria Walker, provided me with a memorandum detailing her preliminary findings and recommendations on 18 November 2002. A copy of Ms Walker's advice was provided to this Committee during the hearings conducted at the end of last year. I am happy to table a further copy if the Committee wishes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Yes.

Ms KRUK: I will do so. In her preliminary findings and recommendations, Ms Walker recommended that the department undertake a further and more extensive investigation with the assistance of independent clinical expertise. She also recommended if that follow-up investigation found evidence of clinical malpractice, that the individuals concerned should be referred to the Health Care Complaints Commission [HCCC]. In her advice to me she did not recommend referring matters to the police. When I reviewed Ms Walker's preliminary findings, given the seriousness and extent of the allegations, I took the decision that the allegations needed to be investigated externally at arm's length from the department—the allegations about patient care and the complaints handling procedures by the HCCC and the issues of potential corruption and maladministration by the ICAC.

My decision to refer the allegations to the HCCC for independent investigation is noted on the memorandum from the director of audit dated 18 November 2002. As I indicated, a copy of this memorandum was provided to the Committee last year. On 18 November I subsequently referred the allegations to the HCCC. The same day I made a reference under section 11 of the Independent Commission Against Corruption Act 1998 to the ICAC regarding possible corrupt conduct. I also formerly advised the New South Wales Coroner and NSW Police by telephone and in writing of the allegations and the actions being taken. I am advised by the director of audit that all documents provided to the department by the nurses, including the official transcripts of interview between the nurses and the department, were provided to both the HCCC and to the ICAC. This is also recorded in correspondence from the New South Wales health department to those two agencies.

There are two other specific issues that I wish to address—one raised by Ms Quinn and the other by Ms Martin. Ms Quinn indicated in her evidence that she did not receive a response to a letter she wrote to me on 15 November 2002 asking for the establishment of an independent inquiry to review the disciplinary action taken against her by Macarthur Health Service. This does not accord with the department's records. The director of audit wrote to Ms Quinn on 21 November 2002 informing her the allegations raised by the nurses had been referred to the HCCC for independent investigation. I confirmed this in writing to Ms Quinn on 30 January 2003. I am happy to table copies of those letters if the Committee wishes.

In her evidence, Ms Martin referred to a press release, which she believes the department issued in February 2003, stating that the department could not substantiate any significant departures from the State health care standards, and that there would be no adverse findings in regard to Macarthur Health Service. The New South Wales Health department did not make those statements. I believe that Ms Martin may have mistakenly attributed a statement by the HCCC to the department. I have copies of the articles in which the statements Ms Martin refers to appear. These statements are clearly attributed to the HCCC. I am happy to table a copy for the Committee if it should so wish.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: That would be helpful.

Ms KRUK: In closing, I would like to make a few final comments. It is on the public record that the budget for South Western Sydney Area Health Service has increased substantially over the last number of years. However, the issues that sit under providing high quality and accessible health care cannot be fixed by providing dollars alone. Funding alone will not bring about the changes that are necessary to enhance quality of care across the sector. Quality of care is affected by a whole range of issues—work force, clinical networking, training, communication and leadership, to list a few.

The events that have occurred at South Western Sydney Area Health Service have been incredibly distressing to the families and patients involved, the staff and clinicians at South Western Sydney Area Health Service, and also the larger group of dedicated professionals that work in our health care system. I, like all

members that work for the health care system, hope that what comes out of Camden and Campbelltown are positive steps that can be used to build upon the quality and patient care initiatives that have been introduced into the New South Wales health system over the past decade.

At the heart of this matter sits fundamental issues that relate to communication, to culture and to the desire of all parties to work in a just environment—an environment that puts the patient at its centre, that recognises and respects the efforts and rights of individuals and, most importantly, that understands human fallibility. We need to concentrate not on making infallible decisions but on putting systems in place that detect and minimise errors or near misses. Mr Chair, I welcome your opening statements and I share them. We should use these difficult experiences from Camden and Campbelltown to improve the health system. I am pleased to work with the Committee in that regard.

CHAIR: Would any other member like to make an opening statement?

Ms GREEN: I shall attempt to be brief. I commence by stating that South Eastern Sydney Area Health Service is a large area health service. There are over 170,000 admissions per annum and over two million non-inpatient occasions of service. This gives a context for the scale of the area. I will talk about two things today in relation to my own area health service. I will speak, first, about where complaints come from and, second, about our philosophy and approach in my area health service.

Complaints come from many places. Sometimes they are raised verbally at the ward, sometimes in writing to the hospital, to the area, to the local member, to the Minister, perhaps to the shadow Minister, through the HCCC, through the board, through the media, sometimes without the knowledge of the family or the patient, sometimes anonymously—and we still deal with those—and sometimes we identify them before the family or the patient does. In relation to our philosophy and our approach in south-east Sydney, we believe that good complaints handling is an integral part of quality management to better meet the needs and expectations of our patients and families.

One of the things to which the director-general referred is the system of incident management. We proactively utilise that system in south-east Sydney across all our hospitals and facilities. Reportable incidents come to me personally. Severity assessment is done. Where it is a SAC 1, a root cause analysis is done. Also in south-east Sydney we have taken a slightly different approach. In some cases we have actually gone to an independent review. What we have actually determined to do this summer is to bring in some expert clinicians from outside our system and certainly away from that complaint, but we have also brought a consumer onto those. Sometimes these are consumers that sit on our quality council.

We now have the view that the consumer is very well placed to represent the interests of the patient and the family—perhaps better placed sometimes than the clinician. We have also adopted the principles of open disclosure through our quality council, and now adopted by the board. This means that I have an expectation, as chief executive officer, that there will be an open explanation to the patient, to the carer or to the family—an expectation that, where problems are identified, we will fix them and, wherever appropriate, that we shall apologise. This is perhaps different from the way we have conducted affairs in relation to complaints handling in the past.

We also utilise the protected disclosures legislation. We have used that for several years for matters that pertain perhaps to the ICAC or to the Ombudsman. We actually advertise this very widely, and we have an independent person to whom the people can come forward. We have found that this has been exceptionally useful, and in some cases clinical cases have come forward. But clearly we need to develop a culture where complaints can be brought forward without fear or favour. We encourage complaints to be managed at the front line, supported by the training to which the Director-General referred.

Sometimes complaints cannot be managed at the front line because they are too complex or difficult. Sometimes they are not well managed at that level, in which case they are managed at higher levels and sometimes they are managed by the HCCC, referred by us or referred by the family. One of the other relationships that area health services have with the HCCC is the patient support officer who is an employee of the HCCC but can advocate for the family in relation to complaints. We have found this role to be very useful but it does need to be well advertised.

We support the view of conciliation wherever appropriate, but in dealing with families we are often dealing with grief and loss and we cannot turn back the clock. It is one of the things I say to families. We cannot change what has happened; we cannot rewrite that story. But most people have a generosity of spirit and hope that next time it will be better. So that is one of the aspirations we have to resolve those things. The skills set that is required is listening, problem solving and conflict resolution. In conclusion, I have expressed some of those sentiments in the February column of *South-Easterly*, and I am happy to table that for the Committee. In summary, that is how we are trying to conduct affairs in south-east Sydney.

CHAIR: Before we open questions I want to reflect on something the Director-General said. In your statement you reinterpreted what I said about privilege and this Committee. Maybe I misheard you and I did not understand the difference between what you were saying I said and what I said, or it may be that you were trying to verbal me or maybe you were trying to give a view to the rest of the Committee. Let me make the point again that privilege applies to everything that is said at this Committee hearing. However, it is my desire that we keep to the terms of reference.

I did say that privilege which applies to parliamentary proceedings, including Committee hearings, is absolute and exists so Parliament can properly investigate matters such as this. It is not intended to provide a forum for people to make adverse reflections on others. The terms of reference refer to failings of systems, not individuals. Therefore, I ask all witnesses to minimise their mention of individual health care workers unless it is absolutely necessary in the light of the terms of reference. I hope that clarifies the situation.

Ms KRUK: Thank you.

The Hon. PATRICIA FORSYTHE: To the Director-General, with hindsight do you believe that you handled the nurses' allegations as successfully as you could have?

Ms KRUK: I think the important issue was that allegations or complaints and concerns are considered in an environment where all parties are given a chance to present their case, ideally to do so through avenues other than the media. I think there are lessons for the health system that came out of the Camden-Campbelltown situation. I think what was important was to ensure an arm's length process to reflect throughout that process on what changes needed to be made more broadly as a result of the issues that were being raised by the nurses, to ensure that there was also a very speedy response in relation to addressing the issue specific to the South Western Sydney Area Health Service and to literally start on the improvements required as a matter of some urgency.

In reflecting back, I think the time frames that have occurred are regrettable. It is important that we now have a process that gives that independent scrutiny to the kind of claims that they raised. My major concern is the grief that the families have incurred through this lengthy process, and I think that is a regret that all parties that have been involved in this incident would share. If we could have avoided that, we would all have endeavoured to do so.

The Hon. PATRICIA FORSYTHE: I turn now to the memorandum of 18 November that you have provided to us, which is a written document signed by Victoria Walker. Prior to the memorandum being put in writing to you, in the course of preparing that did you have discussions with Victoria Walker about the memorandum?

Ms KRUK: I had discussions with Victoria, I think on the same day the Minister contacted me in relation to the concerns raised by the nurses. She certainly kept me verbally briefed in relation to some of the difficulties she had compiling the information. I think she may have felt that I was putting some unrealistic time pressures on her in terms of trying to get an early indication as to the seriousness of the complaints. She certainly kept me briefed in relation to the matters that were being raised in the interviews with the individual nurses. What I wanted from my director of audit, and what I received from my director of audit, was a very preliminary view on the seriousness of the allegations. It was quite clear that I needed to make a judgement to get the matter investigated.

The Hon. PATRICIA FORSYTHE: Was there a discussion that it should be referred to the ICAC, the police and the New South Wales Coroner, as well as the HCCC?

Ms KRUK: What I sought advice on was literally how serious were the matters and what would be the appropriate referral bodies, and I think Victoria looked at that in the preparation of that brief . You will recall, as I just indicated, that I elected to take the decision to refer it to those parties as well. The important issue for me and the options I faced was to undertake an internal investigation within the Health Department or, in effect on the basis of the seriousness of the allegations, to refer those to the HCCC. Also, as there was such a range of issues being raised, I believe that the decision to refer it to the ICAC and to bring it to the notice of the police was correct.

The Hon. PATRICIA FORSYTHE: Did you at any stage seek to water down the recommendations that Ms Walker was preparing?

Ms KRUK: I do not think the action I took could in any way be watered down. I think I took action which indicated that I took the complaints incredibly seriously. I would argue that had I elected to undertake an internal investigation there would possibly have been negative commentary in that regard. The fact that I took the decision to do it at arm's length from the department is a salient one.

The Hon. PATRICIA FORSYTHE: I refer to the particular issue of the referral to the HCCC and the ICAC. The memorandum makes it clear that it was referred to the HCCC. You have also suggested that you also informed the ICAC, or referred it to the ICAC?

Ms KRUK: No. As I indicated in my testimony, I referred it to the ICAC under section 11.

The Hon. PATRICIA FORSYTHE: Did you provide the same details to the ICAC as were provided to the HCCC?

Ms KRUK: The director of audit has confirmed that. All of the documents, including the testimony given by the nurses to her, were provided to both the HCCC and the ICAC.

The Hon. PATRICIA FORSYTHE: Yet this memorandum only makes reference to the HCCC.

Ms KRUK: I clarify again: This was my director of audit's recommendation to me. What I took was action that went beyond the recommendation that she gave me.

The Hon. PATRICIA FORSYTHE: Yet in the letter from Ms Walker to one of the nurses, dated 21 November, it makes it clear that it is referred to both the Health Care Complaints Commission and the ICAC. When did you refer it to the ICAC?

The Hon. AMANDA FAZIO: Is the letter from the nurses available for all Committee members?

The Hon. PATRICIA FORSYTHE: Yes. It can be circulated.

Ms KRUK: Can I possibly seek my chronology of events, which I do not have before me?

The Hon. PATRICIA FORSYTHE: Yes.

CHAIR: Would you like to see a copy of that letter?

Ms KRUK: Yes. I am just confirming the exact date that it was sent.

CHAIR: The date 21 November is written on it.

Ms KRUK: I am seeking the dates of the referral to both the HCCC and the ICAC. I ask that I be able to come back with those dates, Ms Forsythe, rather than confusing the chronology in any way.

The Hon. PATRICIA FORSYTHE: It is of interest to me because the letter to Nurse Quinn to which you referred earlier, which is dated 30 January 2003 and which you have provided to us, refers to complaints going only to the HCCC.

Ms KRUK: Probably the quickest action is for me to provide copies of the letter both to the ICAC and to the HCCC so that you have the dates before you.

The Hon. PATRICIA FORSYTHE: That would be helpful.

Ms KRUK: I stress again—this is important—that my director of audit gave me a course of action and I elected to go above and beyond that course of action. I have received clarification by way of a note that it was referred to the ICAC and to the HCCC on 18 November. I am very happy to table those documents.

The Hon. PATRICIA FORSYTHE: The first letter to which I referred was signed by Ms Walker. It is quite clear that it is a reference to both the HCCC and the ICAC. But your letter to Nurse Quinn in January refers only to the HCCC.

Ms KRUK: I see what you mean. Without doubt I understand your confusion in that regard. I will clarify the issue.

The Hon. CHRISTINE ROBERTSON: However, the letter on 21 November to Nurse Quinn mentioned the referral to the independent commission.

The Hon. PATRICIA FORSYTHE: But it is signed by Ms Walker. That is the point I am making: one is signed by the director general and one is signed by Ms Walker. It is clear from that letter that there was an intention to refer the matter to the HCCC and to the ICAC. I am seeking clarification from the director general as to when she actually made a referral as opposed to informing the ICAC.

Ms KRUK: It was 18 November.

The Hon. PATRICIA FORSYTHE: But you just said that you would clarify the date.

Ms KRUK: I have been given that advice and I will provide the letters to confirm it.

CHAIR: Would you also indicate whether you want that material to be kept confidential?

Ms KRUK: That material has possibly been provided to the Parliament previously so I have no concerns with it being kept confidential.

The Hon. AMANDA FAZIO: I want to ask some questions about the NSW Health submission to our inquiry. On page 4 you talk about New South Wales health care in context. Partway down the page you say, "New South Wales was the first jurisdiction, for example, to adopt a method developed by the Veterans Health Administration in the United States to identify the exact cause of health system errors and identify appropriate corrective action." That goes to the heart of this inquiry. In relation to the incidents at Camden and Campbelltown hospitals, what caused the complaints to be handled in such a way as to inhibit appropriate corrective action being taken? Were the proper procedures identified in your submission not carried through? Was it a resourcing issue? Was it a management issue? Why do you think the corrective measures were not taken?

Ms KRUK: I will first provide a bit more background information on the root cause analysis. This was world-class; it was about bringing about cultural change within the health system. Last year I attended a two-day training course on the introduction of root cause analysis. This was a massive shift in culture—I think Deb Green has picked it up as well—that encouraged clinicians from all disciplines to sit down together and examine the situation where they were aware that an adverse event had occurred. What is significant is that it is only a very new system to run out, and New South Wales is the first of all Australian health jurisdictions to do so. We are still in the infant stages of the introduction of that system. That has with it a whole range of issues about cultural change—openness, the ability to look at a situation and learn from the situation. There is no doubt that this is an important part of the way forward. I stress that point.

In relation to the events at Camden and Campbelltown, there is no doubt that we will get some very important insights both from this Committee and the work being undertaken by Bret Walker as to the issues that underpinned the events that occurred there. As I indicated, it is not as simple as the funding issue. The evidence given by the nurses the other day relates very strongly to issues of culture and very strongly to issues—which

Deb Green picked up as well—about having complaints systems in place that deal with it in the workplace, as opposed to having to rely on a system that elevates itself to the highest level. Communication is fundamental. It is quite clear that systems were lacking in South Western Sydney Area Health Service. It is quite clear that a number of staff had concerns about the ability to raise complaints, to do so in an environment of open disclosure and to do so without fear of retribution. I think that has been put on the public record.

I think some very clear lessons will come out of South Western Sydney Area Health Service about the systems that underpin the quality and safety areas. It is quite clear—I hope that I have picked these issues up in my introduction—that we now have good policies and procedures in place that aim to systemise and put at the forefront of all clinicians' minds the issue of patient care. There is no doubt—and I made it quite clear in my opening statement—that many of those things are in their infancy and still require further work. Cultural change is quite fundamental. I think one of the most significant achievements is the work that Professor Picone—I understand that you will be meeting with her this afternoon—and her team have implemented in a very short period of time to deal with education and the issue of culture, to put in place a professional practice unit that gives staff at all levels an avenue to raise their concerns and to be confident that they will be acted upon. I think also the changes that the professor has put in place and is currently seeking to advance deal with the concept of a just culture that recognises that the patient is at the heart of our business but that our work force is pivotal in relation to delivering that.

The Hon. AMANDA FAZIO: On page 5 of your submission under the heading, "Causes—Individual Responsibility Versus System-wide Focus", one sentence says, "Inadequacies in the clinical work force where they exist clearly need to be addressed through clinical supervision and support and continuing education and training." How does NSW Health balance these needs against staffing constraints and service provision demands?

Ms KRUK: I will open and then pass to the chief health officer to provide more detail. Work force constraints are one of the major limiting factors in the health system at the moment—whether that be specialist nurses or the various specialties of clinicians. Those issues have arisen at Camden and Campbelltown and they are issues that sit at the heart of a whole range of problems across the health system as a whole. We have worked very actively to try to encourage and support clinicians in those various professions. But regrettably you are looking at a whole range of individual choices about the professions that people elect to work in and their ability and their desires to meet family and work obligations. I ask Dr Stewart to provide more detail in that regard.

Dr STEWART: This comment is made in the context of human error—that is, individual error—and issues in systems. The director general has made that point a couple of times. One of the issues around systems is an adequate work force. Regrettably, New South Wales, like the rest of Australia and some parts of the rest of the developed world, has issues with work force supply. We are addressing it in various ways, but I will not go into the detail of that now.

The point here is that whenever you look at a serious adverse event you will inevitably find system issues, not just individual human error that has occurred. As an example of that, I personally investigated an incident at Canterbury hospital in 1999 where, instead of an ordinary, what is called a radio opaque dye, a contrast medium, being injected, a contrast medium containing phenol was injected. On the surface one would think that there must have been a gross human error for that to occur. Investigation showed that there was a chain of errors—10 points—where there might have been an intervention, but a little intervention, and that all added up to the chain that led to that very serious adverse event. You will find that usually in serious adverse events it is a chain of errors, and systems issues need to be addressed, and that is the key point here.

The Hon. AMANDA FAZIO: On page 5 of your submission, the scope and nature of complaint, you have given some figures statewide, metropolitan and rural for two financial years. Has there been any significant variation in the number of complaints from the South Western Area Health Service versus other areas, both in complaints initiated by patients and complaints initiated by staff?

Ms KRUK: Firstly, what is important is that this is a relatively new concept, the compilation of this data across the health system. Area health services are required to provide us with this information on a quarterly basis. In turn, we feed that back to them as a means of benchmarking that, and that is a very important guide for all chief executive officers [CEOs] across the health system. Complaints from the South Western Area Health Service, from memory—and I am happy to provide a bit more detail—made up only about a third of the

complaints of the health system as a whole. Can I also put a cautionary note there. In many instances you would be more concerned were there no complaints about the adequacy of your complaints handling system. If I was the CEO of an area health service and I had a clean sheet, I would be looking quite seriously at whether I had good systems in place to pick them up. I would be more worried than in instances where I was registering complaints.

What is also significant in that data is the range of issues that come up. We have identified access, treatment and communication. What is significant also is the number of complaints and I think, from memory, more than 80 per cent of those complaints were resolved by conciliation, the parties talking, and that comes back to my point about communication being quite pivotal. It also comes back to my point about how important it is that that is done at the level at which you receive service in the first instance.

The other thing, which I think Deb Green picked up, is the importance of being able to say you are sorry when something has gone wrong. In this position and in other positions it is quite clear that when mistakes occur, when humans err, families want some indication, even in their grief, that this will not happen again. That is a very clear message, and I do meet with a lot of families where this might have been the case. To answer your question, I am happy to try to get more detail but the figures in relation to South Western Sydney Area Health Service were 3 per cent, from memory, but we need to look at those figures with some caution.

Mr McGregor has just provided me with some additional information. Complaints as we detail them here do not correlate closely with adverse events. We are picking up here—and Deb Green mentioned it in her statement—that complaints range through a whole range of things. They may have to do with complaints about food, complaints about access to services, about transportation or unhappiness about your clinician being able to sit down with you and detail some of the issues being addressed with your family member. So, every adverse event will not be the subject of a complaint, and some complaints will not relate to adverse events. That is why we are trying to get an integrated system to try to bring those two together.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: I ask my question of Victoria Walker. How long have you been Director of Audit for New South Wales Health?

Ms WALKER: Less than 18 months, nearly 18 months.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: So, you came in only just before this incident happened?

Ms WALKER: No, about six months before. It was about April of that year.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Did you inherit much material from your predecessor? Was it a smooth handover?

Ms WALKER: What sort of material?

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: When you took over the job were a whole lot of files pending that you might have taken on?

Ms WALKER: Jobs to be done?

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Yes.

Ms WALKER: No, there was a normal cycle of activity there. There are five separate units there that do different types of audit issues or investigation issues. The cycle of work was proceeding and is continuing to do so.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Who was your predecessor?

Ms WALKER: Anthony Clark.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: When the whistleblowers came to you did you say they would be protected under the Protected Disclosures Act?

Ms WALKER: I treated them as a protected disclosure, which we tend to do. We have a series of procedures of how we deal with investigations, and I checked with our Legal Branch because in this instance they had already been to the Minister's office and they had given their names, obviously, but protected disclosure has a number of ramifications. One of them is that there will be no retribution on them from within the organisation. The other is that they will be informed within a set time of the outcome. So, as a practice we treat this type of investigation as a protected disclosure.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Were they informed of that?

Ms WALKER: Yes, they were.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Do you believe that would have been the same if they were referred to the Health Care Complaints Commission, that the same situation would have pertained?

Ms WALKER: The protected disclosure?

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Yes.

Ms WALKER: It was entirely up to the process that followed. From my perspective, even within the period that we were receiving information from them, a number of them had gone to the media. We are talking about seven women. Two of them clearly did not want protected disclosure. They wanted their jobs back and they wanted to negotiate openly using their names with the Area Health Service. So, there was a diversity of ways in which they proposed to use it in practice. They went publicly to the media. I think it was about 21 November they came to my office and they had been on television and they told me they wanted to watch themselves on television in the office. They were clearly not interested in the sort of protection and privacy that protected disclosure could offer them. So, when I talk about the practice of my office, it does not necessarily mean that that would be the practice of other inquiries in which they were involved.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: So, protected disclosure only exists if you do it secretly? That is the essence of the deal?

Ms WALKER: No, it does not. A protected disclosure can extend to people who do not even formally ask for it.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Yes, but the implication of what you were saying was if they go to the media then all bets are off?

Ms WALKER: If they go to the media and give their names, one would presume they were not seeking that sort of protection, but in our practice we treat them as protected disclosures, and we did. So the document you have before them, my briefing to the director-general, used no names. I disclosed no names in the internal communication. That is part of our practice.

Dr STEWART: May I add something here. There is a common misunderstanding about the term "protected disclosure", that the protection is protection of anonymity. The protection is protection, as Victoria says, against adverse events as a consequence of the disclosure. The Act is quite clear about this. The complainant can be named. If they allow themselves to be named that is specifically dealt with in the Act, or if for reasons of procedural fairness they need to be named. So, protection is not about anonymity, it is protection from adverse consequences arising from the disclosure.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: I understand that, and perhaps we should have an inquiry into the success of it, if one looks at the track record of people who made them, but that is another issue. Were you happy with the response of the Department of Health to your recommendations?

Ms WALKER: Was I happy is an odd way of putting it. Perhaps you need to clarify, happy about what?

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Did you think the response was timely and appropriate?

Ms WALKER: In terms of referral to the Independent Commission Against Corruption and the Health Care Complaints Commission?

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Yes.

Ms WALKER: Indeed I did. They were done on the day I gave my report. This was taken as a very serious and urgent matter, and the recommendations I gave, as the director-general noted, she actually accelerated them to a higher level. She was not looking at what I had suggested which was dealing with them in Campbelltown/Camden in-house, she wanted them looked at by an independent third party and I thought that was taking the matter very seriously, and I applauded it.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Did you suggest that this should go to ICAC?

Ms WALKER: I did not, no. If you look at my recommendations—

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Yes, I know that you mentioned only HCCC in the memos you circulated.

Ms WALKER: I suggested the HCCC if certain findings emerged, but I did not suggest the ICAC because I was really only looking at a series of allegations. Before you can refer things to the ICAC you would need to have stronger evidence of corrupt conduct, and I certainly did not have that evidence in the initial discussions.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Did you get evidence of people shredding documents?

Ms WALKER: No, I did not. I got a phone call from one of the witnesses sometime later that she had heard that this was occurring, but not during the period we are talking about here.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Subsequently that allegation was made to you?

Ms WALKER: I did not, and by that stage it has moved out of my responsibility. I did this as an investigation. It then went on to another agency, and in the course of the work of my office I then addressed other investigations and audits. Some of the nurses telephoned me later mainly to find out what was going on, procedural matters, how long was its going to be with the HCCC and what was happening. In one of those phone calls—I think it was Nola Fraser—the shredding of documents was mentioned, and I passed that on through my office, through the department, to the office of the director-general to contact the Area, I understand.[1]

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Was that transmitted by you to the ICAC?

Ms WALKER: Not at all, no.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: If the allegation was that the area was destroying documents, surely it would be circular to inform the area of that allegation?

CHAIR: She said she went to the director-general.

Ms WALKER: Not at all. The Area is made up of a large number of individuals. I do not imagine that it was being done at an Area office. The allegation was that it was being done in the hospital, I understood.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: So, it went to someone in the area about the hospital?

Ms WALKER: I presume so, but it did not come from me.

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[1] Please refer to correspondence received from Ms Victoria Walker, Director, Audit, NSW Health Department, dated 23 March 2004, available as a separate pdf document with this transcript.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You did not take it to the ICAC, you took it to the Director Robyn Kruk?

Ms WALKER: I took into the Director's office.

The Hon. CHRISTINE ROBERTSON: The committee has received some excellent information from you people about the processes and the policies for complaint handling and clinical governance issues. It would appear that there are issues in implementation right across the system. Would you outline the future process for this implementation?

Ms KRUK: I touched on it in my earlier response. The policies are very sound, as are the various guidelines. The challenges for us now are: to have a fully integrated system, training and support and clinicians engaged totally across the system. As I indicated, I think 2,000 clinicians have been trained on the various methodologies. As Deb Green indicated in relation to her Area Health Service, it is the constant reinforcement of how important this is across the health system, the focus of it at the chief executive officer level, at board level and the need to have people at the front line so that when an issue or concern is raised by a family member there is someone receptive to it.

What is also really significant—to pick up part of your question—is to make sure that when an incident or an adverse event occurs in one area health service that we can very quickly extrapolate that learning to a system-wide basis. I gave some examples but, quite honestly, it is a system in its infancy. With the pure size of the health system, the number of staff who are involved in direct care, the complexity of the chain of care, the fact that there are so many providers whether it be a general practitioner, the relationship back into a hospital, the relationship between hospital wards and the transfer of a patient from a hospital environment into and aged care facility, it is just not a hospital-centric issue. Our ultimate challenge in this regard is to have a system that looks at care across that chain. We are not there yet. That is an ambition that we are well placed to meet, but it is a challenge in relation to bringing those parts together.

I have been massively encouraged about—and as I said I attended one of the two-day training courses—the preparedness of the system to work to do so. I think a number of clinicians, quite rightfully, during the course of the South Western Sydney Area Health Service incident, have been very concerned about the way forward. It is important that we, and the Government, as a system really do provide support for changes in this regard. The importance of having that open disclosure environment, the ability for clinicians at all levels to be able to reflect on adverse incidents and to do that not in fear of it becoming a major criticism of their own professionalism, but in effect, as part of the learning process. I will ask the chief health officer to add to it.

Dr STEWART: I can only reinforce that. The submission covers these issues. In an enormous complex system of the New South Wales health system with 89,000 full-time equivalent staff, 1.3 million admissions per year and several million outpatient occasions of service, it is inevitably the case that you must continue to improve. In terms of the theory of improvement, the theories of Deming is that you "plan, do, study and act". This is the "quality cycle". We attempt to do that at an individual level in terms of individual units and we attempt to do it across the system. During the past few years in New South Wales we have introduced some remarkable changes in the way we do our business.

We were the first State in Australia to introduce a quality framework which has since been picked up across Australia by the National Quality Council. As the director-general has said we were the first State to introduce the Safety Improvement Program that has been touched on several times - a much better mechanism for reporting of adverse events, and scoring those adverse events using a score called the Severity Assessment Code [SAC] and when there are serious adverse events, analysis of that.

One needs to emphasise that root cause analysis is not something that was invented in the past few years. In other industries it has been around for decades. In fact, in May 2002 the doctor who heads up the system in the Veterans Administration Service in America, Dr Jim Bagian, came to Australia to launch our safety improvement program. His background in NASA as an astronaut, as well as being a medical practitioner, was brought to the Veterans Administration System. As a matter of interest, he led the recent route course analysis around the Challenger crash.

The Hon. CHRISTINE ROBERTSON: Real rocket science.

Dr STEWART: Yes. They were the first people in the world to do it and it has led to remarkable changes in the way that business is done in the Veterans Administration Service. As far as I know we were the second in the world to do it. Mr Knowles launched that in May 2002 and over the next 12 to 18 months we trained 2,000 key people across the New South Wales health system and issued a policy around the Safety Improvement Program and assisted area health services in implementation. Frameworks and policies are one thing but implementation is another and it is necessary for the whole system to turn its attention to implementation.

What do we do in terms of acting on adverse events that are reported to us? The director-general has given a couple of examples about resuscitation bags. We found that there were several reports during the past 12 months or so, specifically in relation to resuscitation bags, the details of which I will not go into. There has been system action to improve that. This seems like a trite or mundane example but there is an issue both in New South Wales and across the world in relation to the safety of bed rails, and we have issued directives around that. There are other examples that we are working on.

The Hon. CHRISTINE ROBERTSON: In relation to the implementation, and the difficulties sometimes with different clinical groups coming on board with the clinical team process, I know a lot of work has been done but it is still an issue. What has come out of that initiative?

Ms KRUK: I mentioned the establishment of the Institute of Clinical Excellence a few years ago. That recognises that that was one of our major challenges. The institute has already done some incredibly impressive work in relation to safety and patient flow. This involves clinicians through a process called "collaboratives" where we literally get the best minds together—our best nurses, our best allied health workers, our best doctors—to look at solutions in a health care environment. But it is at a very early stage. The institute is less than two years old. The Minister, I think, foreshadowed a strengthening of its role, recognising very much that this is about capacity. Again, it is about culture. Health has the benefit of having some of the most intelligent individuals as part of its work force, but it is that need to bring them together to provide solutions in relation to a chain of care. The Institute of Clinical Excellence was a major step forward in that regard.

The various clinical craft groups, the professional groups, are also significant in relation to putting forward solutions for system-wide change. We picked up in a background submission the number of major committees, whether it is perinatal or maternity or whether it be the group specifically given the responsibility of looking at incidents occurring under anaesthetics or in surgery. They are major bodies in relation to system reform and system improvement. That is probably one of the things that will drive change over the next couple of years. We really do need that at the grassroots level. The instances at Camden and Campbelltown—the difficulties the nurses identified in relation to their ability to raise complaints, to be confident that their complaints were being followed through—are a salient lesson. What is important, and I receive data on this on a regular basis, is that the majority of the area health services now have in place quality committees and the majority of area health services now have in place clinical governance frameworks. It is critically a matter of having a range of checks and balances in place so that people are watching that issue of care and safety but, more importantly, actually bringing about improvement.

Finally, to pick up on Deb Green's point. She touched on the issue of the consumer, the user of the health system, having a role in this regard. One of the most important initiatives that came out of the government action plan was the setting up of the Health Participation Council as an overarching consumer body to tell me directly and the Minister of their concerns about the quality of health care and how we deliver it. The important thing is that that body is mirrored at the area health service level through various community and advisory bodies that take it back to the quality of the service we are providing. There is more to health than statistics. At the end the day, we are judged on the quality of health care we provide by the perception of the people who use our system. We referred also in our submission to the work of the Chief Health Officer in his report that reported a satisfaction with the health system of over 90 per cent in the most recent survey. That in no way attempts to negate the fact that there are issues that we need to address. But the fact that the system is now actively seeking feedback from its users and trying to improve itself as a result of that feedback is a significant step forward.

The Hon. PATRICIA FORSYTHE: Ms Kruk, how closely does NSW Health liaise with the Health Care Complaints Commission [HCCC]?

Ms KRUK: I cannot speak about before my time. The pattern has been to have regular meetings. I have sought regular contact with the commissioner in relation to the progress of the various inquiries. It may be because I am not a longstanding player in health, but I sought a series of formal structures, more than anything else, and that was the relationship.

The Hon. PATRICIA FORSYTHE: Ms Walker, in the letter to Nola Fraser, referred to earlier, signed off by you on 21 November 2002, you make it clear that you have forwarded both agencies, that is, the Health Care Complaints Commission and the Independent Commission Against Corruption [ICAC], a copy of the information material that has been provided to you. Would you outline what your actions were in dealing with the information provided by the nurses?

Ms WALKER: What sort of action are you talking about—in terms of forwarding?

The Hon. PATRICIA FORSYTHE: How you dealt with it once you met with the nurses.

Ms WALKER: In particular, to of them provided additional evidence—Nola Fraser and Sheree Martin. Nola's came in several parcels. When she first came to be interviewed she brought some. I can give you the precise dates, in fact. When Steve McGuckin and I interviewed her on 15 November she provided some material then. The reason why the interviews were delayed for about a week was that her brother, whom we were asked to contact first, said there was difficulty in getting the material together. Because we wanted to progress the matter, I think we gave her some manila folders and said to sort it out into groups of information that she sees best and bring it into us. She was concerned that we would lose it. We assured her that we would return it to her on the day. We sent things back to Sheree in an overnight envelope.

She brought in a second lot of material on 21 November and we photostated those and returned them to her. We put them in manila folders under specific headings as she had determined. When the reference went out to the ICAC and the HCCC, we gave them copies of all the material we had at that stage. There were still some transcripts of interviews. The interviews we had done with most of the nurses were taped. It is important that they get a copy of those transcripts so they can make any edits to them if they want to make any changes. We had a process where I wrote to them, and sent them again in express delivery envelopes, a copy of the transcripts for them to make any alterations they wished. When we got those back in, we forwarded them to the HCCC and to the ICAC. They were the only delays. In terms of the documentation that Nola Fraser gave us, they were photostated immediately in my office. I know it took a considerable amount of time and they were taken personally to those offices by my staff.

The Hon. AMANDA FAZIO: What was the nature of those documents? Were they incident reports or clinical records?

Ms WALKER: They were a mixture of things, including local policy documents from the area, an enormous number of emails, handwritten exchanges between Nola and various staff members and some that were on formats in the nature of an incident report. I cannot say what that format was. They were very varied. In the main they appeared to be copies of emails.

The Hon. PATRICIA FORSYTHE: Did you believe they should also be referred to the NSW Police or the State Coroner?

Ms WALKER: No, I had no reason to do that. I had only allegations in front of me. Those things should be referred when you are aware of potential criminal conduct, but I was not.

The Hon. PATRICIA FORSYTHE: Last week in the statement made by the nurses there was a suggestion that they understood from the interview with you that the information was sufficiently serious that it be referred to the Coroner, the police, the ICAC and the HCCC.

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

The Hon. PATRICIA FORSYTHE: Ms Kruk, did NSW Health issue a media release on 22 November 2002 indicating that matters had been referred to the HCCC and the ICAC, and NSW Police and the State Coroner were also notified?

Ms KRUK: Could I check that, if you would not mind, Ms Forsythe?

The Hon. PATRICIA FORSYTHE: Yes, thank you.

The Hon. AMANDA FAZIO: In the evidence that Ms Fraser gave last time she said, referring to you, Ms Walker, "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." You were not aware of that at all?

Ms WALKER: I find that absolutely fanciful. I have no idea where it came from, but it certainly did not come from my office.

The Hon. PATRICIA FORSYTHE: When you provided the report to the director-general you said, in answer to a previous question, that you supplied the report to the office of the director-general. Was it personally to the director-general, or merely to the office?

Ms WALKER: No, it was not personally to the director-general; it was to her office.

The Hon. PATRICIA FORSYTHE: In relation to the other issue that Dr Chesterfield-Evans asked about earlier, the shredding of any documents, did you ever receive an email confirming shredding?

Ms WALKER: Never. I never received an email from any of these witnesses at all, no.

The Hon. PATRICIA FORSYTHE: I did not ask about the witnesses. Did you ever receive an email at all making an allegation of shredding of documents?

Ms WALKER: Never.

The Hon. PATRICIA FORSYTHE: Never?

Ms WALKER: Never. As I said a minute ago, I have got copies of emails and documentation, but they were about the issues that were raised in the interviews. I have never received, and I would have been surprised if I did, because my assumption was that they were not working; they were not on a system. All our exchanges were verbal.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Did they make allegations about an email on shredding documents, or the deletion of material from the hard drives?

Ms WALKER: No. The allegations they made to me were all about this historic period when they worked in the hospital, about specific areas of the hospital in which they worked. They were not these sorts of broad matters at all, matters about the administration in general; they were really about their experience as nurses. They were very emotional—

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: My understanding was that these were second-hand from other people who had observed document destruction or deletion from hard drives.

Ms WALKER: Say again?

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: My understanding was that those allegations were not while the nurses were there, but that subsequent to that there was deletion of material from the hard drive and shredding of documents, and that that information was conveyed to you.

Ms WALKER: This is the first time I have heard about a hard drive. As I mentioned earlier, during the course of the investigation by HCCC I probably received two or three phone calls from Nola Fraser or Sheree Martin, and they were mainly about, "Oh, why haven't you done anything? What's going on? We are destitute.

We are distressed." I did my best to assure them that the matter was being followed through, it was simply going to take time and some patience, and they would need that patience. In one of those interviews, among other very emotive parts of the conversation, Nola Fraser did say that she had been told that things were being shredded, and that was all that she said. She certainly did not talk about removal of things from hard drives. I have never heard of that before at all.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Were you surprised that the HCCC did not come back with findings that more had to be done? The reports in the media on 25 and 26 February were "hospital inquiry rules out discipline" and then complaints about the nature of it. The following day the inquiry was reopened. After your investigation, were you surprised that the HCCC was not taking further action?

Ms WALKER: I cannot say I was surprised. I initially looked at a pattern of complaints from these women. I was not looking at the actual facts or the evidence of the matter. That was up to another body. I know that, when things are investigated in detail, there can be quite different findings.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: So you were happy to go with the HCCC's conclusion?

Ms WALKER: It is not a question of whether I am happy. I am simply an observer, like anyone else. I did not really have a view about it.

Ms KRUK: Chair, may I comment?

CHAIR: Yes.

Ms KRUK: The director-general of audit was asked to do a preliminary investigation but, I think it is important, over a short time period. Also, to pick up Ms Forsythe's question: I am happy to provide the documentation in relation to the various press releases. Mr Chesterfield-Evans, I think it has come up in testimony beforehand that the then commissioner of the HCCC issued a clarification as to what the HCCC had said in relation to the findings of that inquiry. Now, I cannot, off the top of my head, remember, but I think that there was further commentary in the media in that regard. As I said, I think there was a clarifying statement issued.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: When you had an allegation of corrupt behaviour from Victoria Walker, she said you referred it back to the area health service.

Ms KRUK: No.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You did not refer that to ICAC?

Ms KRUK: No. It comes back to the questions asked earlier: I made the decision on the basis of Victoria's report, and I also looked through the transcripts to refer the matter to the ICAC at the same time as I referred it to the HCCC.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: This was a later allegation, though, wasn't it?

Ms KRUK: From memory, there was a subsequent email received from one of the complainants in relation to the shredding of documents. I am happy to be corrected, but in the initial transcripts there were suggestions of documents being missing. So that was my rationale, amongst other reasons, section 11 being something where I have to exercise my own discretion to make the decision to refer it to the ICAC as well as the HCCC. The other point is that the letter that I replied to, I think, from Ms Quinn focussed specifically on patient care issues, and my response to her was identifying the HCCC as the body being referred to focussed on those components. Ms Forsythe has kindly reminded me that it was in the public arena already in mid to late November that the allegations had been referred to both the HCCC and to the ICAC.

The Hon. PATRICIA FORSYTHE: There were suggestions you had done that. We are still trying to find out whether you actually did it.

Ms KRUK: I did it. I am happy to table the documents now that you were seeking, now that I have had a break to do that. Can I just confirm the date on which I did that was 18 November, the referral to the ICAC.

The Hon. PATRICIA FORSYTHE: Was that referring it to them or informing them of it?

Ms KRUK: It is referring it to them under section 11; so that is a formal referral. That requires them to have a look at it on that basis. It is not for information. I appreciate your question.

The Hon. ROBYN PARKER: I wanted some clarification from Ms Walker regarding the email about purported shredding of documents. Is it true that you have been asked by the ICAC to explain the location of that email on the hard drive of your computer?

Ms WALKER: I never received an email. The ICAC has taken evidence from my computer. I have not received a response from them, but I believe they will not find it because I never received it. So, yes, the ICAC has taken appropriate action to investigate my computer to confirm whether or not I did receive it. But, from my perspective, I did not. And I had no way of checking that because, as a matter of course, our network is cleansed every three months because we get so much material. They have gone to the hard drive of the network, and they will be able to give a definitive answer as to whether an email was received.

The Hon. ROBYN PARKER: I have some questions of the director-general. You have talked today about a culture of learning. We have heard evidence of bullying and a culture of fear among staff at South Western Sydney Area Health Service. Do you have a comment to make about that?

Ms KRUK: I think when this came through in Professor Barraclough's report to myself, and the Minister as well too, he commented on the issue about the lack of openness and the culture issue. I think there are important lessons there, and I think what is significant are some of the changes that have been implemented since his findings. That will not change overnight. I think we have to be realistic in that regard. This has to do with good systems, and it has to do with good policies, but it ultimately relies on people actually communicating and feeling there is a trust to be able to raise those issues. So, no, I am not surprised, and that is the need to act quickly, as we have.

The Hon. ROBYN PARKER: The *Sunday* television show did a program about the Campbelltown and Camden hospitals. Can you provide the committee with information about what material, if any, your department provided to the program?

Ms KRUK: I did not see the program, but I am aware of what was on it. To my knowledge, the department provided no material to the program. To the contrary, from my briefing, a number of the statistics provided and utilised in the program were factually incorrect and could not be substantiated.

The Hon. AMANDA FAZIO: I refer back to the submission. I have read it very carefully and I want clarification in relation to page 7, paragraph 4.1 entitled "Complaints—Patients, Families and Communities". The point is made that patients, their families and members of the community need to know how to make a complaint. How does the department advise them about that? I know there are patient representatives and advocates, but many people to not want to talk to a do-gooder hanging around a hospital. How do you let patients know that there is a formal complaints system they can utilise if they are not happy?

Ms KRUK: We need to do it at various levels. That is important. We pick up in the submission the establishment of the 1800 line. That is obviously an opportunity to raise the issue with the area health service and on a broader basis. It is important that it become part of communication with the health care system. People should know that they have the opportunity to raise concerns and not to wait until they have a problem. We talk about it being a complaint, but in many instances it is a simple issue of knowing how I get my mother from Gosford for a second opinion at one of the major teaching hospitals. We can avoid that by having good communications systems. As Ms Green said, it is a matter of staff being able to give patients and families those options, that being supported by appropriate literature and a community understanding that there are people they can approach to get that advice. Being called patient advocates does not matter.

Nothing in the first instance replaces good communication between the clinician and the family member. In many instances, that can address the concern. Families should not have to resort to the freedom of information system [FOI] to obtain background information about the care of patients. That is what sits that the

heart of the system we are seeking to grow. FOI is an important check and balance mechanism; it is critical to have a strong regulatory requirement. So, when something does occur and members of the community do not appear to be getting an open hearing, or being given the response they require, they can elevate their concerns to one of the professional boards or the HCCC. It is a graded series of responses.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: We had evidence from Brett Holmes of the Nurses Association that the deeds of release were standard documents that some of the nurses signed. Are they standard documents?

Mr McGREGOR: There is no standard document that NSW Health holds or issues to area health services about deeds of release.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: So these documents are not in widespread use.

Mr McGREGOR: Deeds of release are occasionally used in health services as they are in the private sector and elsewhere in the public sector.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: The deed of release between the Nurses Association and Macarthur Health Service had as one of its conditions that neither side would criticise the other.

Mr McGREGOR: I believe that is so.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: That is frightfully convenient because it means the hospital system can get rid of whistleblowers without the union complaining and the union can get resignations from people who are less than competent in the area health system but still allow them to apply for jobs after having been forced to resign. It is not in the public interest from either direction.

Mr McGREGOR: The department has a policy, issued in 2001, which indicates that area health services and hospitals are not at liberty to enter into deeds of release.

CHAIR: Will you repeat that?

Mr McGREGOR: They are not at liberty—

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

Mr McGREGOR: From 2001.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: So this was after that time.

Mr McGREGOR: That is so.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: The deed of release was not within the NSW Health policy guidelines.

Mr McGREGOR: It was not issued with the authority of the department.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: The resignation was from a departmental area health service. They are not entirely autonomous; they are still under your control.

Mr McGREGOR: The area health service was negotiating with the nurses to secure a deed of release. That was not consummated. They were acting outside the department's requirement that they should not enter into deeds of release without our approval, except where they were entirely consistent with an award or a decision of the Industrial Relations Commission or in settlement of a workers compensation matter.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: There was a workers compensation matter and presumably the amounts paid corresponded to the overtime and the part time work when they were stood down and could be said to be within an award.

Mr McGREGOR: I understand, having seen that deed of release since that time, that it offered to make some payments in respect of lost penalty rates for shifts, but not for overtime.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: In effect, it was a facilitated release with a hush clause.

Mr McGREGOR: I think the clause was that they would not make disparaging remarks.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Either way?

Mr McGREGOR: Yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: That is very convenient for the department with regard to whistleblowers and the people forced to resign as a result of incompetence, because they will not have an adverse reference when they apply to the hospital down the road.

Mr McGREGOR: As I said, there is no standard deed of release; the department does not normally endorse deeds of release containing those terms. No such deed of release was submitted to the department by the area health service for consideration prior to signing.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: So that deed of release was outside the department's guidelines.

Mr McGREGOR: They are not guidelines; it is a clear policy that they shall not enter into deeds of release without departmental approval.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: This happened.

Mr McGREGOR: It was not consummated.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: They got to a point and would not sign.

Mr McGREGOR: They could not agree.

CHAIR: We might need to recall the witness on that point.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Ms Kruk, were you happy with the HCCC report that involved no disciplinary action being taken against any staff? Did you think that was inconsistent with the material you sent?

Ms KRUK: I again come back to the point that there was confusion in the media about what the HCCC had said and not said. That probably needs to be clarified by the committee. The issue of disciplinary action or otherwise against staff was unresolved from my point of view. That was a matter that the HCCC subsequently referred back to the department for further action when it made the decision to focus specifically on patient care issues. I raised that in testimony in my earlier appearance before this committee.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Route cause analysis [RCA] is a management tool. It has been said by people to whom I have spoken that they spend so much time doing them that they cannot do their work. It effectively involves managing upwards and sending information upwards such that they cannot solve problems downwards. Do you think that having this management structure, which is focused on covering for the people above, means that the work is not being done by the middle levels?

Ms KRUK: As the name implies, the route cause analysis is a chance to reflect back and learn. One of the best examples I have seen of its application was in Ms Green's area after there were some difficulties in relation to the calibration of equipment to treat esophageal cancer. This is indicative of a very good model. The area health service was very transparent and information was put out into the public area quickly, but only after family members had been told that there were problems and it was intended to undertake an independent route cause analysis. That is an important part of the chain of care. That is not an add-on to the job; it is chance to

learn when something has not gone as one would wish, whether it be a near miss or an adverse event. It is not managing up; it is managing down in relation to patient care.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: That example is obviously very good. However, there are many individual cases where reports are being written to ensure that if the Minister hears about it he has an answer. The issue is the amount of time being spent writing reports about past cases or people above rather than dealing with clinical problems in areas where there is a shortage of people to start with.

CHAIR: We are beginning to get into the level of statements of opinion on an issue that is not correctly on our terms of reference. I want to give an opportunity for last questions.

The Hon. PATRICIA FORSYTHE: We have a number of questions for the Director of Communications, but I suspect that we will not get to all of them in the time available. I must come back to the director-general in relation to the documents she provided to us, the correspondence to the ICAC. I see from the letter dated 18 November 2002 you say, "I am notifying you of allegations." You advise that you have referred these allegations to the HCCC for full investigation. Nowhere in here do you ask the ICAC to investigate.

Ms KRUK: Can I have a copy of the letter so that I can read from it? "I am writing to you in accordance with S11." This is not a notification for information. This is saying that I have made a decision on the basis of that provision of the Act, and I am referring it to the ICAC on that basis.

The Hon. PATRICIA FORSYTHE: Do you want to read the whole of the two paragraphs?

The Hon. AMANDA FAZIO: Don't you understand the ICAC legislation?

The Hon. PATRICIA FORSYTHE: I am asking the director-general for clarification. Do you want to read the whole of the two paragraphs?

Ms KRUK: It reads:

> … I have received of possible corrupt conduct in South Western Sydney Area Health Service, in particular, at Campbelltown and Camden hospitals. Following preliminary investigation by my Audit Division, I have referred these allegations today to the Health Care Complaints Commission for a full investigation.

There is, as I indicated in earlier evidence, a very close co-operation between the various regulatory and investigative bodies. Both received a referral from me, neither of which were for information. There were issues that were relevant to the ICAC and there were issues that were clearly relevant to the HCCC. It is customary—it is more than customary, it is required—of those bodies to get together to look at the issues being raised. The transcripts provided by my Director of Audit to both of those bodies raised a plethora of concerns. It was not possible for me to make a judgment on the basis of a preliminary report regarding the veracity of those concerns. I took them seriously, obviously, by referring them to both parties with the expectation that they worked together on it.

The Hon. AMANDA FAZIO: In relation to the severity assessment code that both the director-general and Dr Stewart referred to, part 4 of the questions your guidelines say you must ask to determine the level of severity of an incident, item 4 is deliberate patient or staff harm. At the hearing last week we heard considerable evidence that allegations were made that doctors and nurses were acting with intent when they either withheld treatment or harmed patients. I believe it was fairly inflammatory sort of evidence that could impact negatively on staff morale of other clinicians in our health system. Could you clarify for us how many SAC you are aware of since you introduced this new system that have been put down to clinicians engaging in deliberate patient or staff harm?

Dr STEWART: This is page nine of the submission where it refers to adverse events that are not subject to root cause analysis because of four items listed there, that is a criminal act, an intentionally unsafe act, where alcohol or drugs are involved, or where there is deliberate patient or staff harm. Those are the rules we set in terms of root cause analysis. If those things occur we say, "You don't do an RCA, you do what's necessary under the criminal law or in terms of disciplinary proceedings." The answer to your question is I do not know the answer to that, but on the basis of the hundreds of reportable incident briefs, and I think we are getting up to hundreds of root cause analyses being undertaken now, I am not aware of specific cases, but I imagine there are a handful of cases in areas where there would be, say, alcohol or drugs involved.

The Hon. AMANDA FAZIO: But you are not aware of any where there has been deliberate patient harm?

Dr STEWART: I am not aware.

Ms KRUK: What is important is that the root cause analysis gives an opportunity to actually review those circumstances surrounding the care and, if necessary, a referral to an appropriate body or professional board can come out of that process. I think Professor Brian McCaughan picked that up in his testimony last week.

The Hon. ROBYN PARKER: You would be aware of the concerns by the medical community, particularly the AMA, about the safety of the Camden maternity unit. What advice has the department provided, either Minister Knowles or Minister Iemma, regarding the unit?

Ms KRUK: I am conscious of your time. I think the department provided all the documentation in another place only as of yesterday relating to this issue. That details the advice, so I would ask that you look at those.

CHAIR: The question has been raised because the documents have been given to us. We have seen them.

Ms KRUK: To summarise it, what is the most important issue is that Professor David Henderson-Smart was commissioned to undertake a review regarding that facility, but more significantly maternity and perinatal services for the South Western Sydney Area Health Service as a whole. I am awaiting his report. I understand that is nearing completion.

The Hon. ROBYN PARKER: Are you in possession of any advice that suggests Camden obstetrics unit should be closed?

Ms KRUK: I am awaiting Professor Henderson-Smart's report. There has been, I understand, debate in the media about that today in terms of the views of certain parties. The reason for bringing someone as eminent as him into this debate is to look at both facts and the service delivery. I stress it is not just Camden and Campbelltown, it is for the Western Sydney Area Health Service as a whole. He has called on, from my understanding, a range of other clinical advisers to assist him in his deliberations.

The Hon. ROBYN PARKER: The department has not, at any point, received advice that it should be closed?

Ms KRUK: I think the letter in the paper referred to submissions from the anaesthetist from RCA, from memory, and I am happy to be corrected when we have gone to the area health service in the first instance, any material we have had, any concerns that have been raised in relation to the service or otherwise are certainly making up part of Professor Henderson-Smart's current work.

The Hon. ROBYN PARKER: Do you agree with the AMA that there is no such thing as a low-risk birth?

Ms KRUK: I am not a clinician. I would be out of my depth to make a commentary in this regard. I would rely on clinical evidence to give us advice in this regard.

CHAIR: I have heard considerable discussion among women who have experienced birth to day on that particular issue. I thank you for your presentation. A number of items here are in confidence. Are they to be kept in confidence?

Ms KRUK: My understanding is that those documents have been the public arena before, the letters to the ICAC. I would be very happy, should other matters arise during the course of your deliberations, to reappear before your Committee to address them.

(Short adjournment)

LORRAINE IRENE LONG, Founder and Chief Executive, Medical Error Action Group, sworn and examined:

CHAIR: I think you were not in the room at the commencement of the hearing when I delivered my opening statement, and I will not repeat the statement because it is lengthy. However, your testimony today is given under privilege. The Committee's terms of reference primarily relate to failings in the health system, rather than the failings of individuals. We would ask you, therefore, to minimise the mention of individual health care workers, unless it is necessary for the case you are wanting to present. As I said, your testimony is given under privilege, even on issues that may be before other courts and are sub judice. Nevertheless, we may discuss such matters if we consider them to be relevant. Do you wish me to give you a more elaborate statement than that?

Ms LONG: No.

CHAIR: If you wish to give any evidence which you believe would better be heard in camera, please advise the Committee and we will accede to your request. Do you wish to make an opening statement?

Ms LONG: I would like to refer to what I included in the foreword to my submission about mistakes and the handling of them. Facing mistakes head on saves time, money and reputations. Full disclosure and honesty restores trust and professional and personal reputations of hospitals and doctors. Ethical, moral and sensible legal decision making is the humane approach. Any organisation that treats patients and affected families honestly, fairly and timely is a place of integrity and compassion.

CHAIR: Are you willing to be questioned?

Ms LONG: Yes.

The Hon. ROBYN PARKER: I do not have a copy of your submission in front of me at the moment. Could you outline your organisation's roles, as you see them, and the reason you wanted to appear before the Committee?

Ms LONG: I was asked to come here today. The role of the group is to help families affected by medical error; that was the basis of it being set up. Once medical error hits a family, there is nowhere to turn and there is no-one to help you. It was on personal experience and the experience of about 25 other families that we set up the group, and that was the contact point for other families.

The Hon. PATRICIA FORSYTHE: Initially you referred to 20 families or so. Was that in one particular area or over a particular period of time?

Ms LONG: Initially, in 1996, I was working on my own doing it. The experience I had been through was too valuable not to share with other families. So I contacted families I had read about in the media, and it resulted in a meeting at my home. They were families from different areas of Melbourne and Sydney, including the Campbelltown area and the North Shore. We just sat around all day and discussed our own personal experiences, and at the end of the day we decided that we would set up a group to try to change the hospital system.

The Hon. ROBYN PARKER: This inquiry aims to establish better practices and a better health system. What outcomes from this inquiry do you hope for?

Ms LONG: A complete change of approach to complaints handling, because the one that is now in place is unsatisfactory.

The Hon. ROBYN PARKER: In what way do you see it as being unsatisfactory?

Ms LONG: When you are dealing with the health department and the area health network, you do not get anywhere because no-one will listen to you. The family becomes the problem, and the best way to deal with the family is to ignore them. That is what drives people to lawyers.

The Hon. PATRICIA FORSYTHE: You said no-one listens to you. There is a process for complaint management. Could you outline what has been the experience of your members in relation to the existing process?

Ms LONG: The existing process means that something goes wrong in a hospital or with health care, and they will contact their local member of Parliament, who writes to the Minister, the Minister writes back and tells the person to go to the Health Care Complaints Commission. The person has to rewrite their complaint and lodge it with the Health Care Complaints Commission. The commission would only investigate the complaint on the evidence given from the family. Most families could not get medical records, so a complaint could never be investigated, nor was it. Basically, when dealing with the Health Care Complaints Commission, after a certain period, say around 19 months, they would shut the complaint. They would say, "We do not have any more resources, we do not think there was anything untoward about the care of the person". The complaint would be shut down. People reach a dead end and have not found out what has gone on. No-one has been made accountable, and that is what drives them off to lawyers, to try to get some sort of redress.

CHAIR: Does a large number of your members have the same experience?

Ms LONG: The majority.

CHAIR: Is it a regular feature that they cannot get medical records in order two initiate the complaint?

Ms LONG: Yes, if anyone contacts us and cannot get the records, we ring a hospital and tell it to release them to the family. Some hospitals are very good and will do that within 24 hours; others force people into the FOI process, which we object to. We ring a hospital and say, "Hand over the records, that is all you need to do at this stage".

The Hon. PATRICIA FORSYTHE: Are you suggesting that there is no consistent policy about the provision of documents?

Ms LONG: That is correct.

The Hon. PATRICIA FORSYTHE: Would you recommend development of a policy in that area?

Ms LONG: Yes. No-one should have to undergo FOI for anything from a government department. If someone asks for documentation, it should be freely given.

The Hon. PATRICIA FORSYTHE: Are you referring to someone's personal situation?

Ms LONG: Yes, not other people's information. Hospitals should ask patients whether they want their medical records on discharge. It would save a lot of mucking around further down the track. Also it then stops the tampering of records and records disappearing. And that is a concern.

The Hon. PATRICIA FORSYTHE: It is a very serious suggestion that records are tampered with. Does your organisation have proof of that?

Ms LONG: Yes we do, substantial proof. It is normal routine procedure that medical records are tampered with.

CHAIR: Could you clarify that; do you mean that some medical documents that should be in the records are missing?

Ms LONG: Yes.

CHAIR: Are documents shredded or altered?

Ms LONG: When they are altered you do not see that in the record. Someone rewrites the page. When we go through records we can tell by the chronology of the care, and there are gaps, fresh sheets are put in, then there is a gap, then there is a fresh sheet, then there is another page where it continues on. We can tell by inconsistent handwriting.

The Hon. PATRICIA FORSYTHE: What do you do when you discover that? I presume it is the role of your group that gives support?

Ms LONG: We tell the family and also ring the hospital and say that the records it has sent to the family are inadequate. We get the family to go back to the hospital with the bundle that they have been provided, to view the records at the hospital, and to check every page. So they will have the records, and the hospital records are there and someone from the hospital supervises them. They can turn every page and check. We always tell them that if there are 160 pieces of paper in their records they should make sure that there is the same number in the hospital records. If there is not, they should ask the hospital to photocopy the missing pages.

The Hon. AMANDA FAZIO: Are you referring to both private and public hospitals?

Ms LONG: We focus mainly on public hospitals, because private hospitals will not hand over their records, unless we ring them and ask them to.

The Hon. AMANDA FAZIO: Does your organisation still receive complaints from people who are dissatisfied with care in both private and public hospitals?

Ms LONG: Yes.

The Hon. AMANDA FAZIO: Are you aware of the new complaints handling mechanism that NSW Health has introduced, which is based on the health complaints mechanisms used within the veterans health administration[VHA] in America? Do you think the system that has been introduced in the past three or four years will improve situations for patients who are not happy?

Ms LONG: If NSW Health has introduced that system, based on the VHA, which I have written about extensively over the years, they have not informed my group and I am not aware of it.

The Hon. AMANDA FAZIO: Were you here this morning to hear the evidence?

CHAIR: No, Ms Long was not here. I remember it being said that the system has been introduced over the past two years. There is now a new complaints handling system. It was subsequently asked how widely that was being communicated with patients and their families.

Ms LONG: Not widely at all. We do not know about it. NSW Health has not informed us of it.

CHAIR: I gather from what the director-general said, that it was primarily training for NSW Health staff in how to handle complaints mechanisms, so it may be that there is not a means of communicating that to the wider public.

Ms LONG: I have not heard of anyone being awarded an ex gratia payment or compensation to wrap up a complaint, not by NSW Health anyway.

The Hon. CHRISTINE ROBERTSON: Elements of complaints handling that you are supporting look very positive. The hospital sector is trying to deal with issues as quickly as possible. Have most of the people who come to you already been through a process with the hospital, especially in recent times?

Ms LONG: Sometimes. Sometimes straight away, if people have a problem they contact us. Sometimes they contact us a year later, when they have gone through the whole process and hit a brick wall. They ask us what they should do next. They are still no further ahead of finding out what went on. They still do not have all the documentation, cannot get anyone to look at their complaint. If the hospitals and NSW Health listened to their complaint instead of shutting it down—because with the Health Complaints Commission, they get an expert to provide an opinion on the case. That expert opinion is kept secret from the family. The doctor who has been complained about gets all the information that the family provides to the commission, but the family does not get any information that the offending doctor has provided. None of that information comes back to the family.

The medical opinion that the commission seeks is kept from the family as well. The commission then writes that it cannot find any problem and the complaint is now closed. That is it. So the family is still kept on the outer. The family should be allowed to see everything that the doctor has to say so they can challenge it, instead of just the commission ruling that there is no basis for a complaint.

The Hon. CHRISTINE ROBERTSON: Do you understand that the commission has gone through a complete overhaul?

Ms LONG: Yes, I do.

The Hon. CHRISTINE ROBERTSON: What would you expect that to produce for your people?

Ms LONG: The new one, accountability, straight off, and to be taken more seriously and that families have legitimate concerns and complaints. I think I am looking forward to the new commission.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Does anyone fund your organisation, apart from yourselves?

Ms LONG: No, families around Australia fund the group. The Government does not give us any money, although we have asked for it; we have been knocked back. We produce about three reports a year and sell them to institutions and hospitals. That is what keeps our group going. Anyone who seeks help from the group is asked for a donation. That is how the group survives.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Do you produce a database of complaints and where they come from, and reports on various organisations? Or do you not have enough complaints to get statistically significant material together?

Ms LONG: Generally we have about 3,000 errors logged a year, maybe 2,500 depending on what is happening. We produce a report based on that. We will name the hospital and also log the errors we have had from the hospital that we deem to be an error.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: That is a fair few. So you are almost a private HCCC expert chugging along, are you not?

CHAIR: Private ombudsman.

Ms LONG: We are sort of like a ginger group just sitting there monitoring. And when hospitals come out and say they are doing all these great things, they are not coming out and talking about trying to repair the damage they have already done, they have become very defensive. Anytime we are putting out a hospitals report, we contact the top 40 hospitals and ask them have they got anything to say because we are going to put a report out and they are in the top 40 worst hospitals list, it is interesting to hear the comments that will come back from them. Apart from being abusive, some of them will tell you what they have done to reduce their medical error rate for the past year.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: That is what they should do, is it not?

Ms LONG: That is right.

The Hon. ROBYN PARKER: How do you define the 40 worst hospitals? And is that across New South Wales or across Australia?

Ms LONG: Across Australia. We define it by status. It is just by families contacting us, and doctors and nurses too.

CHAIR: By complaint.

Ms LONG: By complaint.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Do you produce an annual report that we could have a look at?

Ms LONG: We certainly produce a lot of reports. We produce close to 20.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You do not produce them annually though?

Ms LONG: Yes, we produce a hospital report about every February. It depends on what subject it is. We did one on medical indemnity; we have done one on the coronial benefits system; we have done one on patient safety; we have done a survey of 5,000 families.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Do you have a web site?

Ms LONG: No, we do not. We do not have any money. We use the media's web site—the ones who give us the best coverage.

The Hon. CHRISTINE ROBERTSON: Have you ever approached the New South Wales Health Department or have they approached you or your organisation to work with them on their quality programs? They have got this consumer group. I am just wondering if you have ever had anything to do with that?

Ms LONG: No, I have never had anything to do that, but I think about 18 months ago I was on a clinical governance committee. I attended a few meetings and the meetings were changed to early in the morning and I could not attend. I have not heard anything further about it.

The Hon. CHRISTINE ROBERTSON: So you were actually a member of that committee?

Ms LONG: Yes.

The Hon. CHRISTINE ROBERTSON: Was it any good?

Ms LONG: Well, I do not know what the outcome of it was and whether a report was put out because I have not been contacted. I have had no communication whatsoever about it for well over a year.

CHAIR: Could you define the area of your work? Although you are called medical do you cover all aspects of clinical intervention: nursing, hospital care, management, administration, those sorts of issues as well, or are you specifically medical?

Ms LONG: We deal with the aftermath of medical error. When something goes wrong—maybe in a hospital system—we get calls from people where there has been a misdiagnosis from general practitioners, things like that. But it is mainly problems inside hospitals.

CHAIR: So it has to be usually an adverse medical event that occurs?

Ms LONG: Oh yes. People contact us even to ask us how to get medical records. People contact us for basic drug information.

The Hon. CHRISTINE ROBERTSON: A lot of your problems have been with mental health work, have they?

Ms LONG: No.

The Hon. CHRISTINE ROBERTSON: I thought you just said mostly with psychiatric hospitals?

Ms LONG: No, not at all.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: So you have not had any systematic input? You were contacted by this clinical governance group but you have not been contacted by the new consumer contact group under the current director of communications? I do not know if you heard the evidence about that earlier this morning?

Ms LONG: No, I am not aware of it.

The Hon. CHRISTINE ROBERTSON: Are you on any consumer groups at all?

Ms LONG: The Australian Council for Safety and Quality in Health Care Consumer Network.

The Hon. AMANDA FAZIO: Is that a Federal body?

Ms LONG: It is Federal. The main work we do is direct with the hospitals. If hospitals have got a problem they will ask us to come up and see them. For a day you go through everything. You go through case outlines—depending on what the hospital wants. Once the report comes out they want to know why we have logged that many errors; why are they only hearing about us; what are we doing wrong. So there is feedback on that. We deal directly with the hospital, we do not go through the health department for any of that.

The Hon. CHRISTINE ROBERTSON: How many of the hospitals in New South Wales do you think have approached you to work on issues after your report has gone out?

Ms LONG: Probably everyone that has been on the top 40 list.

The Hon. CHRISTINE ROBERTSON: Do you feel that they are looking at those issues in some systematic way so that they might be resolved?

Ms LONG: Some of them are. Some of them are very defensive and outraged that it would even be considered to put them on a blacklist. We can only go on information that we are given from families. We have a panel of doctors and we get the panel to look at the medical records. Also we can rely on doctors and nurses. We hear from a lot of doctors, not so many nurses. It is mainly doctors who will give us information; even tell us if a patient has died, and will report to the Coroner. They have said they have taken it to management and they have been ignored and told to be quiet.

The Hon. ROBYN PARKER: Could I just explore that a little further? You are saying that the most feedback you are getting is from doctors who feel their complaints are not being heard. What reasons do they provide to you?

Ms LONG: Every doctor who has contacted the group has not ever provided us with any paperwork. They have never provided us with medical records; they have never breached that part of it, but they have certainly told us about patients who have died and what wards; they have told us which doctor was the cause of it and they have said they have gone to management and have been told to be quiet.

The Hon. ROBYN PARKER: Why have they been told to be quiet? Have they explained what the situation was?

Ms LONG: Not really, other than they would be ostracised and they would lose their job, that it is probably better to be quiet and it is far easier to whistleblow through medical error action; we can just either contact the hospital or the coroner's office or the media, along those lines. Once the hospital knows we have heard about it they do then start becoming quite defensive and they will call in lawyers or the spin doctors and they will have a statement already prepared. But I think the number of deaths we report to the Coroner can substantiate what we do hear.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Do you have a high success rate when you report a death to the Coroner? Does the Coroner go and investigate that?

Ms LONG: We have never had a knockback anywhere around Australia on anything we have reported.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Do the doctors who report it get witch-hunted?

Ms LONG: No, I have never known that.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: But I mean there is only a limited number of people who know about each case and if you then take the people who know what should have happened and thus are in a position to report the difference between what happened and what should have happened, that always narrows it down to two or three cases?

Ms LONG: That is right, but the coroner's office does not report to me. Once we report it to the Coroner under the Act and what part of it we are reporting it under we only keep tabs on it from the outside as to how the investigation is going. We do not get involved in the investigation; we do not steer it; we do not even point the coroner's office in any direction, we just tell them this has happened, the date it happened, the time and the hospital.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Do the doctors come back to you and say they knew someone leaked it and they suspect you and do they give you a hard time? Do they come back to say something like that?

Ms LONG: That has been said but mainly it has been done in secret and the finger has not been pointed at one particular person, because there could be a number of people on duty during a shift. So basically is has got to fall on all of them. Doctors contact us, I do not even know their names, I have never asked. Some of them just say, "Don't you want my name and phone number?"

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You say it is up to them, do you?

Ms LONG: If they give it to us, but I would never disclose who has given us information from any hospital.

The Hon. ROBYN PARKER: As you know, this inquiry has come out of problems about South Western Sydney Area Health Service. Did you receive complaints from doctors from Campbelltown, Camden or Liverpool hospitals?

Ms LONG: Yes, I have. I have heard from one doctor from Campbelltown hospital.

The Hon. ROBYN PARKER: Was that during the period of time that the nurses have made complaints as well?

Ms LONG: Yes, it would be in that time. But there have been problems at Campbelltown before that period, serious problems, and those problems have not been addressed and the families have been ignored.

The Hon. ROBYN PARKER: So complaints from doctors from those hospitals, can you run through what happened about those complaints and what follow-up action you took?

Ms LONG: We have got a substantial number of families from Campbelltown and the Camden hospitals on our books, probably just under 300 families—quite substantial.

CHAIR: Can I just clarify that? That is 300 from Campbelltown and Camden, not the whole area?

Ms LONG: No.

CHAIR: Just from those two hospitals?

Ms LONG: Yes. We mainly focus on the hospital, not the area.

CHAIR: Okay. So that is 300 complaints.

Ms LONG: That is just a bit of a ballpark figure. In the 290s—it would be around that.

The Hon. ROBYN PARKER: How many complaints from doctors would you have received?

Ms LONG: There has been one doctor at Campbelltown who has given us some information which certainly validated a couple of complaints that we have had on our books. When the Health Care Complaints

Commission [HCCC] report came out, most of the cases there I could recognise because I already knew about them. I had given information to the commission on things that were happening at Campbelltown, but I never heard back from them.

The Hon. PATRICIA FORSYTHE: I am sure you are familiar with some of the media comments on the evidence from the nurses from time to time. Have they been verified by the comments that have come from families?

Ms LONG: Not all that. There has been some concern from families about what some of the nurses have said because they had been given the opportunity to speak up about particular cases and they did not.

CHAIR: So the complaint is not that the nurses claimed too much, but they in fact claimed too little?

Ms LONG: Yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: So you would say that the problem is more extensive than the nurses have suggested?

Ms LONG: From what I have got on my books, it most certainly is, but Campbelltown and Camden are not the worst hospitals in New South Wales. I can tell you that now. They have had a lot of publicity and I think the geographic location has meant they have been ostracised. They have been considered to be a population of ignorant and perpetual complainants when in fact they are not. But the hospital, certainly from what I have been able to see, is nowhere near the worst hospital. There are a couple of others out there that are far worse than that and they do not get the bad publicity that they should.

The Hon. PATRICIA FORSYTHE: I think you need to identify which ones.

Ms LONG: Canterbury Hospital and Bankstown-Lidcombe.

The Hon. PATRICIA FORSYTHE: That is based on volume of complaints?

Ms LONG: Yes, and also on information we have been given. The other area of problem hospitals is in the Northern Sydney Area Health Service.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Does this reflect the population you draw from and perhaps how well you are known throughout the State?

Ms LONG: Well, you can look at it from that angle, but just based on the group's research, there are certainly problems in hospitals in the lower North Shore. They have either got a very careful media person within that area who has stopped it from getting to the media—because until the nurses came out, did the media sit back and think all that the Medical Error Action Group was saying is true?

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Sure. You might say that merely because of the combination of personalities at Campbelltown, who insisted on getting information out despite the obstacles, that has drawn attention to that hospital, whereas statistical analysis from your perspective would not have indicated that?

Ms LONG: Yes.

The Hon. PATRICIA FORSYTHE: Can I get this clear? When you talk about problem hospitals, are you talking about the actual incidence of concerns related to medical problems or are you talking about the way that the complaints are dealt with?

Ms LONG: No, I am talking about straight negligence resulting in death—high death rates at certain hospitals and in certain areas of medicine.

The Hon. PATRICIA FORSYTHE: When your members have had concerns in relation to some of these other hospitals, when they have sought information or have sought to make a complaint, are you able to

say whether they have had co-operation from those hospitals and those area health services or if their complaints have been largely ignored?

Ms LONG: The complaints have been largely ignored and there has been no co-operation with the families and that is why they have contacted our group. NSW Health does refer people to our group and so do some area health networks.

The Hon. CHRISTINE ROBERTSON: I asked this question before but I am just interested to know how often you refer people back to the hospitals to deal with the issues when they ring you up?

Ms LONG: No, we do not. We deal with the hospital for them.

The Hon. CHRISTINE ROBERTSON: When people ring up, you become a negotiator for them?

Ms LONG: There are a number of steps. When people contact our group, basically they want to know what to do, how to do it and where to start. We have an information pack that we send to them. It gives them all the tools, all the directions, and we give them all the short cuts. We will tell them the path not to take and departments not to deal with because they will not get anywhere and they will just hit brick walls the whole time. It is a matter of short cut information, and if people ring up we tell them what they have got to say to the hospital to get the records, and we say that if you do not get them, ring us back. They ring up and say, no, I have to go FOI and I have to pay for photocopying and it will take six weeks. We just ring the hospital, direct to the chief executive office, and ask them to release the records to the family immediately. We have not had any problems when we do that.

The Hon. PATRICIA FORSYTHE: Have you sought to make a submission to, or have discussions with, Bret Walker, SC, in relation to this inquiry?

Ms LONG: Have I?

The Hon. PATRICIA FORSYTHE: Yes.

Ms LONG: No. I have not heard from the Bret Walker inquiry.

The Hon. PATRICIA FORSYTHE: Have you sought to make a submission to his inquiry?

Ms LONG: I have indicated to the Minister for Health's office that I would, but we need to be paid to make a submission because of the substantial work involved.

The Hon. PETER PRIMROSE: Can I ask how many times you have made a referral to the Independent Commission Against Corruption [ICAC]?

Ms LONG: Only once.

The Hon. PETER PRIMROSE: And what was the outcome?

Ms LONG: No response.

The Hon. PETER PRIMROSE: On how many occasions have you been made aware of allegations of cover-ups, deaths and a whole range of what amounts to corrupt behaviour? Have you taken any other action to refer to the ICAC?

Ms LONG: No, only a complaint to the Minister for Health's office about ICAC not listening, not taking our concerns seriously. In the end, it is better not to deal with them.

The Hon. PETER PRIMROSE: What about people like, for example, Professor Barraclough? Have you had any contact with him?

Ms LONG: Yes, quite a lot, along with his consumer network.

The Hon. PETER PRIMROSE: What are his views?

Ms LONG: I have not discussed ICAC with Bruce at all because I see him as Federal. He is involved with the Federal council and not by State, even though he does come from New South Wales.

The Hon. PETER PRIMROSE: Does he share your concerns about cover-ups of hundreds of deaths?

Ms LONG: No, he does not, no. He does not. He seems to think that negligence is rarely the issue.

The Hon. PETER PRIMROSE: So he does not share your concerns in relation to the cover-ups?

Ms LONG: No, he does not. Well, he has not expressed them to me.

The Hon. PETER PRIMROSE: Has the department ever, for instance, invited you to sit on one of their HCCC referral committees?

Ms LONG: No. The HCCC asked me to go in for a talk one day for about 10-15 minutes a couple of years ago, and I did that.

The Hon. PETER PRIMROSE: You have never been on, for instance, a Department of Health committee looking at the HCCC in terms of referrals?

Ms LONG: No.

The Hon. PETER PRIMROSE: Never attended even one meeting?

Ms LONG: No. I do not think so, no.

CHAIR: Ms Long, can I take you back to the beginning. You said that when people were complaining in NSW Health or to the HCCC, the complaints or medical records were not handed over, but the other thing was that even when they were, the HCCC eventually did nothing. They hung onto the complaints for long periods of time.

Ms LONG: That is right, nearly three years.

CHAIR: And then the complaints were dropped?

Ms LONG: That is right.

CHAIR: Would you like to expand on that? Did the HCCC actively, to your knowledge, investigate the complaints or did they just hang on to them, hopeful that the complainant would drop off?

Ms LONG: Well, they said they investigated the complaints, but the problem with the commission was that there was a high staff turnover. As for case management, each time a person would make a complaint, the commission then reports the complaint back to them, and that is where the communication problem starts because once the commission then interprets the complaint as being like this and the family says, no, it is like that, the family spends all their time trying to correct the commission on what the issue is. But generally after 19 months the complaint has reached a dead end, and then you can pretty well say by three years the commission then shuts the complaint, usually citing that it has no more resources. There is a deliberate intent to hang onto reports until the statute of limitation runs out and then the people are at a loss.

The Hon. CHRISTINE ROBERTSON: The Health Care Complaints Committee of this Parliament recently produced a report on these issues, which is why action has been taken on health care complaints. It outlines the problems quite specifically in relation to this issue.

CHAIR: Yes.

Ms LONG: We have got quite a file of letters from the Health Care Complaints Commission about their failure to act. It is usually in the norm.

The Hon. ROBYN PARKER: You mentioned that some area health services refer families, patients or complainants to you?

Ms LONG: Patients.

The Hon. ROBYN PARKER: Could you tell us which area health services in New South Wales do that?

Ms LONG: Not off the top of my head. I would need to be able to refer to my records. I could certainly provide that to you.

CHAIR: We can take that question on notice and maybe you could let us have an answer to that.

Ms LONG: Yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You have said that you disagree with Bruce Barraclough in that you regard negligence or incompetence as a greater cause of the problem than system failures?

Ms LONG: Yes, I do.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: But you are still advocating a non-blame culture? Are not those two things slightly in opposition to each other?

Ms LONG: I am not advocating a non-blame culture; I am advocating accountability, and with accountability comes honesty and also the idea that they will learn from the mistake and will not do it again. Doctors always say that they want it in a non-blame atmosphere but they go to such lengths to cover it up. If they have not done anything wrong—which they keep saying—why do they go to such lengths to smother it?

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Well, if there is a blame culture, as soon as you admit that you have done something wrong, you will get shot, presumably?

Ms LONG: The blame culture gets down to the legal action because, in the end, they have to find out who erred.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Would you argue for legal indemnification or immunity from prosecution in this more open system?

Ms LONG: Well, they have already got qualified privilege and now they have got open disclosure, and the two do not meet, because with qualified privilege they can talk to their peers knowing that that information will be kept secret, but when you have got open disclosure you are supposed to tell the family what has gone on and who did it.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: They then retain their rights in tort to sue, though, do they not?

Ms LONG: They do, but in most cases if they do take that path, they do not get off the ground.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: That may be a failure in the tort system rather than a conceptual failure? If they did get the information and did sue, they would be in a stronger position, would they not?

Ms LONG: That is right. It is entirely up to them if they want to do that.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Yes, it is up to them at the moment, but it may be that you have to trade off some rights in tort to sue for the open culture, which will give better prevention.

CHAIR: This goes beyond our—

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: No, it goes to how a complaint is dealt with and what will happen. It is really right on the point. What would be your view about that trade-off?

Ms LONG: As long as it was completely forthcoming and it was completely open and on the table, I would agree with that. Clearly, at the moment people sue because there is no other option and there are no choices. That is the way the system is at the moment. If you do not like what the Health Care Complaints Commission has done, you can go to a lawyer and take that path and whether you succeed or not is entirely on the performance of your lawyer and also on the medical evidence you can get to support your case.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: But you are saying that if it was completely open, then you might allow the tort lawyers not to be able to go straight ahead?

Ms LONG: Yes.

CHAIR: I take it that you are happy for us to incorporate into our papers the addendum to your submission?

Ms LONG: Yes, that is part of what I have written for the Safety and Quality Council, going back a couple of years, and they were the recommendations and solutions we put forward.

CHAIR: Thank you very much for your attendance here today.

(The witness withdrew)

(Luncheon adjournment)

BRUCE HENRY BARRACLOUGH, Chair, Board of the New South Wales Institute for Clinical Excellence, sworn and examined:

CHAIR: Thank you for attending this afternoon. Earlier this morning I made a very full statement, which I do not intend to go over now. That statement concerned the privilege, which applies to all parliamentary proceedings, including these Committee hearings, being absolute. I referred also to the rights of the Parliament to investigate matters such as these. Although, of necessity, you might have to talk about individual health care workers, we would prefer you to look at systems issues and their failure or otherwise. Our aim is to try to improve NSW Health. Professor Barraclough, in what capacity are you appearing?

Professor BARRACLOUGH: I appear as the Chair of the board of the New South Wales Institute for Clinical Excellence.

CHAIR: Would you care to make a brief opening statement before Committee members ask you any questions?

Professor BARRACLOUGH: I will make a brief opening statement. The Institute for Clinical Excellence [ICE] was set up a little over two years ago in order to put in place education and other programs to improve health care in New South Wales. It has as its mission to make health care safer and better for the people of New South Wales.

CHAIR: Earlier today a number of witnesses referred to the influence of your work. Is there anything that you wish to say about the general issue of complaints handling within NSW Health?

Professor BARRACLOUGH: The papers that I have given to the Committee about the work of the Institute for Clinical Excellence and related matters pretty much stand by themselves and are a reasonable report about the activity in which we have been involved. ICE, of course, is not an institute that is involved in the taking of complaints or in the investigation of complaints; its involvement is in the improvement of clinical practice.

The Hon. ROBYN PARKER: Did you at any time face criticism from the Government for your findings on Macarthur Health Service?

Professor BARRACLOUGH: No. Your question relates to my task when I was chair of an expert clinical review group. Upon the director-general receiving the interim report from the Health Care Complaints Commission into a number of cases, she asked my team to look at the standards of care and activity at Macarthur and south-west Sydney and to make recommendations for further improvement, where opportunities existed, and to oversight some of those improvements. As far as the members of my team and I are aware, our report was received very favourably. We have been thrilled by the support that has been given to people working in south-west Sydney in order to put in place the recommendations that we made in a short period of time.

The Hon. CHRISTINE ROBERTSON: One of the issues that this Committee is examining is complaint handling. However, it becomes involved with quality, which is your territory. One of the issues that has come up is that your Institute of Clinical Excellence, which is powerful, is working to implement programs across the State. However, there are problems relating to general implementation across the system within each area health service and each hospital. Could you outline what ICE does to enable that to occur?

Professor BARRACLOUGH: I will pass around to you some brief information about the safety improvement program that is basically the key to the work of ICE. When you get that information you will see that the safety improvement program is stimulating the identification, reporting, investigation and analysis of health care incidents. Our objective is to make health care safer by correcting system vulnerabilities through understanding why errors occur. Over the past 18 months or so we have taught the methodology of root cause analysis to some 2,500 people in NSW Health. We were also involved in some preliminary activity about the understanding of human factors, which is how humans interact with humans and machines.

CHAIR: Dr Barraclough, I seek clarification on an issue about which the director-general spoke earlier. Is this program directed mainly towards staff? Are members of the public or members of the community aware of what you are doing in relation to this root cause analysis?

Professor BARRACLOUGH: I guess that the man in the street would not know about this.

CHAIR: But is it not for the man in the street to know?

Professor BARRACLOUGH: Absolutely.

CHAIR: The man in the street might be the victim of some medical mishap or problem.

Professor BARRACLOUGH: There are community and consumer representatives on various committees in different health areas. One would hope that through the health areas and their interaction with their communities that information would be understood.

CHAIR: Is there a systematic way in which you distribute that information to the community?

Professor BARRACLOUGH: We have an annual report and a newsletter goes out widely within the health system. We have not been funded for, or taken the opportunity, of a broad external communication program at this stage. ICE is funded to the tune of about $2.5 million a year. If you look at the range of programs that are being performed, you will see that ICE has been focused on the main game, which is clinical practice improvement.

CHAIR: You can understand why other people feel that, if they do not know what complaint handling systems are in place, they cannot use properly that system. They do not know what happens when you get down to the root cause of problems.

Professor BARRACLOUGH: I can certainly understand that. I think it would be useful for the community to understand. I hope that exercises like this will help that understanding.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: When you put together these prioritisations can we assume that the people involved were all reporting back to a central body, or were they initiating investigations? One of the points that was made about Campbelltown was that the procedures were fine but that they were not being followed. Do you look at the notes and flow histories of people who might have been sub-optimally managed?

Professor BARRACLOUGH: No, we do not do that. That is not our task. Our task relates to the education and dissemination of the processes and methodologies around clinical practice improvement. We do not manage health areas, complaints or investigations. That is not our task. There are others who do that.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: But there are people doing that. It seems to that there could be areas in which these things are being sub-optimally managed. They might be sub-optimally managed, perhaps at an administration level, or at practitioner level. It appears as though these policies and self-improvement exist but that they are not being applied in these areas? Even though poor practice is the norm it might not be noted as such. Why does that not happen in the average case, or in some cases?

Professor BARRACLOUGH: I believe, once again, that you have misunderstood what ICE is about. The department determines policy and the individual health areas put that policy in place. There are various other structures around the handling of complaints, both within health areas and within the broader New South Wales community—through the Health Care Complaints Commission and other activities. ICE is not involved in the investigation of individual complaints or individual activities. We are out there helping people on the ground and people who manage health areas to put in place processes that allow better care. We have not been part of a process of collecting adverse events. That is not our task. We have stimulated further reporting of adverse events, and the very fact of this program being put in place—I guess this is partly a further answer to the Hon. Christine Robertson's question, which I did not quite finish answering—

CHAIR: I have not forgotten.

Professor BARRACLOUGH: By virtue of this safety improvement program and the other programs of ICE, there has been a dramatic increase in the reporting of severe adverse events to the Department of Health and to individual health areas. This is what we aim to do: We aim for a dramatic increase in reporting so that we can know where problems exist and so that the vulnerabilities can be corrected. This is a program about correcting vulnerabilities, not about collecting reports.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You set up this institution that has been running for a couple of years. This Committee under the chairmanship of Dr Brian Pezzutti had a presentation from the group, talking about the length of stays and improvements in that as an index of quality. All this happened yet until these nurses cut the Gordian knot, as it were, blew the whistle and drew attention to quality issues—the identification of problems by Fiona Tito in 1995—the number of adverse events does not seem to have been seriously challenged at a grassroots level. Is that correct?

Professor BARRACLOUGH: I do not believe so. I think there has been a vast number of activities going on around the country, both nationally and in individual States, to try to address the complexities and the problems relating to those complexities in the delivery of health care, particularly high-quality health care. A vast number of activities are being undertaken by folk at a management level, a clinical level and even at a consumer level across the country to improve health care activity.

The Hon. CHRISTINE ROBERTSON: As an extension of the question about the difficulties of implementing this process on the ground—I am talking system wide not necessarily about the individual centre—has the process and how it works been quite difficult to sell to some clinical groups? Was it easier to sell to some clinical groups than others?

Professor BARRACLOUGH: We have been thrilled by the response that we have had. We believe that response has been as positive as it has been—that is, very positive both from management and from many different groups of health professionals—because it looks at what happened, why it happened and how it happened, and then identifies potential ways to stop it happening again and to improve the system. Asking what, why, how but not who puts the causation back into the system where it should be. The organisational psychologists and other high-reliability industries that are complex and risky like health care—such as airlines, nuclear power or mining—know that 90 per cent of problems are based on the system. So if you address the system issues, you address 90 per cent of the problems. If you address the personal issues, you address about 10 per cent of the problems. While the personal issues cannot be left out of it, the attractiveness of this is that it actually addresses the large proportion of underlying problems whenever a particular issue surfaces.

That has been very attractive to all personnel because, without any change in the legal system, any change in culture or any change in any other aspect of their work, they are reporting much more freely and openly than ever before. While we do not have hard evidence of this, we believe—as do others overseas—that this is because they now feel that something will be done because systems issues have been identified. So the outcome of these investigations does not make the burden of caring greater; it actually makes it less by improving the system in which people work.

The Hon. AMANDA FAZIO: The NSW Health submission refers to its safety improvement program and the key point and mechanisms it has introduced being based on the veterans administration system in the United States of America. Could NSW Health have borrowed from or introduced other systems or is that the best system of which you are aware internationally?

Professor BARRACLOUGH: That was the best one we could find internationally. It had been proven in a series of hospitals of much the same sort of total size as in NSW Health. It had been put in place by people whom we had access to. Those people allowed us to use their intellectual property without cost and they were able to train our own people, as a train-the-trainer exercise, so that we could move forward very quickly with this program. Undoubtedly there are other practice improvement activities, and ICE has picked up some of those activities in its other programs. The Institute for Health Care Improvement in Boston has popularised the breakthrough collaborative process, which is based on process mapping and process re-engineering. That is part of the flow and safety collaborative that we have run. Yes, there are other methodologies, but in terms of looking particularly at incidents and adverse events, the root cause analysis program was the most appropriate that we could find to put in place in New South Wales.

Another hat that I wear is that of chair of the Australian Council for Safety and Quality in Health Care, which is answerable to all health Ministers. That council has obtained agreements from all States to use root cause analysis as the methodology of choice for both education and analysis of severe adverse events in health care.

The Hon. AMANDA FAZIO: You said earlier that as a result of the root cause analysis that is now being undertaken you expected there to be a large number of incidents reported initially. That same comment was made in a NSW Health submission. Once system changes are introduced and improvements are made, how dramatic do you expect the fall-off in notifiable incidents to be?

Professor BARRACLOUGH: I do not expect a fall-off at all, and I am not looking for a fall-off. I think as health care becomes more complex we have new activities to improve every day. The complexity of health care is increasing and is not likely to slow down. People are starting to write that is the most complex activity undertaken by man at the moment because of the vast number of human-human, human-machine and human-drug interactions. So I would expect that vulnerabilities will continue to be identified and will continue to be reduced.

I will tell you a story—stories about adverse events are very powerful and stories about improvements can be quite powerful too. Jim Bagian is an astronaut, doctor and engineer who used to work for the National Aeronautics and Space Administration [NASA]. He did the root cause analysis on the *Challenger* disaster and was seconded from the veterans administration back to NASA to work on the *Columbia* disaster. He developed this program. In the first year of the veterans administration in the United States he found about a 900-fold increase in events reported. When they needed to report directly to Congress, the congressmen were rather concerned about the 900-fold increase in reporting after all the money they had spent. Jim said, "Well, you need to understand that this is not an increase in adverse events; this is an increase in vulnerabilities corrected and the system is that much safer because those vulnerabilities have been corrected."

CHAIR: While what you say is very comforting and I find it assuring in a number of ways, the evidence we received from various nurses and others had nothing to do with highly technical, highly complex human-to-machine and human-to-human interactions; they were basic issues of failures in infection control, clinical procedure and the like for which policies are written yet there has been a breakdown in discipline in ensuring that they are observed.

Professor BARRACLOUGH: I guess once again there has been some slight misunderstanding of the way in which I expressed things. The complexity of health care is not always highly complex individual activities. The complexity is the multiple interactions to correct a problem. So, if you break your wrist and walk into an emergency unit you might meet 25 different people to get that fixed. It is each step of that 25-step process that needs to work 99.9 per cent repeating if you are going to get a 99 per cent good result. It is that complexity that is the problem. You are quite right in another sense in that operational discipline is something that is required at every level and it needs to be repeated time and again to get the end result for a patient. It is those process issues, those individually simple but taken together complex process issues, that are always the problem. If there are not enough trained and appropriately supervised people in place to deal with the level of care that is required by the people presenting, that is when you are most likely to have problems.

CHAIR: And not only providing the care but checking that the care is being done?

Professor BARRACLOUGH: That implies that people are working in a process, a system, that supports them to do that; that supports them with enough staff to allow that to be done; supports them so that they are not always being interrupted in every step of their working lives; supports them so they have somebody to ask if there is a question; supports them with the background to allow them to make appropriate decisions. These support issues, the building of good systems around good professionals, is what clinical practice improvement is all about. It is the building of systems to allow people to work to the competencies that they hold.

CHAIR: We have had examples of systems breaking down in the most elementary ways. For example, a lady going in to have a breast removed and the wrong breast being removed; issues of amputation, where the wrong limb was amputated. That kind of very serious issue does not require rocket science.

Professor BARRACLOUGH: None of this is rocket science, as Jim Bagian tells us. He was an astronaut, and he uses that phrase very commonly. This is not rocket science, it is probably more complex than

rocket science because people will continue to be fallible. When people are fallible and they are not working in a system that supports them perfectly all the time that fallibility will come to the fore and we all forget to return that video. From time to time I have ended up at the wrong hospital in the middle of the night. We do that, that is human nature. We need to build into the system supports that stop us from doing that or allow that to be corrected before it converts into harm.

Another person who has written widely on this subject is a man called Professor James Reason, who is the Professor of Organisational Psychology at Manchester. He advises the Civil Aviation Safety Authority in this country and many airlines around the world. He would tell us that to get an adverse event—in other words, something causing harm to a patient in health care—we need to have a whole series of gaps in the defences of a system. In health care sometimes there is only one barrier, and that is very fragile because it is a human barrier, and that human will get it wrong from time to time. With wrong-site, wrong-side surgery, wrong patient and wrong procedure, in most places there would be somewhere between 10 and 15 different process steps that stop that wrong-site, wrong-side procedure from happening.

CHAIR: All of which have failed.

Professor BARRACLOUGH: All of which have failed if it turns out to be an adverse event. So, if you were doing an analysis of that you would work out which of those things had failed, why they failed and what you needed to do to stop them from failing again.

The Hon. PATRICIA FORSYTHE: You have just referred to support mechanisms.

Professor BARRACLOUGH: Yes.

The Hon. PATRICIA FORSYTHE: Specifically in the case of Camden and Campbelltown, what support mechanisms were absent?

Professor BARRACLOUGH: The expert clinical review team that I lead spoke to many staff, to managers and to the board of South West Sydney. We made a number of recommendations, which are in the public domain, and we had a report which is also available. I have it here if you do not already have that. We found that the problems—in other words, the vulnerabilities—that needed to be corrected in order to make the necessary improvements so that, as has been identified in the press recently, the gaps are narrowed—and there has been some comment about people falling through gaps—were significant attention to work force so there were adequate, appropriately experienced and appropriately supervised workforce for the level of care being offered; improvements in culture, in that the culture needed to be open and fair—in other words, a safety culture where people are encouraged to report and act on the issues that they find without fear of any retribution. We also felt that there needed to be stronger and more consistent leadership, particularly where there were no appropriate people in place to provide that leadership, and we felt that some systems needed to be redesigned, particularly around the transfer of patients and the ability to access appropriate diagnostic services.

The Hon. PATRICIA FORSYTHE: When the Camden maternity unit was established, it was established for "low-risk" deliveries. Is there such an animal as low-risk deliveries?

Professor BARRACLOUGH: I am not sure I can answer the question in the way you have asked it. Let me just say that in order to define what such a low-risk service should look like in the context of the staff and facilities available at Camden, bearing in mind what is available within 15 or 20 minutes drive in other places in south-west Sydney, the new management of South West Sydney asked Professor David Henderson-Smart and a team of people to review the obstetric services of south-west Sydney and how they were provided and to develop further information for us about what the "low-risk service" at Camden should look like. In other words, what were the protocols and pathways that needed to be in place that everyone understood and adhered to so that appropriate people were cared for in an appropriate way where the appropriate resources exist?

He has come forward with recommendations about that and I for one am very pleased about that, because not only his work in advising us about the obstetric service across south-west Sydney but the work that we asked Professor Jeremy Wilson to do to develop an area-wide service plan will help with the linkages and the sharing across the various hospitals of south-west Sydney that will allow high-level human resources to be shared in an appropriate way so that wherever people access the system they will have equity of outcome.

The Hon. PATRICIA FORSYTHE: Last week a witness use the expression "nurse perfectionists". Is it appropriate that nurses strive for perfection?

Professor BARRACLOUGH: I would imagine that all in health care are motivated by a desire to do good. People come to work to do good. Everybody does. People are striving to do the very best they can for the patients they are caring for. The people working in south-west Sydney have certainly been doing that. As I have expressed on a number of occasions, people out there were working very hard to deal with a far greater number of patients than their colleagues in other parts of New South Wales, and dealing with them very well, but with limited support because of the organisation across south-west Sydney.

The Hon. CHRISTINE ROBERTSON: I have another question in relation to a group called the Medical Error Action Group.

Professor BARRACLOUGH: Lorraine Long's group?

The Hon. CHRISTINE ROBERTSON: Yes, that is correct. I understand that this group produces reports at least annually on its perceptions of where the health service is at. I wonder whether you could outline if there are any issues in relation to those reports and the information?

Professor BARRACLOUGH: As I understand it, the activity of the Medical Error Action Group is designed to highlight the problems that are occurring in the health system, to recognise where people have been harmed and to draw that to the attention of those who are in authority and in managerial and other positions in the health system. As I understand it, it tends to be a self-reported activity from people who have either heard about, or been involved in, episodes that have harmed them. You can learn an awful lot from the stories of people about harm that occurs in the health system. Those stories are often quite cogent in terms of helping us correct problems. The numbers themselves may not stand up to scientific rigorous scrutiny because of the way they are collected, but nevertheless they are a useful indicator that there are continuing problems that we need to address.

The Hon. AMANDA FAZIO: In regard to supports for complaints procedures that you investigated then you looked at the Campbelltown and Camden hospitals, you identified that leadership was missing. At what level was it missing? Was it supervisory, middle management, senior management, clinical or just administrative? Last week some nurses who gave evidence to the committee had extensive education after they had graduated, had really gone a long way, had developed a lot of experience and had a lot to contribute. Most people in any sort of leadership role within an organisation would be loathe to lose very senior and highly trained nurses such as those we heard from last week. Would you comment on that in terms of the lack of leadership to which you referred?

Professor BARRACLOUGH: We have identified in our report and recommendations a need for academic leadership of a number of clinical departments. We have demonstrated a need for some extra medical leadership in some departments. We have demonstrated a need for an increased number of clinical nurse consultants and nurse educators. All of those levels in various parts of the hospitals that we looked at needed improvement. It is not at one level, and neither is it in every department that leadership is lacking. There are some departments in that organisation that we looked at that are exemplar for the rest of the State. The ambulatory care service is one and paediatrics is another where individual leaders were performing superbly well.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: If you have a good system where adverse events, and mean or collected outcomes are reported routinely, and there are good discussions of adverse events in an open framework, would a tort system under which patients can sue be removed? Are the two in opposition? How would an open culture of discussion exist with a tort system where if you do not prove fault you do not get any money?

Professor BARRACLOUGH: I answer that by referring to the open disclosure standard that the Australian Council for Safety and Quality in Health Care has put together, and which we are in the process of implementing across the health system of Australia. That open disclosure standard has three components: the hearing and the telling when an adverse event occurs, and the support that is required for that; a commitment to in depth analysis such as a root cause analysis; and a commitment to fix the problem. There is reasonable but not high level evidence across the world that complex organisations that have taken on board that open disclosure is

desired by their clients—in this circumstance by health care consumers and patients—that those folk who have been involved in a harmful episode are more satisfied with the result because they understand it more clearly, understand it clearly at the time, understand that the problems will be addressed and understand how the problems are being fixed.

There is some evidence in health care, even with an aggressive tort system such as in the United States of America, that there will not be an increase in litigation, but possibly a decrease. The open disclosure standard is not in any way set up in order to reduce medical litigation. Probably something less than half of 1 per cent of all adverse events are compensated through the courts. The nexus is not as strong as intuitively you might understand it to be.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Information is not given for fear of tort? In a sense, tort is a stick?

Professor BARRACLOUGH: I do not think that is the only fear. It is one fear and it does not help, but others are: fear of ridicule, fear of loss of job, fear of peer criticism and fear of loss of practise. There are many inhibitions for humans to admit their mistakes. I mean, next time you scratch the car you may not admit it the moment you get home. There are lots of fears about people being open about problems, and I am not trivialising the harm that occurs in medicine by giving that analogy. The harm is real. When people hide that harm or hide the reasons for it, the black anger is extreme as Lord Wolf said in his report entitled, "Access to Justice" in 1995 in the United Kingdom. The black anger of health care litigation makes it different from all other forms of litigation. Let us not minimise that, but it is only one of the issues why people do not report.

People will not report if they believe that nothing will be done. If they believe that something will be done they are much more likely to report. We have demonstrated a 50-fold increase in severe adverse events being reported in New South Wales, and we are starting to see similar activities in other States as they start to teach root cause analysis as well.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: However, if a relatively pure mistake was made in which an incorrect treatment was done, and realised later by the doctor, it was not a system failure because that person knows it was his/her own mistake.

Professor BARRACLOUGH: It is often still a system failure in that you may not have access to the reference activity. If you think about the prompts that come up with an electronic system around dispensing drugs, those prompts help you to make right decisions, or prompts that have charts on the wall as you do things. There are all sorts of systems issues that help people to make the right decisions at the right time. Even when you are the person who is closest to the incident there still needs to be a situation where that particular circumstance is likely to happen again, either to you or to somebody else. We need to look at the things that we can do to make that less likely to happen. In other words, what can we put in place to help you make the correct decision every time?

What you have described is a type of error not dissimilar from forgetting to return the video. Because you have been focussed on something, you have gone down a different street, and you actually have not called in and returned the video. And so you have been led to a different end point in your decision-making. No doubt you will blame yourself for that, as I would in that circumstance, but if we are going to get beyond depending on the randomness of human fallibility, we need to look at systems as well.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: However, if one assumes the patient was unaware that they had been mistreated or not optimally treated, the only way they would find out would be if the person who did it spruiked up and admitted it, unless somebody else noticed.

Professor BARRACLOUGH: Absolutely.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Effectively then they are actually giving somebody a stick, who otherwise would not only not have it but may not have needed or wanted it?

Professor BARRACLOUGH: I think that this week in the annals of internal medicine in the United States of America there has been a technical study of open disclosure in health care asking people about various activities. It does support the view that open disclosure is unlikely to increase litigation. If people know that

there has been a problem, and there is trust between the clinician and the patient, that openness is occurring, and it usually does not bring forth troublesome legal events.

The Hon. ROBYN PARKER: In our discussions and your definition of root cause analysis you talked about identifying incidents and management having control of effects. You also referred to the staff in Camden and Campbelltown hospitals working very hard and you discussed management issues. Would you comment on resources and the effect of the lack of resources on incidents and how that related in those areas?

Professor BARRACLOUGH: There will never be enough money in health care to meet community expectations as they increase at an exponential rate. The Federal Government's intergenerational report suggests that there will be an extra 1 per cent of GDP spent on health every 10 years till 2040. We have not yet reached a peak in the increase of technology and drugs and all the other things. When my dad had bad hips he wanted two sticks. I want two hips; in fact, I want four hips if the first two fail. It is the answering of expectations that is one of the problems we face: expectations of a perfect result are almost always there. We have done some focus groups through the Australian Council for Safety and Quality in Health Care. People do recognise that health is risky, they recognise it is complex, they recognise that accidents will happen, but almost to a person they say, "Not to me". So there are expectations out there that we are never going to meet. That needs, as Reverend the Hon. Dr Gordon Moyes suggested earlier, a communication exercise with the community so that there is an understanding of that.

I do not believe that in the circumstances of the South Western Sydney Area Health Service it was impossible to provide the staff with the level of financial resources that were there. That health area, in particular, has an increase in financial resources every year because it is a growth area and because it is, in some ways, dealing with people who are from a socioeconomic background that maybe needs more care in some parts of that health area. There are enhancement funds virtually every year going to that health area and to others where need is identified through a resource distribution formula. You might ask Professor Picone later, who is the administrator of South Western Sydney Area Health Service now, about the extra staff that have been put in place over the past few months to meet the situation so that people working in the health areas are better supported. It will probably cost in the order of $5 million to $7 million per year recurrent in a health area that might actually spend something in the order of $800 million per year. I would suggest to you it is how you spend the money, not the total amount of money.

CHAIR: Professor, thank you for your contribution. We wish you well in your work. It is absolutely crucial that you are effective.

Professor BARRACLOUGH: Thank you.

(The witness withdrew)

CHAIR: Welcome to the next session. I will not repeat the statements I made at the beginning of the Committee's hearing this morning about our terms of reference, the role of media and so on. But I will briefly say that the terms of reference of this inquiry require the Committee to examine the systems for handling complaints in New South Wales and whether the health system in New South Wales encourages people to reflect upon their errors. The individual experiences in the system will help us to understand how complaint handling systems work, or do not work. I ask you to reflect upon our terms of reference.

I make it clear to you that the privilege that applies to parliamentary proceedings also applies to this Committee, and that privilege is absolute. It exists so that Parliament can properly investigate matters such as this. It is not used primarily as a forum to make adverse reflections upon other people. We are here to examine where there have been failings in the systems so that we can correct them. I would also like to make the point, for the benefit of those of you who perhaps have never been witnesses before a parliamentary hearing, that part of the protection of parliamentary privilege to these proceedings extends to what could happen to you after you have given evidence today. Any adverse reaction against you by any supervisor as a result of what you say in this hearing is, in fact, a contempt of Parliament and is a very serious issue.

The Legislative Council bases its practices on those of the Senate in most respects as to the protection of you as a witness. The Senate resolutions of 1988 declare that any interference with witnesses and the infliction of any penalty on witnesses in consequence of their giving evidence would be treated as a contempt of Parliament, and that is a very serious and indictable offence. In the Legislative Council there have been several instances where this has been invoked as a consequence of actions taken by persons towards a witness following a parliamentary inquiry. I would ask any supervisor or those in authority who are present to be mindful of this, and I also put on record that discussions between myself as Chair and the director-general of the department have taken place to ensure absolutely that there is no intimidation of witnesses who give evidence to this inquiry or no direct impact upon their career path.

I would like each of the witnesses, when sworn, to give your function and also indicate whether you are appearing in a professional or in a private capacity.

DEBORA PICONE, Administrator, South Western Sydney Area Health Service,

CLAIR JOYCE CAMERON, Manager, Public Affairs, South Western Sydney Area Health Service,

GREG DRIVER, Area Human Resource Manager, South Western Sydney Area Health Service,

MARY DOWLING, Manager, Professional Practice Unit, South Western Sydney Area Health Service,

RAAD TERENCE RICHARDS, Chief Executive Officer, Carrington Centennial Trust,

SUSAN BERNADETTE CONNELLY, Public Relations Consultant, South Western Sydney Area Health Service, and

CATHERINE MAREE O'CONNOR, Nursing Unit Manager, Intensive Care Unit, Campbelltown Hospital, sworn and examined; and

LISA KREMMER, Nursing Unit Manager, Emergency Department, Camden Hospital, and

MALCOLM RAYMOND MASSO, Private Citizen, affirmed and examined:

Ms KREMMER: I appear before the Committee in a professional capacity.

Mr MASSO: I was previously employed with the Macarthur Area Health Service, but I now appear before you as a private citizen.

Mr RICHARDS: I am Chief Executive Officer of the Carrington Centennial Trust, previously employed by South Western Sydney Area Health Service, and I am appearing in a professional capacity.

CHAIR: Does anyone want to make a statement at the beginning?

Associate Professor PICONE: I have a statement that I think would provide useful information to the Committee on what constitutes the South Western Sydney Area Health Service and then the issues within the health service regarding complaints management. South Western Sydney Area Health Service comprises seven local government areas, including the major suburban centres of Liverpool, Bankstown, Fairfield and the outer urban centre of Campbelltown, as well as comparatively isolated localities around Camden, Wollondilly and Wingecarribee shires. Members may be aware that the South Western Sydney Area Health Service has the most culturally and demographically diverse population of any area health service in New South Wales.

Parts of the area are among the most socioeconomically disadvantaged areas in Australia. It is also one of the fastest growing areas of Australia, with a current population of around 800,000 people, and this is expected to rise to 842,000 people by 2006. The area health service has almost 8,000 staff, working in six general acute hospitals—Liverpool, Bankstown, Campbelltown, Fairfield, Camden and Bowral—and there are four other major facilities. Considerable attention has been focussed in recent months on the investigation by the Health Care Complaints Commission into complaints about patient care and safety at Campbelltown and Camden hospitals, and also the past management of staff grievances. Members would be aware that those, and related matters, are now the subject of investigation by both the Independent Commission Against Corruption and the Special Commission of Inquiry conducted by Bret Walker SC.

CHAIR: Professor Picone, if I could interrupt you for a moment, as you have mentioned that, so that people might understand the nature of giving evidence that is also before other courts. Those other courts might be the Industrial Relations Commission, as former staff are currently before the Industrial Relations Commission; there are discipline tribunals; and there is the special inquiry by Bret Walker that you have just mentioned. I would like it known that the sub judice convention requires that this Committee should consider discussing such a matter that is currently before other courts of law. The weight of legal opinion supports the view that we may discuss a matter that is being considered before other courts. In other words, you cannot say, "Because this is sub judice, I cannot talk about it." The fact is that it may be discussed, if this Committee requires that. The Parliament is in effect the court that makes the laws. The other courts are in the business of administering the laws. So the Parliament has a right to consider things even though they may be sub judice. Normally, we will not do that, unless members bring up matters.

Associate Professor PICONE: Thank you. As you said, other matters covering a range of individual cases are also currently being examined by the NSW Police, the Coroner, the New South Wales Medical Board and the Nurses Registration Board. When joining South Western Sydney Area Health Service in October 2003, I made it a priority to meet with as many of the patients and staff as I could, as well as a wide range of community members and representatives. I have also had a number of meetings with patients, family members and staff who have made complaints about patient care and safety in the area health service, because I wanted to understand their experiences first hand. We have learnt a great deal in a short time from talking to the people who have raised concerns and we are putting a lot of these lessons into practice.

I also place on record my admiration for the professional and dedicated staff across the area health service and acknowledge the overall commitment to and support of the wider community of south-western Sydney to its health service. Nevertheless, the investigations have shaken community confidence in the health services and have had a telling effect on the morale of the staff, with nursing and medical staff at Campbelltown and Camden hospitals in particular under terrible strain over the past 12 months. We are all working hard to take the organisation forward, and I believe we are now beginning to restore community confidence and see staff morale rebuild. In October 2003 a review team commissioned by the Director-General of New South Wales Health—that is, the Barraclough committee—identified significant shortcomings in the structures and practices of the South Western Sydney Area Health Service. It made a series of recommendations about clinical and management issues.

I would like to present a full picture of the work we have undertaken in the few short months since then to improve the relationships with and responsiveness to the concerns of the patients and staff. Of course, this goes to the heart of the committee's terms of reference. In a little over five months the area health service team—that is, the team across all the hospitals and area health services—has taken many steps to improve staffing and systems to provide better patient care and safety. We have made a range of clinical appointments and are now finalising the area health services clinical service plan. This has been developed by a clinical

strategy group comprising prominent clinicians from across the area health service and led by the head of the area clinical council, Professor Jeremy Wilson.

In December 2003 new ambulance referral systems were introduced to deliver emergency patients to hospitals at which their care requirements could be more appropriately met. Ambulances no longer take emergency patients to Camden Hospital and an average of five to six ambulances per day take these cases to facilities with appropriate emergency departments. One of the most exciting initiatives under way at the moment is the establishment of an acute care response unit. The unit will be set up at Liverpool Hospital to take calls from individual clinicians from other hospitals within the area to move critically ill patients across the area in a much more responsive manner than previously.

One of the lessons I have learnt is to ensure that the area's senior management has its complaints handling and grievance management practices as a high priority. The area's current complaints and grievance handling policies show that they are up to date and appropriate. Complaints are best handled at the local level. It is the role of senior area management to ensure that patient advocates and managers on the ground, such as nurse unit managers, have the necessary skills, knowledge and experience to deal professionally with complaints and grievances as they arise. As honourable members would be aware, current best practice in these fields focuses on mediation and conciliation of the complaint and grievance at the time and place that it happens.

In the period January to June 2003, the area health service resolved 640 complaints. In the following six months to December 2003, 422 were resolved. We are clearing our way through current complaints by devoting resources to complaints and grievance handling and by examining our management processes. My observation is that quality management and complaints were handled differently in each facility across the area health service. This left people to deal with matters with the level of skills they happened to have at each facility. Information on practices was also not routinely shared and management approaches at times were not co-ordinated. The strongest organisations in health encourage a culture of learning based on teaching and research. It is in this sort of environment we plan to deal with complaints. The area has not been able to conduct sophisticated complaints follow up, risk management and trend analysis, and it has lacked a unified, area-wide complaints management database. We are now implementing that as a high priority.

In order to focus our attention and resources on these important areas of complaints handling and grievance management, I also decided in December 2003 to establish a South Western Sydney Area Health Service professional practice unit. The new unit, set up with mediation, clinical and legal skills, receives grievances and handles patient and next-of-kin complaints about care and safety. The new unit has contacted 42 of the 47 patients or next-of-kin involved in cases in which findings were made by the HCCC following the release of the final report on 12 December 2003. The remaining people were either not contactable or did not wish to be contacted. For many of these patients and next-of-kin it was the first time they had been contacted in relation to the HCCC investigation, and many were surprised and concerned when told that their cases were involved in the report. When making contact with patients or next-of-kin, the unit has explained its role of providing support, counselling and ongoing advice. A number of those contacted have expressed support for the establishment of the unit, saying that it will be beneficial to the community of south-western Sydney. In February 2004 I went on to establish a high-level clinical reference panel to examine clinical circumstances surrounding issues involving questions about patient care.

I will provide an example of a local hospital complaints issue. In 1999, in the first year for which complaints data is available for Campbelltown and Camden hospitals, 253 complaints were made about patient care and safety. The figure in 2003 was 312 complaints. Over the same period inpatient activity rose by 10.7 per cent. The important thing to understand is that we are talking not simply about complaints; they are only one component of the quality chain. It is apparent that we need to bring together assessment of risks from a number of perspectives, including patient safety, medico-legal, public relations and the like. I have 30 years of experience in the New South Wales health system. In my view it must continue working towards open disclosure in our health services. Frank and open communication with patients and families allows us to address problems promptly and appropriately at the local level. That has been my experience in clinical practice.

The key elements of open disclosure with patients and families involved in an adverse event are an immediate factual explanation of what occurred, an explanation of the potential consequences, an expression of regret and an account of the steps being taken to manage the event and to prevent it happening again. For health professionals there is an ethical responsibility to maintain honest communication with patients and their support persons, even when things go wrong. In an environment of open disclosure people feel supported and

encouraged to recognise and report adverse events. Finally, I want to link these themes to good clinical governance. In the end, this is what will drive better risk management and systems of quality improvement. Good governance involves a system of accountability from the chief executive officer down to ensure that changes are implemented and their effectiveness is reviewed. We are doing this in south-western Sydney. In July 2004 we will implement an entirely new clinical governance structure across the area health service.

In closing, I return to the people of south-western Sydney. It is, after all, they for whom this service exists. The people of south-western Sydney are a wonderful community. Our primary purpose, which is set out in the Health Services Act, is to provide relief to sick and injured persons through the provision of care and treatment, and to promote, protect and maintain the health of that community. The team at South Western Sydney Area Health Service is focusing its energy on revitalising this area health service to provide the community with what they deserve, the best possible health care.

CHAIR: I might say with admiration that that was textbook presentation. Are there other persons who would like to make an opening statement?

Ms KREMMER: On behalf of Catherine O'Connor and myself, much has been said over the last 18 months about Macarthur Health Service. This has suggested that staff who raise concerns about clinical care are routinely victimised and harassed within the organisation. As nurses who have worked at both Campbelltown and Camden hospitals for 17 and 18 years respectively we want to say that that is not our experience. Adverse events have happened at Campbelltown and Camden hospitals, as they do everywhere. In our experience, staff make every effort to use problems as opportunities to improve care and services, and we have been supported in this by senior management. We have worked in an organisation with policies and procedures about complaints, problems and critical incidents. We have copies of these documents with us if the Committee wishes to view them.

These policies are clear and used in everyday practice. We encourage problem reporting and the lodging of complaints. In 2002, 1,313 individual problems or incidents were reported by Macarthur Health Service staff. Nurses at all levels and in all units across the service use this system. From memory they were the major contributors or lodgers of the problems. Not only do we encourage staff to report issues or incidents of concern, our patient, carers and others are supported likewise in doing so. Within the acute services continuum alone, 110 complaints were lodged in 2001 compared to 170 in 2003. We work in a health service that has improved the ways in which we review and respond to critical incidents. Between 1998 and 2001 the critical care committee held more than 40 meetings. These were held monthly, including over the Christmas break.

In 2001 alone, 34 cases were presented and reviewed. It should be noted that these cases were identified by staff reports and patient complaints. As the number of cases increased in April 2002 the critical care committee agreed to prepare a submission requesting this establishment of the acute services review team. This was designed to be a proactive process that actively sought out potential errors. This new process was given the absolute and unequivocal support of the general manager and the executive at that time. As an example of how this committee functioned, all 149 deaths within acute services between January and August 2003 were reviewed. Of these, 120 had no errors or omissions in care. In 26 of the cases the issues identified did not contribute to the patient's death. However, three deaths were forwarded by the Committee to the general manager for root cause analysis, which is an investigative process mandated by the Department of Health to identify systems failures, recommend actions, might intimidation and evaluate these on a regular basis.

These efforts to improve quality care are complemented by ongoing education and training for nursing staff. In the intensive care unit alone there has been an extensive program of in-service education as evidenced by the 327 hours of ward-based education received in 2001 alone. There have been many allegations that nurses have been prevented from making medical emergency team or MET calls. However, this is not our experience and the increasing number of MET calls would suggest otherwise. We have data to corroborate this, should the Committee require it. We believe this increase is the result of ongoing staff education and encouragement, and shows good use of the system. We have never witnessed, nor heard reports of people being bullied prior, during or after calling a medical emergency team.

Campbelltown and Camden hospitals have been subject to excessive scrutiny for over 18 months. Investigations have been welcomed. However, the unrelenting media publicity has made it extremely difficult to provide quality care to our patients. It is unfortunate that there has not been better co-ordination between the different investigative authorities, because Macarthur cannot progress until the matter is resolved, nor can the

community be confident in our care. We have not had the opportunity to have our issues investigated in a way that is fair, open and ensures procedural fairness. The impact of the last 18 months has been to create a climate of fear that threatens the agenda of open disclosure, and will significantly hinder our progress. Finally, allegations that nurses turn their backs on patients and withhold care with the intention of causing harm, injury or death are abhorrent and offensive. This behaviour is clearly contrary to the code of professional conduct and ethics for nurses in Australia, and is contrary to our experience working in Macarthur Health. We thank the Committee for providing us with the opportunity to make the statement.

CHAIR: Are there any other members who are present who would like to make a statement?

Mr MASSO: My name is Malcolm Masso. Thank you for the opportunity to make an opening statement. I held the position of Director of Nursing and Health Services with the Macarthur Health Service from August 1998 until November 2003, but I appear today as a private citizen. In June 2002 I was on leave from the end of February until the beginning of December to undertake full-time tertiary studies, returning only for a two-week period in June to relieve the general manager when she went on leave. Some of the issues already considered by the Committee occurred during this time and, hence, I am not in a position to comment on the detail of those events. However, I would like to make some pertinent comments from my time in Macarthur. The Australian Council for Safety and Quality in Health Care estimates that overall about 10 per cent of hospital admissions in Australia and other developed countries are likely to be associated with a potentially preventable adverse event.

Whether the rate of adverse events at Campbelltown and Camden hospitals differ from the estimates over the last five years is unknown. Some 47 cases were reviewed by the HCCC. To place that in some kind of perspective there were, as I recall, approximately 3,500 problem reports and 900 complaints dealt with by Macarthur Health during the same period of the claims investigated by the HCCC. Although not all were concerned with issues of patient care, the majority were. The system of reporting problems was widely used by all levels and categories of staff. In June 2003 in Australia the Council on Health Care Standards concluded from the review of the Macarthur Health Service, "The reporting of adverse events, complaints and incidents is service wide and extensive, with good documented processes and an analysis of data actions and outcomes. Considerable effort has been made in developing a culture of recording and reporting, with effective outcomes and increased reporting."

The report also stated that overall across the Macarthur Health Service there is a healthy and positive approach to the management of risk. In February 2003 the severity assessment code system for rating incidents, together with technique of root cause analysis, has, in my view, greatly enhanced the ability of any health service to deal with that volume of incidents that I referred to previously, identify the most urgent cases and respond in an effective manner. I commend those initiatives to this Committee. I would also suggest that implementation of a statewide system of uniform incident reporting would greatly enhance this process by allowing for greater opportunities for hospitals to learn from each other, rather than each hospital having a different system.

There has been much speculation regarding the issue of resources and the impact this may have had in Macarthur. In 1998 when I took up my position, my assessment—and it was not unique to me—was that the major issue facing the organisation was the need to build up the medical infrastructure with additional junior medical staff, registrars and specialists. Of particular concern was the almost total absence of registrar cover out of normal business hours in the specialties of orthopaedics, surgery, medicine and anaesthetics. We had one surgical registrar at Campbelltown and had to import medical registrars from overseas because we could not recruit local doctors to fill these positions.

In terms of taking a systems approach to improving care, I believe that the work to increase medical staff at all levels has been both the greatest challenge and the greatest achievement. It is pleasing to see that continuing to the present day with the recent enhancement to services. There are two main schools of thought about the events in Macarthur: those who believe that Macarthur was in some way atypical of the health system and those who believe that it is no different to the rest of the health system. I would suggest that, despite the multiplicity of inquiries, the definitive answer will never be known, but that the truth probably lies somewhere between those two extremes.

Every organisation has its own unique features, and as such has to accept responsibility for the impact of that uniqueness on the quality of the service provided. By the same token, the clinicians and managers in Macarthur have come to that organisation with a wealth of experience and expertise gained elsewhere. They do

not somehow become incompetent just because they get a job at Camden and Campbelltown hospitals. I worked for 25 years in the New South Wales public health system. Many of the finest people I have ever worked with have been in Macarthur. Their dedication and hard work, in often difficult circumstances, has been extraordinary.

I believe there is a need for some calm reflection about the events of the last 18 months, and I ask the Committee to consider the following. Not long after referral of the investigations to the HCCC, a group of staff from Macarthur were advised by the HCCC in a meeting at Campbelltown hospital that, despite the volume of material provided by the nurse informants, none of it raised sufficient concern to warrant investigation of individual cases. This was greeted with amazement by those present because serious allegations about patient care had already appeared in the media. The staff, including myself, asked for the incidents to be investigated. In fact, most of the incidents had already been reported and reviewed within the Macarthur Health Service, with action taken to prevent recurrence.

We wanted the cases investigated fully by the HCCC from the very beginning. Soon after that, in February 2003, the HCCC concluded that there were no findings to support any loss of confidence by the Macarthur community in the quality and safety of their health services, and that there were no significant departures from State and national standards of health care. Reports to that effect appeared in the media. Then, with the intervention of a talkback radio presenter, the inquiry was reopened, resulting many months later in the HCCC's final report. The head of the body producing that report was promptly dismissed.

In the middle of all this, Macarthur Health was surveyed by the Australian Council on Healthcare Standards [ACHS]. It is my understanding that, aware of the sensitivity of anything to do with Macarthur, the ACHS went to considerable trouble to use experienced surveyors. The surveyors went to every department and service in Macarthur, using a process that has developed over a 30-year period that sets the standard for health services in this country. The surveyors produced a report that included many favourable comments about Macarthur and the awarding of accreditation. It is hard to believe that the HCCC and the ACHS were talking about the same organisation.

We now have this upper House inquiry, the special commission of inquiry, an investigation by the Independent Commission Against Corruption, and the involvement of the Medical Board and the Nurses Registration Board. Speaking as a taxpayer, a private citizen and an ex-servant of the people of the State, there surely must be a better way of doing this in future. The term "collateral damage" is used to describe harm to innocents who are injured in warfare. This sequence of events has resulted in enormous collateral damage to staff, patients and their relatives that will require years of healing. Some people may never recover. I referred earlier in my statement to the system of root cause analysis implemented last year. I would suggest that a similar approach to incidents that involve whole health services is required so that this scenario is not repeated in future.

CHAIR: The Committee will now take questions.

The Hon. PATRICIA FORSYTHE: Associate Professor Picone, you described yourself as the Administrator of the South Western Sydney Area Health Service. Are you also continuing in your role as Deputy Director of General Policy?

Associate Professor PICONE: No, I am not.

The Hon. PATRICIA FORSYTHE: Do you believe that bullying of nurses is commonplace at the South Western Sydney Area Health Service?

Associate Professor PICONE: I have found evidence of bullying and harassment of nurses, but I do not believe it is endemic across the organisation.

The Hon. PATRICIA FORSYTHE: But you have found evidence of it?

Associate Professor PICONE: Yes.

The Hon. PATRICIA FORSYTHE: Earlier in your statement you referred to a policy of open reporting of mistakes. For how long has that been a clear policy of the South Western Sydney Area Health Service?

Associate Professor PICONE: Open disclosure as a policy approach is a relatively new concept, evolving through the Australian Quality and Safety Council and overseas experience. So it is starting to take root in area health services across the State, but we have quite a way to go on that. Some of the obvious impediments can be legislative impediments and concerns by staff not to self-incriminate, and other legal issues. But it is starting to occur.

CHAIR: Open disclosure on issues where there have been complexities is a management tool that has been around for decades—

Associate Professor PICONE: I am sorry, Mr Chair, I was talking about patient-related issues.

CHAIR: Even on patient related issues. Surely there has been an approach over the years to encourage people in the health system to be open about disclosure and apologetic when mistakes have been made.

Associate Professor PICONE: It has certainly been my experience in the places I have worked. Even clinically, which is now going back 10 or 15 years, that is how I operated. But there are concerns about how much information is provided and when it is provided, when it is a very serious matter and there are legal or other implications. I suppose the concept of open disclosure within the system has been around for a few years, and it is now strongly encouraged.

The Hon. PATRICIA FORSYTHE: Do you believe that the nurses, the whistleblower nurses in particular, understood that there was a policy of open reporting of mistakes and misconduct?

Associate Professor PICONE: From my meetings with them, I would have to say no.

The Hon. PATRICIA FORSYTHE: But they did seek to report mistakes and misconduct?

Associate Professor PICONE: Yes, they did.

The Hon. PATRICIA FORSYTHE: Did the managers understand the policy?

Associate Professor PICONE: I believe they did.

The Hon. PATRICIA FORSYTHE: Do you have full confidence in your managers at the South Western Sydney Area Health Service, and are you confident that they have not been involved in the past, or are involved, in the bullying, intimidation or harassment of nurses?

Associate Professor PICONE: Because it is a very large organisation, I would not be able to give an account for every manager position from first line up. But I do know that the policy within the organisation is to allow those things to occur, and I feel confident that certainly the people I have met are doing that. But it is a very large organisation, so I cannot give you an account for every individual manager, of which there would be hundreds I imagine.

The Hon. PATRICIA FORSYTHE: Did you provide any material to the *Sunday* program for its story on Camden and Campbelltown hospitals?

Associate Professor PICONE: I certainly did not.

The Hon. PATRICIA FORSYTHE: You aware that quite private material about some of the nurses was provided to the program, such as tax records and other privileged material?

Associate Professor PICONE: No, I am not.

The Hon. PATRICIA FORSYTHE: Who in the South Western Sydney Area Health Service or NSW Health would have access to that sort of material?

Associate Professor PICONE: I would have to know what sort of material you are referring to.

The Hon. PATRICIA FORSYTHE: Tax records.

Associate Professor PICONE: I would imagine that the human resources department would be where that material would be contained.

The Hon. PATRICIA FORSYTHE: Would you take the question on notice and provide the information to the Committee?

Associate Professor PICONE: Yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Mr Masso, were you responsible for the staffing issues of the hospital as a whole? You said that there was a shortage of human resources, or difficulties, when you got there.

Mr MASSO: In Macarthur Health we set up the organisation in 1998, bearing in mind we combined the previous Camden and Campbelltown health services. We looked at the situation and felt that because of the issues around what we felt was a weakness in the medical infrastructure, that would best be addressed by freeing up the time of the medical superintendents, as they were previously called, to focus more fully on issues around the long-term recruitment strategies and clinical governance issues. The line managers for what we call continuum—and I was responsible for the acute procedures of continuum which included medicine, surgery and critical care—were responsible for the day-to-day operational management.

My responsibilities, for example with medical recruitment, was certainly a lot of the day-to-day stuff in terms of trying to recruit registrars or, as I said in my statement, get people from overseas, to try to fill those positions. That fell to myself. Obviously I had the back-up of the director of medical services if I needed it, but the day-to-day responsibility of recruiting CMOs, for example, for the emergency department fell to me, and the other people who are managing the different continuum.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Were you responsible for decisions about what registrar cover was given to the hospitals, particularly after hours?

Mr MASSO: It would have been a joint decision between myself—and I guess the main three players who would be involved in that sort of decision were myself, the director of medical services and general manager; but primarily the general manager, because of the resource issues and things like that. It would be in co-operation with the different medical departments. We certainly would be making a decision to try to vary the registrar cover.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You were one of three; I am more concerned with the number than the people. If there was a problem with staffing, should Camden offer a comprehensive service or not? It must have been decided that with your medical staff resources you could deliver adequate services at Camden hospital, 24 hours in casualty, or emergency?

Mr MASSO: At Camden hospital, with the after-hours situation for example, we generally had one doctor in the emergency department and someone covering the wards. At night we had one person covering the whole hospital, including emergency. Bearing in mind that soon after Macarthur Health was formed we started a process of moving a number of services from Camden hospital over to Campbelltown. For a period of time, which was early 1999 to the end of 2001, there were very limited services at Camden hospital. Certainly there was an emergency department and a combined medical ward and palliative care ward, but that was it.

When we sought to return services to Camden hospital, to something approaching the previous level of activity, two main issues arose in terms of medical staffing. One related to surgery, where the department of surgery said it was not happy to admit overnight patients for surgery at Camden hospital. Because we did not have the resources to increase the medical cover we made a decision to do only day-surgery at Camden hospital. At the time that fitted in quite well, because we had a free-standing day surgery unit at Campbelltown hospital which we needed to demolish in turn. So we just moved it holus-bolus over to Camden. And that situation has remained until today. With regard to the maternity unit, the situation is quite different. For example, the departments of obstetrics, paediatrics and anaesthetics were involved in a lot of discussions about what level of medical cover they deem to be acceptable.

The department of anaesthetics said with eight or nine anaesthetists they were not happy to provide two separate anaesthetists rosters to the two hospitals. They believed that to provide a separate anaesthetists roster to

Camden to cover maternity adequately they needed five additional staff specialists. Obviously getting five additional staff specialists in anaesthetics is not easy. But we were not going to open a unit without what the different departments were saying was adequate to medical staff. A process then started to try to recruit staff specialists from overseas. We did recruit five staff specialists in anaesthetics from South Africa. Once they were recruited the maternity unit opened at Camden.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You were keeping the casualty and emergency open at Campbelltown. Did you have 24-hour surgical registrar cover there?

Mr MASSO: At Camden or Campbelltown?

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Camden.

Mr MASSO: No, there was not.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You could not call on a surgical registrar?

Mr MASSO: No. It might be useful for the Committee to have the roster, if you want that level of detail. Usually there were only two doctors in the place until about ten at night. And then one doctor overnight, covering the emergency department and the hospital.[2] There was no surgical registrar in the hospital.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: If Campbelltown was on code red, presumably the ambulance would go to Camden?

Mr MASSO: Yes, that is true.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: And there was only a CMO on after 10.00 p.m., just one?

Mr MASSO: Just one.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: And you were aware of that?

Mr MASSO: Yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: And the emergency department was kept open for 24 hours, despite the fact that there was only one CMO and no registrar?

Mr MASSO: That is true.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: At the time you were making the decision to keep that open, were you aware of the resources available at that time?

Mr MASSO: I am not sure that it was my decision to keep it open.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You must have been aware that there were those resources and that the hospital was being kept open with very little resources. Did you protest that that was an impossible ask?

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[2] Clarification provided by Mr Malcolm Masso, 2 April 2004

"Prior to January 2003 there were two doctors rostered on duty until 10pm but this was only on Saturdays and Sundays. On other days of the week there were two doctors on duty until 6pm and one doctor on duty after that time.

In January 2003 the roster was changed to have two doctors on duty until 10pm on all days of the week.

In February 2003 a second doctor was rostered on duty overnight. This doctor was to provide assistance if any patient in the Maternity unit required a caesarean section but was available to work elsewhere in the hospital at other times if required."

The Hon. CHRISTINE ROBERTSON: Is the Hon. Dr Arthur Chesterfield-Evans trying to shut down every district hospital in New South Wales with that criteria?

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: I am just asking about the resources implications.

Mr MASSO: In terms of after-hour medical care at Camden, when we reopened the emergency department it was, as I recall, the same as it was prior to us reducing services to move a number of other services to Campbelltown hospital.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: But the population had increased dramatically around Campbelltown Hospital during that time, had it not? It was not a cottage hospital anymore as it had been historically?

Mr MASSO: The level of services had not changed. When I say we reopened Camden, it did not reopen, because it never closed. But when we moved the services back from Campbelltown Hospital one of the things we were not sure of was the extent to which the activity would increase; whether it would decrease back to previous levels or go higher.

CHAIR: We can leave that, at that point.

The Hon. ROBYN PARKER: Ms Picone, you would be aware of the case of Miss Sarita Yakub, who died at Nepean Hospital in August 2002. Is it correct that you handled that case on behalf of NSW Health?

Associate Professor PICONE: I co-ordinated a review of the care that was provided. I met with the next of kin on a couple of occasions.

The Hon. ROBYN PARKER: When you say "co-ordinated", what was your objective?

Associate Professor PICONE: I would have to take that question on notice, simply because it was quite some time ago and I cannot remember the terms of the review, or a lot of the details. To assist the Committee, it would be better for me to take your question on notice. It really was quite some time ago.

The Hon. ROBYN PARKER: Further on that case, did you withhold information from Mr Yakub, and not provide him with a full report into his wife's death?

Associate Professor PICONE: I provided Mr Yakub with a series of recommendations in relation to care and assisted Mr Yakub in referring the matter to the HCCC and to the Coroner.

The Hon. ROBYN PARKER: Did you telephone him on a regular basis?

Associate Professor PICONE: I cannot recall, I would have to look at my diary. I did have several telephone conversations but I do not know how many.

The Hon. ROBYN PARKER: Were you aware that there was a full report?

Associate Professor PICONE: A full report of what?

The Hon. ROBYN PARKER: Into his wife's death—the investigation?

Associate Professor PICONE: There was a clinical review team that looked at the care that his wife received at Nepean hospital and they provided a report, yes.

The Hon. ROBYN PARKER: Can you also tell us how closely you were working with Minister Knowles in managing the Yakub case?

Associate Professor PICONE: I do not quite understand what that question means.

The Hon. ROBYN PARKER: In the management of the case what sort of discussions did you have with Minister Knowles?

Associate Professor PICONE: The department provided briefings to the Minister's office but, once again, I would have to check the details of those briefings.

The Hon. PATRICIA FORSYTHE: I know you have suggested you would check the details and come back to us but in the documents that were tabled to the Parliament on this case some time ago it would seem that there was clearly a full report that may not have been provided to Mr Yakub. I just wondered where the decision was taken not to provide it to Mr Yakub?

Associate Professor PICONE: My recollection was that the materials were forwarded to the Health Care Complaints Commission [HCCC] and to the Coroner, but I will have to take that on notice.

The Hon. PATRICIA FORSYTHE: Who in the department were you briefing in relation to this matter?

Associate Professor PICONE: The director-general was briefed at one stage. It may have been more. It is very difficult because this was a matter quite some time in the past and I have dealt with many patients since then. I am just concerned that I would not be giving accurate information. I do not have these materials in front of me and in fact I have not looked at them for months and months and months. I am happy to take it on notice.

CHAIR: We note your concern.

The Hon. PATRICIA FORSYTHE: If you were not dealing with the Minister directly would you have been dealing with others in his office?

Associate Professor PICONE: As the department executive we met regularly with the Minister's office and had regular meetings with the Minister on a whole range of matters.

The Hon. PATRICIA FORSYTHE: What was the objective of that? Was that to keep him informed?

Associate Professor PICONE: They are the regular meetings that would go on between the senior executive of an agency and the Minister.

The Hon. PATRICIA FORSYTHE: So who is the department executive that you referred to?

Associate Professor PICONE: The director-general and the deputies have regular meetings with the Minister.

The Hon. PATRICIA FORSYTHE: The Minister and Minister's office?

Associate Professor PICONE: And discussed a range of issues.

The Hon. PATRICIA FORSYTHE: Could I return to the issue that I raised earlier about the *Sunday* program? I suggested that it seems that the program included confidential material relating to the nurses personal files—I suggested tax records. Could I suggest that in addition to tax records there was also information about their pay records? I guess for completeness, because you said you would take that on notice, I really need to know who in the department would normally have access to that material?

Associate Professor PICONE: You are asking who in the South Western Sydney Area Health Service?

The Hon. PATRICIA FORSYTHE: Yes, or NSW Health.

Associate Professor PICONE: I am happy to take that on notice.

The Hon. PATRICIA FORSYTHE: Would you at any time have discussed with health officials the character or backgrounds of any of the whistleblower nurses and, if so, with home?

Associate Professor PICONE: I did have meetings with the nurse complainants and in attendance at that meeting was the Deputy Director-General of Health, my colleague Mr Robert McGregor. I do not recall going into the characters or the backgrounds. Are you talking about the employment history?

CHAIR: Maybe medical history? Mental health history?

Associate Professor PICONE: Certainly not.

The Hon. AMANDA FAZIO: Could I ask a question to clarify something? With reference to the Hon. Patricia Forsythe's question about pay record and tax records, I have got a transcript of the Internet of the *Sunday* program and there is no reference to that in there so I do not know if that issue really exists or why we are discussing it here.

CHAIR: You are entitled to wonder that.

The Hon. AMANDA FAZIO: I think most people who read the transcript or watched the show might wonder as well.

The Hon. PATRICIA FORSYTHE: Earlier this week the Coroner found grandmother Niki Kotzaitsis was discharged within 24 hours of surgery at Bankstown hospital to free up a bed in September 2000 and died four days later. Could you please comment on this case and assure the Committee that this policy was not common practice at the South Western Sydney Area Health Service?

Associate Professor PICONE: Whilst I am aware of this tragic event, and I have reviewed the materials from the Coroner, the recommendations and briefing materials provided on it, I do not want to, once again, mislead the Committee. I do not have the details in front of me. I would be very happy to provide a brief on that. I wish I could pull it forward because it is sitting there, but I would be concerned that I would not give you a correct account.

The Hon. PATRICIA FORSYTHE: I am not specifically asking about that case but the policy of releasing somebody to free up a bed. That is the real issue here, is it not, whether that was a common policy within the area health service?

Associate Professor PICONE: The issue in relation to that individual patient was that my recollection—I am being very cautious here and I hope I am given an opportunity to correct this if I get any of this wrong—is that with that particular individual patient they would have been discharged. It was a 24-hour or 36-hour procedure. This was not the issue with this patient. The issue with this patient was that the clinical chemistry and pathology was not read. So this was not an issue of discharging the patient to get a bed, there was a failure to read the clinical chemistry and the pathology results. But if I could please take that on notice, given that I do not have all the materials here.

The Hon. PETER PRIMROSE: Are you aware of any member of this Committee who has been out at the South Western Sydney Area Health Service, including its hospitals, seeking information on the terms of reference relevant to this inquiry?

Associate Professor PICONE: No, sir, I am not. Just looking at the Committee members, I am not aware.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Just for the record, I have visited both hospitals.

Associate Professor PICONE: Dr Chesterfield-Evans, I would have welcomed you with a cup of tea and I would have been happy to brief you. I hope you enjoyed your visits.

The Hon. PETER PRIMROSE: Could you please take that question on notice? I would be interested in who was contacted and what information was sought.

Associate Professor PICONE: Yes, sir, I will.

The Hon. PETER PRIMROSE: Could I then ask Ms Kremmer a question? Obviously it has been a pretty tough time out there lately. I am wondering if you have noticed any changes and improvements on the ground recently?

Ms KREMMER: In terms of staff morale?

The Hon. PETER PRIMROSE: Generally in terms of staff morale but in terms of procedures? I know you have given an opening statement but I am asking more in terms of staff morale and systems. I am aware that it has been pretty tough in the past few months. Have things changed recently?

Ms KREMMER: I think the provision of health care services is an evolution and we continue to evolve and we continue to try to improve our systems and our services. Yes, there have been recent improvements and they may be in staff morale, which varies depending on what it is that we are being scrutinised for or how we are being scrutinised at that particular time. Recently staff morale has been much improved.

The Hon. CHRISTINE ROBERTSON: I would like an answer to this question from whoever feels it is most appropriate to answer. We have heard quite a bit of evidence that indicates that there is a problem with the community knowing about the complaints process. I would like to know what policies and procedures are in your area health service for community knowledge of complaints processes?

Associate Professor PICONE: I would be happy, if you are happy, to take that question. One of the things I have learnt since I have been on the job is that complaints handling can be different at each facility, so one of the reasons for setting up the Professional Practice Unit, and Mary Dowling is sitting next to me, is to provide an opportunity for community members to put a complaint directly into there—I would rather people do it locally in the first instance—but to increase community awareness of how to lodge a complaint. I wish that we had today the little promo that we are going to put out everywhere about the establishment of the unit and improvements in complaints handling generally, but I would hope that would be completed by the end of your inquiry and we could provide it to you.

The Hon. CHRISTINE ROBERTSON: What community consultation processes are set up in your area health service?

Associate Professor PICONE: Very extensive and impressive community consultation processes. There is a community advisory council in each one of the hospitals and their associated community health services, and then there is an overarching area council. On those committees are people who are in the community locally. They are very active. They are very involved in the life of the health service. In fact, yesterday I interviewed for three new general managers and a community representative was actually on the interviewing panel. I would not make a move, let me assure you, without seeking the advice and the opinion of those community representatives because, if I do, they chase after me. Prior to taking a decision around the Camden emergency department, I put that to them prior to taking that final decision. I have been very fortunate; they have been very supportive of all of the work that we are undertaking.

The Hon. ROBYN PARKER: I have some questions for Clair Cameron. I wonder if she could come close to a microphone. You will be aware of an issue surrounding the death of Mrs Hamilton. I wonder if you could tell me who wrote and authorised a statement claiming the son of Mrs Hamilton was happy with his mother's treatment?

Ms CAMERON: Several people, including the deputy chief executive officer [CEO], the CEO, and various other senior staff who contributed to putting together the release. As with all public statements from the South Western Sydney Area Health Service, they are either signed off by the CEO or the deputy CEO.

The Hon. ROBYN PARKER: That was a complete fabrication, was it not?

Associate Professor PICONE: Chair, I am wondering if I could take these questions? At the end of the day, I authorise, and if I am not present my deputy authorises, all media releases from the area, so my media relations officer would not release anything without my direct authorisation.

CHAIR: The buck stops with you. We understand that.

Associate Professor PICONE: I am in charge.

CHAIR: But the media liaison officer is responsible for producing the statements, taking into account input from other people, so I would be happy if she continued to reply, but I recognise that you have the authority.

The Hon. PETER PRIMROSE: But surely, Chair, she is able to indicate that she would prefer that question to be more authoritatively answered by Professor Picone.

CHAIR: Of course she is.

The Hon. ROBYN PARKER: I prefer to ask Ms Cameron, if that is all right, thank you. Ms Cameron, why did you include information about the background of the nurse who made the allegations about the death of Mrs Hamilton?

Ms CAMERON: I was given that information to include.

The Hon. ROBYN PARKER: And who gave you that information?

Ms CAMERON: It was either the deputy CEO or the CEO. I cannot remember.

The Hon. ROBYN PARKER: Do you think that was a deliberate attempt to undermine the credibility of the notice?

Ms CAMERON: I do not believe so.

The Hon. ROBYN PARKER: Have you ever backgrounded journalists on the whistleblower nurses?

Ms CAMERON: No, I have not.

The Hon. ROBYN PARKER: Have you ever said anything to journalists off the record about the past of Nola Fraser, for example?

Ms CAMERON: No, I have not, and I only started at the area health service at the beginning of December, just for the record.

The Hon. ROBYN PARKER: Do you know anyone who has done that then?

Ms CAMERON: No, I do not.

The Hon. ROBYN PARKER: Ms Cameron, have you ever rung Channel Nine's newsroom in the evening and made allegations off the record about Nola Fraser?

Ms CAMERON: No, I have not.

The Hon. ROBYN PARKER: Have you repeatedly refused to make Professor Deborah Picone available for interview with the *Daily Telegraph*?

Ms CAMERON: No.

The Hon. PATRICIA FORSYTHE: Ms Cameron, having read the documents that were provided to the Parliament yesterday, it seems clear that Mrs Hamilton's daughter was most unhappy with the statement that was authorised. Did you discuss the matter with her daughter?

Ms CAMERON: I did not speak to the family members.

The Hon. PATRICIA FORSYTHE: Where was your source of information for the preparation of the statement?

Ms CAMERON: From various people—senior managers, including the deputy CEO and the CEO.

The Hon. PATRICIA FORSYTHE: Were you at Camden hospital on the day that the Health Care Complaints Commission [HCCC] report was brought down? Were you at Camden hospital on that day?

Ms CAMERON: No.

The Hon. PATRICIA FORSYTHE: Is there another member of your department here with you—another one of the media public relations people?

Ms CAMERON: A colleague?

The Hon. PATRICIA FORSYTHE: Yes.

Ms CAMERON: Yes. Here today?

The Hon. PATRICIA FORSYTHE: Yes.

Ms CAMERON: Yes.

The Hon. PATRICIA FORSYTHE: Who else would have been in attendance on that day, if you were not?

Ms CAMERON: Susan Connelly.

The Hon. PATRICIA FORSYTHE: Would she be able to indicate whether she was at Camden hospital on that day?

Ms CONNELLY: Yes, I was at Camden hospital on that day.

The Hon. PATRICIA FORSYTHE: You were at Camden on that day? I am sorry, I cannot hear the answer.

Ms CONNELLY: On the day that the HCCC was brought down?

The Hon. PATRICIA FORSYTHE: Yes.

Ms CONNELLY: Oh, no—originally, way back—no. Which period?

The Hon. PETER PRIMROSE: You need a note to work out which one.

The Hon. PATRICIA FORSYTHE: No, I have to get the date. I am trying to remember which date. There were two of them. Can I come back to that?

CHAIR: Yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: I have a question for Lisa Kremmer. You were the director of emergency at Camden, is that correct?

Ms KREMMER: No, I am the nursing unit manager of the emergency department.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: But your tasks, your job description, meant that you were effectively in charge, or the person who was in charge was under you. Is that right?

Ms KREMMER: I am sorry, how do you mean, the person who was in charge was under me? I am the nursing unit manager.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Directly reported to you.

Ms KREMMER: I have nursing staff that I am responsible for, as I am the nursing unit manager.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: So effectively you had say over the hospital, both the emergency department and the hospital generally at Camden?

Ms KREMMER: As one of the senior members of the nursing staff at Camden, I assisted other areas in the hospital when it was needed. I relieved in positions of nurse manager for Camden hospital but that is a separate position to my role as the nursing unit manager of the emergency department.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: The position of nursing unit manager of the emergency department is separate. That is your position.

Ms KREMMER: That is my role. That is right, that is my position.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: So if there were a problem in medical service delivery at Camden hospital, you would be aware of any problems there?

Ms KREMMER: Possibly, yes. It would depend on where the issue arose. I could not say.

Associate Professor PICONE: Chair, could I assist again in this matter?

CHAIR: Yes.

Associate Professor PICONE: Lisa Kremmer would not always be aware if there is an issue in relation to a medical officer. In fact there are many issues that she would not be aware of in relation to her medical colleagues. I am happy to assist Dr Arthur Chesterfield-Evans in this matter.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: I am not fussed.

Associate Professor PICONE: Perhaps if there are issues to do with medical officers in any of the facilities, those questions are best addressed to me, not to the nursing unit manager of a unit.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: With respect, if one is working in a unit, one has a pretty good idea, in a fairly small unit like Camden hospital.

Associate Professor PICONE: I totally disagree.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: If a doctor is not much good, the chief nurse would know. Surely that is a no-brainer question.

CHAIR: Dr Chesterfield-Evans is following up on earlier evidence about nurses making complaints about medical officers.

Associate Professor PICONE: Sorry, Chair.

The Hon. CHRISTINE ROBERTSON: But not in the emergency department.

Ms KREMMER: Can I say that I, as a nurse, do not believe that it is my role to make judgments on the quality of the medical staff. I think that it is not within my role as a nurse to make those judgments.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You are relatively senior, though, and you were on the Critical Care Committee, were you not?

Ms KREMMER: Yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: So if there were problems at Camden, you would have taken those to the Critical Care Committee?

Ms KREMMER: Yes, I have reported issues of concern, yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: So you would have been reasonably senior and would have seen that there were doctors trying to manage the emergency department, and sometimes one doctor trying to manage the emergency department and the hospital as a whole after 10.00 p.m.?

Ms KREMMER: I was aware of the staff, yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Did you take the fact that that was a problem to the Critical Care Committee?

Ms KREMMER: I cannot recall raising that specific issue through that forum. As the nursing unit manager, I do not have complete control over the staffing or the funding for the emergency department care.

Associate Professor PICONE: Chair, if I could just assist Dr Arthur Chesterfield-Evans again?

Ms KREMMER: I was just going to say that there is a medical director for the department.

Associate Professor PICONE: There is a medical director and there is a line of command whereas the nursing unit manager's opinion on matters, particularly in relation to impaired colleagues, is always valued, in the organisation of health facilities, there tends to be a separate line of command for medical officers.

CHAIR: We do understand and we will be talking to those medical officers.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: While there is much vaunted teamwork and so on, surely if one is a senior at the hospital and there is a problem in a relatively small hospital, and the nursing unit manager has sufficient seniority to be on the Critical Care Committee, one might reasonably hope that she is put there because she has a good overview of that hospital and its problems.

The Hon. CHRISTINE ROBERTSON: Do any of the doctors want to go on the Critical Care Committee?

Ms KREMMER: I am sorry, sir, I am not exactly sure.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: So if there was a problem with the medical staff quality at Camden, you would not regard it as your duty to report it to the Critical Care Committee?

Ms KREMMER: I do not think that that is a reasonable assessment of what I am trying to say. I think that it would be my role to report any issues of concern relating to a doctor working in the emergency department to the director.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: To the director of the—?

Ms KREMMER: The emergency department.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You would not take that beyond that to the Critical Care Committee yourself?

Ms KREMMER: Not in the first instance, no.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: There was, I understand, a problem which came up in the HCCC report of a doctor who, when a patient fell out of bed and broke her pelvis, I think it was, wrote up an examination that apparently, according to the nurse, was not carried out. Were you aware of that?

Ms KREMMER: Yes, I was.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Did you take that issue to the Critical Care Committee?

Ms KREMMER: I directed that issue, with some preliminary investigation work, if you like, to the director of the emergency department.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: And was it followed up?

Ms KREMMER: I am not aware of what the outcome of that was, no.

The Hon. AMANDA FAZIO: Ms Picone, have you been successful at all in getting doctors in the community involved in the quality processes that have been implemented in the South Western Area Health Service?

Associate Professor PICONE: The answer is yes. The approach that we are taking is to implement a new clinical governance arrangement across the area by having area directors of clinical departments and then they will take responsibility for the quality programs by a clinical program. There has been increased activity, even prior to my commencing in quality and safety issues generally after the department's initiatives around the root cause analysis and other areas. I would have to say that my early assessment of that is that we are still in the learning phase with root cause analysis and report administered briefs, but we are getting better all the time and that has led to a great involvement of medical clinicians in quality matters. We do have, in my view—I would be slightly biased at this stage—one of the best trauma departments in the State, and they run one of the best trauma assessment programs I have actually ever seen. I had a presentation on that not long ago, so it is certainly increasing a great deal.

The Hon. AMANDA FAZIO: You know that there have been allegations about euthanasia at Liverpool Hospital?

Associate Professor PICONE: Yes.

The Hon. AMANDA FAZIO: When did you first become aware of these allegations?

Associate Professor PICONE: I first became aware—and I have not got the dates but I am happy to put all the sequence of events—that there was an allegation of euthanasia in relation to a patient actually at Camden, and was made aware of that by the Deputy Coroner. I was given the details of the individual patient and undertook to try and locate that particular patient. Because the name was actually wrong, it took us quite some time to find the location of the patient. It turned out that this patient, who originally we thought was a male, in fact was a female and the person had been at Liverpool Hospital.

It was serendipity that when the media became aware of this we became aware, on exactly the same morning, of who this person was. I have a policy, and have had a policy certainly—and I have had to use it a lot since I have been in South Western—that as soon as we become aware of something, we contact the family immediately. That morning we did contact the family and, in fact, I should read it directly from the brief so I get it correct, the sequence of events.

CHAIR: I suggest you table that one if it is in the brief because we have run out of time on this issue.

Associate Professor PICONE: Yes, Chair.

CHAIR: We will cease questions at this time. Various members of the Committee wish to continue questioning the following people. If your name is not called, you will not be required again and I thank you for coming and for the contributions you have made to date. I have several requests for the following people: Catherine O'Connor, Professor Picone, Raad Roberts, Greg Driver, Lisa Kremmer and Malcolm Masso. I ask you to return for further questioning.

(The witnesses withdrew)

(Short adjournment)

MARY PRENDERGAST, Visiting Medical Officer, Macarthur Health Service, and

JAMES LESLIE PARKER, Chairperson, Medical Staff Council, Macarthur Health Service, affirmed

EDWIN LIM, Visiting Medical Officer and Surgeon, South Western Sydney Area Health Service

RICHARD CRACKNELL, Director of Emergency, Liverpool Hospital, and

CHARLES DAVID HUGELMEYER, Director, Emergency Medicine, Macarthur Health Service, sworn and examined:

CHAIR: I will not go through the rather long and formal statement that I normally make at meetings of this nature, even though you were not in attendance earlier. However, I will say several things that might be of assistance to you. First, we are looking at the complaints handling system rather than at any individuals who may have made errors. So our primary concern relates to the systems that are used. A number of other official courts are examining various issues—matters that come up before this parliamentary inquiry—that have the powers of total authority. We can still consider things that might be before other courts, if they are relevant.

I want to ensure that we follow the procedures that are adopted by the Senate and by other upper Houses in the Westminster system relating to the protection of witnesses. If there is anything that you say that you believe might bring ramifications upon you or on the work that you are doing, those involved in such ramifications would be in contempt, which is a serious charge. In some instances people who have given evidence have suffered later as a result of that evidence. The Parliament would view that issue as the most serious of contempt issues. I place on the record that I, as Chair, have had discussions with the director-general of the department to ensure that witnesses who give evidence to this inquiry are not intimidated. Do any of you wish to make a general statement? Those statements will then be followed by questions.

Dr HUGELMEYER: I do not have any specific opening statement that I would like to make. However, I would like to clarify some information that was given earlier relating to a medical officer at Camden District Hospital. It was alleged that that medical officer had not followed proper procedure in documenting the examination of a patient. Just to follow up, that issue was discussed with the medical officer and a formal report was made to the director of medical outcomes. There was follow up in relation to that issue.

CHAIR: If any of you wish to give any evidence that you believe would be better heard in camera, we will clear this Committee room so that you may give that evidence privately. The Legislative Council might deem it appropriate to publish some of that evidence later, but that matter will be decided only after discussions with you.

The Hon. AMANDA FAZIO: Have any of the doctors had discussions at their places of work with the Hon. Dr Arthur Chesterfield-Evans in relation to this inquiry?

Dr CRACKNELL: No, I have not.

Dr HUGELMEYER: No, I have not discussed it.

Dr LIM: No.

Dr PARKER: No.

Dr PRENDERGAST: No.

CHAIR: A fishing trip that did not catch anything.

The Hon. AMANDA FAZIO: I wanted to know at the outset where we stood.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Dr Hugelmeyer, I understand that you were recruited from the United States of America to an area of need. Is that correct?

Dr HUGELMEYER: That is correct.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: What are the antecedent events to that? What happened when you got here and what have you found?

Dr HUGELMEYER: I was interviewed in January 2000 and matriculated at Macarthur Health Service in September 2000 as the Director of Emergency Medicine—a specialist director. My understanding of the main reason for the recruitment effort was the inability to recruit a local specialist in emergency medicine for the position. That was a core recommendation of the so-called Rotenko report. In 1999 Dr Irene Rotenko, a former staff specialist at Liverpool, chaired an inquiry that made a study and evaluation of emergency services at Campbelltown Hospital based on some adverse cases and advancing concerns that had been raised. One of the key recommendations of that report was that a specialist doctor be appointed, which had not been the case for at least several years prior to that.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: What did you find upon your appointment? Presumably you got your American boards and had worked in the emergency field in the United States.

Dr HUGELMEYER: Yes. I was recruited from the University of Wisconsin, where I was Assistant Professor of Emergency Medicine and an attending physician in the hospital. I assumed duties and found the department to be in some disarray. There had not been leadership in the department for a number of years. Various individuals had assumed the directorship for short periods of time but there was no cohesive directorship and no specialist in emergency position. I found the morale of medical officers and nursing staff there to be exceedingly poor. There was what I would describe as a hodgepodge of medical staffing, relying predominantly on locum physicians to provide coverage, especially after hours. As to a lot of the conditions in the department aside from the physical space and facility—which was woefully inadequate—there was a significant lack in terms of policies, procedures and what I would consider to be state-of-the-art emergency department care.

I also found that the medical officers in the department had I would not say an antagonistic but a suspicious relationship and concern regarding the administration of the hospital based on things such as staffing, rostering and the general feeling that they were not valued within the institution. Essentially that is the scenario that I encountered when I arrived. I was somewhat slow to offer any judgement. As a foreigner, I was trying to be somewhat culturally sensitive, get the feel for the situation and understand the medical system here, which was new to me. Basically, I got right to work, identifying some things that I wanted to work on as a priority and set about doing that.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Did you find problems? Did you report them and what happened then?

Dr HUGELMEYER: I was recruited because there were problems. As far as I was concerned that was a foregone conclusion. That seemed to be generally accepted by administration at the time. I went ahead and addressed the issues that I thought required urgent attention, mainly team spirit in the department and organising both the nurses and doctors in some sort of cohesive department. Certainly initially the reception I got from administration was quite supportive and helpful in terms of trying to do things. Another thing I discovered very quickly was because the emergency department had not had a director it had not been represented throughout the hospital in other departments and other decision-making venues. Therefore, I was called upon to have a very heavy presence immediately on other committees and in other activities of the hospital, some of which I would not have considered to be part of my job initially but which were clearly expected of me at the time.

The Hon. AMANDA FAZIO: When you were working in America did you have any experience working in veterans administration hospitals?

Dr HUGELMEYER: In my training, yes. A substantial portion of my training, particularly in internal medicine, was at the veterans hospital in Portland, Oregon. I did a family practice and then an emergency medicine residency program at the Oregon Health Sciences University. As part of that we spent about 10 months in one program and about another five months in another program at the veterans hospital.

The Hon. AMANDA FAZIO: I am not sure whether you are aware that the health complaints system introduced in the past few years in NSW Health is based on the VA system. Do you feel you had enough clinical

experience in America to comment on how the health complaints system here works vis-a-vis there? Do you think it is effective here?

Dr HUGELMEYER: As far as my clinical experience, I have about 20 years of emergency department experience ranging in facilities from three-bed rural emergency departments to 1,000 bed facilities, Cook County Hospital and Denver General Hospital, which are some of the busiest centres in the United States. So from a clinical point of view I was quite well prepared. When I first arrived at Macarthur Health Service I did not feel that there was a very organised system in terms of complaint reporting, particularly at the grassroots level—or, as you call it, the coalface. Some things were in place but there seemed to be a separateness between what would go on upstairs, if you like, and on-the-floor monitoring and reporting. That was different, although you have to remember—and I am dating myself here a bit—that these quite sophisticated complaints-handling and quality programs were not in existence at the veterans hospitals in the United States at that time, and that is probably what led to the changes that were made them.

The Hon. AMANDA FAZIO: Have you seen any recent improvements in the way staff respond to the complaints-handling system where you work? Any of the doctors are welcome to comment on that.

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

CHAIR: Do other doctors support that view, that there could be some remnants of the old attitudes concerning complaints still existing despite all the good work done?

Dr PRENDERGAST: I personally do not think anything has changed, particularly in our department, and I can only refer to the department of obstetrics and gynaecology. Certainly as far as my practice goes, I have made four major complaints in writing to the medical superintendent dating back to March last year. The most recent one I wrote about a patient was in September last year, and I have yet to receive a reply or any indication that those particular cases have been discussed.

CHAIR: Have you had an acknowledgement?

Dr PRENDERGAST: I have had acknowledgement that the letter has been received.

CHAIR: But no satisfaction?

Dr PRENDERGAST: No satisfaction, and the one I reported in June, exactly the same problem arises in September and there has been no change. That has been brought up through our medical director and it has been brought directly to the medical superintendent, and nothing has changed.

The Hon. PATRICIA FORSYTHE: Would any of the doctors endorse the comments made by the whistleblower nurses, the concerns that they raised? Is that an experience that others would agree with?

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Perhaps we should ask about the clinical care, the clinical care committee.

CHAIR: We will have an answer to Mrs Forsythe's question first. Do any of the complaints made by any of the whistleblower nurses still resonate with you?

Dr PRENDERGAST: I think the principle that they have made complaints and there has been no action, I think that still resonates.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Can I ask about the clinical care committee. Are any of you on the clinical care committee?

Dr LIM: I am on the critical care committee, not the clinical care committee. I was on that committee, but it no longer exists.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You were on that committee but it no longer exists?

Dr LIM: Yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: And Nola Fraser was on that committee, is that correct?

Dr LIM: Yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Did she attend most or a significant number of the meetings?

Dr LIM: I cannot vouch for that in terms of numbers, but she has attended.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Did she raise her complaints about quality at that committee?

Dr LIM: Yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Did the committee take action on her complaints in a significant way?

Dr LIM: That committee is a source in which complaints can be made, and I do not believe she made any more in her contribution than any of the rest of us.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Do you think her complaints were dealt with adequately by that committee?

Dr LIM: I believe so.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: They were referred?

Dr LIM: They were discussed.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: They were discussed by the committee?

Dr LIM: That is right.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Were they minuted as such?

Dr LIM: Yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Do you think the minutes are a fair reflection of what was said at the committee?

Dr LIM: The ones I attended, yes.

The Hon. PATRICIA FORSYTHE: Dr Hugelmeyer, you mentioned that having arrived you expressed a concerning about—I think you used the words—woefully inadequate policies and procedures. You then said you did not do anything initially because you were getting into the system culturally. What action did you take?

Dr HUGELMEYER: I tried a number of things right off the bat the first thing I did was to organise meetings with the medical officers and the nursing staff to engender a team spirit and to describe my vision of what we ought to proceed with. I made some specific media changes in the patient flow and some of the logistics with patient management. For example, medical charting in the department, that was disorganised and records were all over the place and it was sometimes difficult to find documents or lab results until we reorganised things into what I call a chart and rack system, which is what I was used to. As far as I was concerned these were more housekeeping things, more common day-to-day, mundane procedural things.

CHAIR: Would you not describe that sort of medical record-keeping as fairly elementary for an emergency department, when you have documents and files all over the place?

Dr HUGELMEYER: Again, based on my experience, yes, it was disorganised. Again, I had not been to another emergency department in the country at the time, so I did not have anything to compare. Certainly by my standards it was what I had been used to in my practice.

The Hon. ROBYN PARKER: We heard from Dr Prendergast about remnants of the old attitudes, and changes not occurring. I wonder whether Dr Parker or others would like to comment on whether you think there has been change recently, from your experience?

Dr PARKER: When you say change, you mean in response to complaints being made?

The Hon. ROBYN PARKER: Yes.

Dr PARKER: My experience is that there has not being a lot of change in that area. I think people are still putting forward clinical issues that they are concerned about an offer like the same sort of process of dealing with them is still going on. It is hard to get a response and I think it is difficult in the position that managers are in for them to make responses, make decisions and implement change.

The Hon. ROBYN PARKER: Could you expand on that? What do you mean by that?

Dr PARKER: I think they are under a lot of pressure from both sides, from clinicians, administrators and particularly from politicians. That makes it very difficult for them to make decisions at a clinical level. I think there is a lot of passing around of things but not action.

CHAIR: When you say politicians, the only one who would have any authority would be the Minister for Health. Is that whom you are referring to?

Dr PARKER: I guess so, the Health Department.

CHAIR: But within the Health Department there is only one politician.

Dr PARKER: Yes, that would be right.

The Hon. ROBYN PARKER: Would anyone else like to make a comment?

Dr CRACKNELL: I would endorse what Dr Parker said.

The Hon. CHRISTINE ROBERTSON: What sort of complaint issues are you looking at?

Dr PRENDERGAST: From my personal ones, I can give you patient details.

The Hon. CHRISTINE ROBERTSON: No, I do not want to know.

Dr PRENDERGAST: I can give you general details. One complaint was a patient of mine had a miscarriage and was sent to casualty. She was sent home and subsequently miscarried at home and was dreadfully upset by this. She was a private patient of mine. I wrote a letter to the administration saying that I wanted the case discussed. I also supported my patient. I have yet to receive any report from that.

CHAIR: How long would that be?

Dr PRENDERGAST: That was from June last year.

CHAIR: And you have not had—

Dr PRENDERGAST: I have a letter acknowledging but I have had no answer back from the administration.

CHAIR: For nine months?

Dr PRENDERGAST: Yes.

CHAIR: That is time to be pregnant again and deliver a baby. It is quicker to deliver a baby than a letter.

Dr PRENDERGAST: The second patient is a patient of mine who had a post-operative complication in that she had post-operative hypoxia and had an episode of confusion. After she was confused and they called a medical team to come and see her in the middle of the night. They instituted treatment and called her husband in to be with her. The lady was of migrant background and her English was not very good. This all happened at approximately 10.00 p.m. She was also admitted as a private patient of mine and no-one picked up the phone to tell me anything about it. I just discovered her on a routine ward round the next day. I made a complaint to the nursing unit manager of the board. He told me it was not his responsibility to notify me about such cases. In June 2003 I wrote a letter to the administration asking for an explanation, and I am yet to receive a reply to that.

A more recent one was a patient of mine that went into intensive care post operatively because she had some minor hypoxia after anaesthetic. At approximately 5:30 a.m. they required a bed in intensive care so a decision was made to move this patient out of intensive care. They did not discuss it with me. They did not discuss with the resident obstetrics and gynaecology workers who were on 24-hours a day. The patient was transferred to the ward, but there was no bed available so she was put into a treatment room, without any access to a buzzer, and she had a narcotic drip going. I discovered her on ward rounds and was most upset about her management, and the potential for disaster with that management. I was so upset about it I called our medical director to personally attend on the ward. In September last year I formally wrote a letter to the administration, and I am yet to receive a reply.

The Hon. AMANDA FAZIO: Is that at Camden or Campbelltown?

Dr PRENDERGAST: This is at Campbelltown hospital. The issue about that is that the nursing unit manager could not see why I was so upset about the management of this patient.

CHAIR: Was it the nursing unit manager in each case?

Dr PRENDERGAST: In various cases, but yes. I did not complain to them, I complained to our medical superintendent.

The Hon. PATRICIA FORSYTHE: In part, does it go to resourcing?

Dr PRENDERGAST: Certainly, but some of it is basic medical protocols. A patient who is in intensive care should not be discharged without notifying someone, especially in the early hours of a morning. That is just not good policy.

The Hon. CHRISTINE ROBERTSON: Who makes the decision to transfer someone out of intensive care?

Dr PRENDERGAST: In that particular case it was the nursing staff or the junior doctor on duty that evening.

The Hon. CHRISTINE ROBERTSON: That gives the committee a good picture of your kinds of issues. Are Dr Parker's different?

Dr PARKER: I guess, to follow up on what Dr Prendergast is saying. There is a big issue of resources particularly with management of some of the subacute problems. As a medical staff we have put these issues to the previous and the current administrations on many occasions over a number of years, and that is really the point that Dr Prendergast is getting at. We are short staffed, we have been, we still are. We have had scant resourcing of the things that we need. We need, for instance, an extra theatre and we have been battling to get the concept through various management levels for a long time. Finally we have got a complete unanimity from all departments involved—anaesthetic, surgery, and gynaecology—but still we do not end up with the actual resource.

The Hon. AMANDA FAZIO: Where is that new theatre?

Dr PARKER: It is just an example, but the theatres already built, it is just a matter of getting staffing.

CHAIR: Are those theatres actually closed?

Dr PARKER: They are sitting there doing nothing.

The Hon. CHRISTINE ROBERTSON: At which hospital?

Dr PARKER: Campbelltown theatre. Last night, for instance, we had two emergency theatres until midnight because we did not have the theatres open during the day to deal with the appropriate cases appropriately.

The Hon. PATRICIA FORSYTHE: Has the decision to open the Camden Maternity Unit had an impact on the level of resources available?

Dr PARKER: The decision to open Camden Maternity Unit is one of our great bugbears. It involves all of the anaesthetic staff, the obstetric staff and the paediatric staff. That is one third of the medical staff of Campbelltown and Camden hospitals in total but really the issue is the division of resources and staffing 22 units.

The Hon. PATRICIA FORSYTHE: Would you put that in layman's terms. What is the practical impact on anaesthetists by having to two hospitals? How do they maintain their rosters?

Dr PARKER: It means that they have to do a higher level of rostering if they want to maintain these services at both hospitals than what they and their college thinks is a reasonable one. The health service obviously is attempting to get around that problem by recruiting five anaesthetists from South Africa. But that has not fixed the problem in any way unfortunately. That has provided a base line level of staffing but at the current time the current administration has appreciated that that is not enough staffing so it employs locum staffing to do anaesthetics on call at Camden for weekends. That is a very low-risk unit—they would be lucky to be called once or twice in the weekend—for a huge amount of taxpayers money to pay to have those people employed.

The Hon. PATRICIA FORSYTHE: How much is it?

Dr PARKER: We have asked several times. I have asked several times in various executive meetings and people are very reluctant to provide any figures on financial arrangements, particularly with the obstetricians. They have a very secretive contract about which no-one can find out the details.

CHAIR: Are obstetricians who are on call 24 hours a day, seven days a week, on a contract of about $1,000 per day or high?

Dr PARKER: Much higher.

CHAIR: Are they earning somewhere around three-quarters of a million dollars per annum?

Dr PARKER: Because it is a secretive contract we do not know the specific details, but we understand it is more than that.

CHAIR: More than three quarters of a million dollars for work of primarily being on call?

Dr PARKER: Yes, and providing a very high level obstetric on-call cover for a very low level risk unit, one of the lowest level risk units you will find anywhere in the State.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Is covering one hospital on two sites merely sleight of hand as presumably the one person cannot be on call at two hospitals at the same time?

Dr PARKER: Dr Prendergast and I are both obstetricians and we have been working in the hospital in the obstetric departments for a number of years. In the setting up of Camden coming back on-line after it was a recommissioned we were involved in one or two meetings only on how that service should be run from the obstetrics point of view. We determined an on-call arrangement that we would feel was a reasonable thing for us to do to set up separate on-call rosters in the two hospitals. We were not able to provide, with the staffing or recruiting we had available, two sites properly covered obstetric services. So the private obstetric consortium arrangement that is in place now was developed.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Did the medical staff try to lessen facilities at Camden because they felt that they could not staff two hospitals? In what areas was that the case?

Dr PRENDERGAST: Before the change happened? Because we had Camden running and then Camden was closed?

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: I gather Camden was reopened and the controversy was whether it could be staffed adequately and safely with the medical resources?

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

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You were overruled at the bottom line in terms of delivering that service at Camden. It was eventually opened without your services but with a private company at a vast cost?

Dr PRENDERGAST: Basically yes. If there is a problem patient there they are transferred to Campbelltown and we take on full responsibility and manage those patients. We see patients in the context of the antenatal clinic that have transferred over from Camden if they are regarded as high-risk. But the day-to-day running of Camden, as far as the visiting medical officers and obstetrics and gynaecology, we do not have any part of it. The medical director staff clinician has some function in running the unit.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Is Camden the same in emergency?

Dr HUGELMEYER: The situation in emergency actually with Camden was that when I was interviewed I was informed that Camden would probably be closing. I matriculated some months later and I was told now I am director of that site. In the interim obviously there have been discussions and impetus to keep the facility open. Despite the best efforts of some very dedicated people at Camden, it has always suffered from a lack of resourcing and a lack of medical staff support in the sense of individuals feeling comfortable providing coverage at Camden. Staffing was, in fact, a very significant issue. As the testimony was given earlier, there was one doctor in the emergency department who was responsible after hours for the entire hospital. I found that to be a totally untenable situation and contrary to the standards I was used to. So there were a number of issues in terms of the resourcing at Camden that made it very difficult to provide a safe and effective service.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Did you take your concern to management and what was the response?

Dr HUGELMEYER: Yes, I did. At various times I pointed out some of the specific issues—for example, a memo in 2000 to specifically address the issue of Camden staffing and the overnight issue.

The Hon. PATRICIA FORSYTHE: Who was that memo to?

Dr HUGELMEYER: That was to the general manager and director of acute care services. We had discussions regarding that, but it was some time before resources were available to actually address it?

The Hon. PATRICIA FORSYTHE: Did you get a reply to the memo?

CHAIR: Would Government members like to ask a question?

The Hon. PETER PRIMROSE: From what you are saying, and since we are talking about resources as opposed to systems of complaint, do you support the State Opposition proposal to shut Camden hospital? Whare are we talking about—the closure of which departments? Do you support their proposal to shut the hospital?

Dr PARKER: If I could make a comment as chairman of the Medical Staff Council, therefore on behalf of various departments rather than purely from the obstetrics point of view, I think there is very good agreement through all medical staff that the resources and staffing we have make it extremely difficult to provide cover at two separate units, appropriate cover. If we took all the staffing and resources that we have and concentrated them at a single centre, we believe we could provide an excellent level of service and cover with reasonable rostering arrangements, middle level registrar CMO cover in the appropriate facilities that we have. That is our problem: providing acute services at two separate sites.

The Hon. PETER PRIMROSE: To be clear, do you all support the Opposition proposal to shut Camden hospital?

The Hon. PATRICIA FORSYTHE: Mr Chair, lest we get verballed, I would like to place on the record that we have not said we would be shutting it.

The Hon. PETER PRIMROSE: The Opposition supports the hospital staying open?

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Could we stop the political pointscoring and ask the doctors what the situation is?

The Hon. AMANDA FAZIO: You could stop hogging the microphone and let someone-else ask a question.

CHAIR: Now, boys and girls, settle down. Would you please answer the question: Which sections of which hospital do you believe should be closed down if there is going to be adequate medical coverage?

Dr PARKER: The problem areas that we have are the accident and emergency at Camden hospital which, in part, have been addressed already by the changes that have been made. David Hugelmeyer would be much better qualified to speak about that than myself. The other areas we have been speaking about, that is, the maternity unit, and in particular the delivery suite section of the maternity unit at Camden hospital, is an ongoing problem for us with paediatrics particularly and anaesthetics. It is not a problem for us with obstetrics and direct cover. We have two separate arrangements. The people at Camden seem to be happy with their arrangement and we are happy with our arrangement at Campbelltown and we do not have a problem with obstetrics. But paediatrics and anaesthetic cover is of particular concern. Obviously the three departments work hand in hand in terms of running a safe and adequate standard service.

The Hon. AMANDA FAZIO: On my understanding, since changes have been made the obstetrics unit at Camden has been made safer and does not deal with high-risk births now? I know that you cannot define a high-risk birth until you are in the middle of it, but are people who are deemed to be at a high risk are generally referred to Campbelltown and are told that they cannot make arrangements to give birth at Camden?

Dr PARKER: They are, but your point that we cannot predict a high-risk birth is probably the most important point. I was on for obstetrics yesterday at Campbelltown hospital. A patient was induced into labour at Camden the night before, failed to progress in labour and had to be transported by ambulance to Campbelltown hospital for a caesarean section. We made it very clear that the impact of what is happening at Camden directly impacts on us when patient care issues of that sort of transfer occur. We are totally opposed to any intrapartum transfer of someone in labour in an ambulance in a metropolitan suburb of Sydney.

The Hon. AMANDA FAZIO: On my understanding, it is low risk. A patient who had to be induced should not have been induced at Camden anyway.

Dr PARKER: I think you can reasonably argue that.

The Hon. CHRISTINE ROBERTSON: I understand that you have participated in the area or district group that sets up these things. You now have a powerful critical care group, do you not? In the clinical governance process, do you all have the opportunity to participate on how things are set up and what functions should be carried out in what hospital?

Dr PARKER: Not really.

The Hon. CHRISTINE ROBERTSON: Is this situation improving?

Dr PARKER: The Medical Staff Council does not feel that it has appropriate representation on a lot of the decisions that are being made. We would like much more involvement. We feel there is minimal involvement.

The Hon. CHRISTINE ROBERTSON: As the Medical Staff Council or as expert clinicians?

Dr PARKER: As expert clinicians.

CHAIR: We will move on to questions from the Opposition.

The Hon. CHRISTINE ROBERTSON: I have one more question.

CHAIR: The Opposition is next.

The Hon. PATRICIA FORSYTHE: Dr Hugelmeyer, you referred to a memo you wrote to the general manager. Would you confirm who the general manager was?

Dr HUGELMEYER: It was Jennifer Collins.

The Hon. PATRICIA FORSYTHE: Did you get a reply to that memo?

Dr HUGELMEYER: Yes. I honestly do not recall if I got a reply directly from Jennifer Collins regarding it. I did discuss it with the director of acute care services.

The Hon. PATRICIA FORSYTHE: Would it be accurate to say that many of your concerns were the same as those that were held by the whistleblower nurses, in particular, to quote from the memo:

> In the current situation the emergency department is one marked by inefficiency, long patient delay and, most seriously, patient neglect.

Dr HUGELMEYER: If I can clarify something, I think we are perhaps confusing memos. The memo that I was referring to was this document. I would be happy to table it. No, the one you have is a different one. I can certainly discuss that, if you want.

The Hon. PATRICIA FORSYTHE: I would be happy to.

Dr HUGELMEYER: The memo I was referring to was one from 10 July 2002 which specifically was looking at the issue of medical staffing at Camden. The memo you have there which you just showed is a different memo.

CHAIR: Did the Government members want to ask a question?

The Hon. CHRISTINE ROBERTSON: As to the term "role delineation", where people need to work to know exactly what each hospital does, there are general practitioners throughout New South Wales who run on definitions for low-risk births and who rarely make a mistake. When you say that Camden cannot do it, are you saying that all the district and base hospitals that deliver babies are no longer competent to do it because there is not an obstetrician available? I do not mean to sound aggressive; I am just interested in the answer.

Dr PARKER: I do not think it is up to me to make decisions about that. These two hospitals are in metropolitan Sydney. They are not in a district hospital situation in the country, they are metropolitan Sydney

and I think they should be staffed and functioning in the same way with staff that run metropolitan Sydney hospitals.

The Hon. ROBYN PARKER: Dr Hugelmeyer, were you at any time called to Jennifer Collins' office and given a dressing down about raising concerns?

Dr HUGELMEYER: Yes, I was.

CHAIR: The term was "dressed down" by Jennifer Collins.

Dr HUGELMEYER: That is correct.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Did you write to Mr Iemma?

Dr HUGELMEYER: Yes, I did.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Why did you feel it necessary to write to Mr Iemma?

Dr HUGELMEYER: In my perhaps fairly Yankee naivety, I thought that it was a considerate gesture to write to the new Minister for Health, welcoming him to his position, particularly since, as I sat at my desk, there were three complaints that had been sent via the Minister's office regarding care in my emergency department, and I thought perhaps he would like to hear something nice from our emergency department. So I wrote a letter essentially saying: Welcome, congratulations; I don't vote here so this isn't political; I worked with your predecessor to do some good stuff, and look forward to working with you; if you ever happen to be in the area, would love it if you visited our brand new department, which we had just commissioned.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: So you were just being friendly?

Dr HUGELMEYER: That was my perception.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: And what happened?

Dr HUGELMEYER: Basically, I was informed that was a "rude thing to do", that it was overstepping my bounds, that it was not appreciated that I had done that, and copies of that letter were in various individuals' administrative offices.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: So you got an answer from your boss before you got an answer from the Minister?

Dr HUGELMEYER: That's correct.

The Hon. AMANDA FAZIO: Dr Cracknell, have you got anything you wanted to say? You have been a very quiet participant here today. Have you got any comments about changes to complaints management recently?

Dr CRACKNELL: The main reason I have not been piping up is that I have moved from Campbelltown to Liverpool hospital, but still within South Western Sydney, and so I suppose I have moved systems of complaints management. I have observed that at Liverpool hospital there was a better system, or more thorough system, for complaints management. But I was observing that there were changes that had begun at Campbelltown prior to my departure.

The Hon. AMANDA FAZIO: Do you think there was a significant difference in the cultures that you encountered at Campbelltown and Liverpool in terms of complaints handling?

Dr CRACKNELL: I think at both hospitals the idea of corporate governance was promoted, in that when I started at Campbelltown hospital with the director of medical services literature regarding corporate governance was given to me, such as the Department of Health's clinicians tool kit. The problem that I had was the ability to implement these ideas at Campbelltown and to close the loops. We would frequently raise issues,

and they were often acknowledged, but then the implementation phase of any recommendations made seemed to be where things stopped. I think this is a problem in all the hospitals I have worked in, where the implementation phase becomes very difficult, and it seems that it is often passed back to the clinician to then identify and implement change, where perhaps that is at the cost of the other roles in direct patient care.

CHAIR: Doctors, I would just say that we have come to the end of our time. I would propose that we finish in five minutes, if that will be convenient to you. I would ask members of the Committee to raise questions sharply.

The Hon. ROBYN PARKER: I think it is important to clarify something for the record. The colloquial expression "dressing down" was used. Dr Hugelmeyer, could you explain the nature of that term, as you understand it, in terms of perhaps retribution you might have received for that complaint and your memo to the Minister?

Dr HUGELMEYER: Yes, I would define my encounter as a dressing down as well.

The Hon. ROBYN PARKER: What happened? What was the nature of the discussion?

Dr HUGELMEYER: I sense you have a copy, it was widely distributed, and I believe it was even tabled here before. I wrote a memo on behalf of the ED executive committee in, I believe it was, September 2002, outlining a number of issues in the emergency departments of both Camden and Campbelltown, and the initiatives that the ED staff had done. That memo was leaked to the media. I will put on the record here once again that I had absolutely nothing to do with leaking it; I was overseas at the time. When the media attention came to this memo, it was apparently very distressing to management. When I returned I was called into the general manager's office, with two individuals in attendance, and I was essentially very severely reprimanded, intimidated, and basically told that there was no substance to that memo, when in fact it was quite to the contrary.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Did anyone else experience a similar response to complaints? No?

The Hon. PATRICIA FORSYTHE: I would like to ask a question on another issue of basically each of the doctors, but Dr Prendergast initially. You commented earlier about the nature of the resources at the Campbelltown and Camden hospitals maternity unit. Do you believe that the decision to open the Camden maternity unit was a politically motivated decision?

Dr PRENDERGAST: I find it a little bit difficult to discuss, because I was not involved in the politics. But, from a practical and medical position, having a duplicated unit less than 15 to 20 minutes away means you are taking resources away from one unit to create another unit in the practice of obstetrics, where low risk does not really exist. And it is not just low risk management from the doctor's point of view. If you have got a patient bleeding and there are no blood facilities there, you have got to get a taxi to come and collect the sample of blood to take it to Campbelltown or Liverpool, and you have got to get your blood cross-matched and brought back to Camden—while your patient is bleeding. There are other issues involved also. So I certainly was active in not supporting duplicating the units, and felt we could run a better unit and have more diverse facilities, such as a birth centre or a completely midwifery-run centre, run with the university of midwifery centre, next door to a standard unit where you had the resources for better teaching of the nursing staff, and better facilities for everybody. I mean, a birthing centre is not available for the people of Campbelltown unless they want to go to Camden. As far as the politics of it, I can only assume that, yes, it was political, but I do not have any direct input into that.

Mr STEVEN PRINGLE: Can I ask how long Camden has had a maternity unit?

Dr PRENDERGAST: I have only been there since 1988, and there was one existing before then. But it certainly went through a period of being run down. In fact, the establishment of the birth centre was made to try to improve the numbers, because it was felt the numbers there were too poor to run an active unit.

Mr STEVEN PRINGLE: I was just wondering how many decades Camden hospital has had a maternity unit.

CHAIR: It would probably be a district or rural-based hospital that took obstetric cases.

The Hon. PATRICIA FORSYTHE: Dr Parker, do you have a similar view to that of Dr Prendergast, who commented that the decision might have been politically motivated?

Dr PARKER: I would totally agree. The Medical Staff Council has made comments about those issues before, and that has been reported in the media, particularly just before Christmas.

The Hon. PATRICIA FORSYTHE: Dr Lim?

Dr LIM: I have nothing to do with the obstetric department.

The Hon. CHRISTINE ROBERTSON: What is your specialty?

Dr PARKER: I am a surgeon.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: I would like to ask Dr Cracknell a question. You were receiving some cases that had been to Campbelltown and transferred from or discharged from Campbelltown. In the HCCC report it was said that there had been cases that were transferred in very dire straits. Did you receive those and note that there was any pattern to them?

Dr CRACKNELL: Do you mean transfers from Camden to Campbelltown?

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Yes.

Dr CRACKNELL: The major problem with transfers from Camden to Campbelltown was the time delays. Campbelltown was often busy and code red and had no space to receive patients. If there was no bed available on the ward for them to be transferred to, that led to delays. There were cases, particularly surgical and obstetric, in which that impacted on the clinical outcomes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Have you received some of those at Liverpool as well?

Dr CRACKNELL: The issues relating to transfer occur at Liverpool. We receive transfers from many of the surrounding hospitals. Our frequent code red status often delays the processing of those transfers.

CHAIR: Thank you. We will not require the witnesses to appear before the Committee again. We wish you well in your practices.

For the sake of honourable members, Professor Picone has advised that, in respect of the statement she was asked to table in answer to questions asked by the Hon. Amanda Fazio, she does not have the papers in her possession at the moment, but she will find them and make them available.

(The witnesses withdrew)

(The Committee adjourned at 4.31 p.m.)