REPORT ON PROCEEDINGS BEFORE

SELECT COMMITTEE ON OFF-PROTOCOL PRESCRIBING OF CHEMOTHERAPY IN NSW

At Macquarie Room, Parliament House, Sydney on Monday, 31 October 2016

The Committee met at 11:15 am

PRESENT

The Hon. P. Green (Chair)

Mr J. Buckingham
The Hon. C. Houssos
The Hon. T. Khan
The Hon. N. Maclaren-Jones
The Hon. W. Secord
The Hon. B. Taylor (Deputy Chait)

The CHAIR: Welcome to the first hearing of the Select Committee on Off-protocol Prescribing of Chemotherapy in New South Wales. I acknowledge the Gadigal people who are the traditional custodians of this land and I pay respects to the elders past and present of the Eora nation and extend that respect to other Aboriginal people present or those who may be joining us today on the internet. The inquiry is examining off-protocol dosing of chemotherapy in New South Wales and will consider the capacity of electronic prescribing systems to stop the limit of off-protocol prescribing, the process and systems around informed consent for medical interventions, the value of potential new patients information sheet on dose adjustment and the need for notifiable cancer patients to be overseen by a multidisciplinary cancer care team.

The inquiry will examine the capability of St Vincent's Hospital to comply with NSW Health policy directives and guidelines and mechanisms for staff to raise concerns about the practice of clinicians and breaches of the code of the conduct at St Vincent's Hospital and within NSW Health more broadly. Today is the first of four hearings we plan to hold for this inquiry. We will hear today from leaders of the NSW Health department inquiry into off-protocol prescribing of chemotherapy at St Vincent's Hospital and in the Western NSW Local Health District, senior officers from the New South Wales Department of Health and senior administrators, clinical managers and clinicians from St Vincent's Hospital. Tomorrow the Committee will take evidence from Dr John Grygiel and representatives of the South East Sydney Local Health District.

I will make some brief comments about the procedures for today's hearing. Today's hearing is open to the public and is being broadcast live via the Parliament's website. A transcript of today's hearing will be placed on the Committee's website when it becomes available. In accordance with the broadcast guidelines, I inform members of the media who are here or who may be joining us that while Committee members and witnesses may be filmed or recorded, people in the public gallery should not be the primary focus of any filming or photography. I also remind media representatives that they must take responsibility for what they publish about the Committee's proceedings. The guidelines for the broadcast of proceedings are available from the Secretariat.

There may be some questions that witnesses can answer only if they had more time or with certain documents at hand. In those circumstances witnesses are advised that they can take a question on notice and provide an answer within 21 days. In terms of adverse mention and patient privacy, please be careful when using the names of individuals during the hearing in order to avoid unnecessary harm to the reputation of people. Please ensure your comments are relevant to the terms of reference. I also remind participants to respect the privacy of individual patients.

It is important to remember that parliamentary privilege does not apply to what witnesses may say outside about their evidence at the hearing. I urge witnesses to be careful about any comments they make to the media or to others after they complete their evidence. As such, they would not be protected by parliamentary privilege if another person decided to take an action for defamation. Specifically for this inquiry we have some content of this hearing that may be distressing, especially for patients and family members. If anyone in the audience feels distressed by the evidence that they hear today please approach the Secretariat and we can arrange for someone to speak with you.

In terms of delivery of messages and documents tendered to the Committee, witnesses are advised that any messages should be delivered to the Committee members through the Committee staff. Finally, I ask everyone to please turn off their mobile phones or set them to silent for the duration of the hearing.

Professor DAVID CURROW, Chief Executive Officer, Cancer Institute NSW, Chief Cancer Officer NSW, Chairman of Section 122 Inquiry, sworn and examined

Dr PAUL CURTIS, Governance and Assurance, NSW Clinical Excellence Commission, sworn and examined

Dr PAUL GAVEL, Director, Workforce for HealthShare NSW, affirmed and examined

The CHAIR: Do you have an opening statement?

Professor CURROW: I do, thank you. The inquiry's findings have been interpreted and reported in the media and public spheres. It is vital that the findings are considered in their entirety, appreciating the complexities of medical oncology. Chemotherapy protocols provide guidance on dosing, formed by clinical consensus based on the best available evidence. Appropriate variation in prescribing is not only expected but essential. This means the dose is personalised, supported by the best available evidence where it exists. The justification for the dose variation is clearly documented and patients give informed consent, having understood the risks and benefits of the treatment. There comes a point where variation from the protocol is so great that treatment is no longer based on evidence. This is what the inquiry describes as "off-protocol". If a clinician wishes to depart from the evidence to this extent in his or her practice, he or she must only do so with the approval of a Human Research Ethics Committee in the form of a clinical trial.

The inquiry took a systemic approach to identify patterns of prescribing by Dr Grygiel. The inquiry found Dr Grygiel's prescribing with these two particular drugs was not supported by evidence. For many people, the doses prescribed were not personalised, the rationale for the variation was not documented, nor was it communicated and understood by his patients in the process of providing informed consent. Dr Grygiel's practice was conducted in environments that had problems with culture, systems and clinical governance. The inquiry is confident that, in combination, its recommendations will strengthen systems and clinical governance across the State. In future, any clinician who embarks on departure from the best available peer-reviewed evidence will have his or her practice held to account. Thank you, Mr Chairman.

The CHAIR: Thank you, Professor Currow. We will start with questions.

The Hon. WALT SECORD: Professor Currow, thank you for coming today. My first question involves you as the co-leader of the section 122 inquiry. Are you still involved in pulling together materials involving that inquiry?

Professor CURROW: No, that has transferred over to the Ministry of Health.

The Hon. WALT SECORD: Anything that comes up now is handled by the ministry?

Professor CURROW: It is handled by the ministry or the local health districts or health networks concerned.

The Hon. WALT SECORD: Are you comfortable with that?

Professor CURROW: The section 122 inquiry has provided its report and recommendations. That was the extent of the section 122 inquiry, and it now falls to the Ministry of Health and to relevant local health districts to take that work forward.

The Hon. WALT SECORD: Is it correct to say that your work involving the section 122 inquiry has completed, it has come to an end?

Professor CURROW: That is correct.

The Hon. WALT SECORD: Can I get a recap then? How many cases were identified at St Vincent's, St George, Sutherland, Macquarie University Private Hospital and the central west? How many cases involving Dr Grygiel and Dr Kiran Phadke were identified or brought to your attention?

Professor CURROW: If I may, through the Chair, the section 122 inquiry was specifically related to Dr John Grygiel. The section 122 inquiry is not tasked with dealing with issues relating to Dr Kiran Phadke and, therefore, not related to St George or Sutherland hospitals.

The Hon. WALT SECORD: How many patients at St Vincent's?

Professor CURROW: In terms of the numbers, the inquiry identified 129 people who were treated with flat dose off-protocol carboplatin at St Vincent's Hospital and in Western NSW an additional five people who were treated with off-protocol flat dose carboplatin.

The Hon. WALT SECORD: Are you confident that all cases involving underdosing involving Dr John Grygiel at St Vincent's Hospital were provided to your inquiry?

Professor CURROW: All of the issues related to carboplatin prescribing, I have confidence that St Vincent's have shared with us all of the data they have.

The Hon. WALT SECORD: Are you familiar with a drug—and I want to make sure that I pronounce it properly; I will spell it—T-E-M-O-Z-O-L-O-M-I-D-E. Can you pronounce for that me?

Professor CURROW: Temozolomide.

The Hon. WALT SECORD: What is that used for?

Professor CURROW: That is used principally today for people who have brain cancers.

The Hon. WALT SECORD: Were any cases involving Dr John Grygiel providing that drug for brain cancer brought to your St Vincent's inquiry?

Professor CURROW: Yes.

The Hon. WALT SECORD: They were?

Professor CURROW: Yes.

The Hon. WALT SECORD: What happened involving those cases that were brought to your attention, because it does not appear in the report?

Professor CURROW: That is correct, it does not appear in the report, Mr Secord.

The Hon. WALT SECORD: Can you tell me—this relates to underdosing. I will get to that point, if the Committee will please allow. Why was that part not involved? Brain cancer, and underdosing by Dr John Grygiel, why is that not in your report?

Professor CURROW: As you will have noted from the report, the expert panel that assisted the inquiry made a determination which is reflected in the body of the report that palliative treatments have a far wider range of doses and dosing associated with them and, as such, it is far more difficult to draw a line between what is on-protocol and the variations that would be absolutely acceptable in that setting. If I may, through the Chair, I would actually like to take you through what a protocol is and—

The Hon. WALT SECORD: Okay, but I would like you to finish my—

The Hon. TREVOR KHAN: Point of order: It is plain the professor is seeking to assist the Committee. He should be allowed to answer the question in an appropriate way and it is clearly relevant at the present time.

The Hon. WALT SECORD: Further to the point of order—

The CHAIR: Order! I will say this—

The Hon. WALT SECORD: You are closing off a very important line of questioning. There are more cases—

The CHAIR: Order! I am not closing off anything. I am merely going to make a statement.

The Hon. WALT SECORD: Mr Chair—

The CHAIR: Order! The statement I want to make is that I will allow members, for the panel's sake, to cut short your answer in order to move on to another question.

The Hon. WALT SECORD: Professor Currow, we will return to your explanation in a second. I would like to know: Are you confident that all other cases of underdosing by Dr John Grygiel were brought to your inquiry?

Professor CURROW: If I may return to my answer?

The Hon. WALT SECORD: I would like you to answer my question. It is pretty simple.

The CHAIR: Order! The witness also has the opportunity to answer the question how they would like. If you do not get that answer, you can return to your question. Professor Currow?

Professor CURROW: So, as outlined, it is very difficult for peer clinicians to draw a line on what is on- and off-protocol in the palliative setting. The report as it stands very clearly states, Mr Secord, that it relates to first dose of treatment with curative or adjuvant intent. It has not gone to address issues of palliative intent

because it would not be possible to do so. If we think about a protocol, it would be overly simplistic to say, "On-protocol is good. Everything else is bad." In fact, if we look at a protocol, the protocol already has built into it a number of factors that would lead to those variations and sometimes quite substantial dose variation in that setting.

The Hon. WALT SECORD: Thank you, Professor, but my question is very simple. Are you confident that all cases involving underdosing involving Dr John Grygiel at St Vincent's were considered by your inquiry?

Professor CURROW: Yes.

The Hon. WALT SECORD: How many of those were outside the carboplatin that involved the brain tumour drug to which I have just referred?

Professor CURROW: Again, if I may return to my—

The Hon. WALT SECORD: I would just like to know a number.

The Hon. TREVOR KHAN: No. Let him answer.

The Hon. WALT SECORD: He was not answering my question.

Professor CURROW: I am trying to convey that those cases were not considered in detail because the inquiry did not pursue trying to define dosing for palliative intent.

The Hon. WALT SECORD: Professor, how many cases fell into that category, which you did not consider warranted an inquiry, that were underdosed and that you said were in the palliative sphere?

Professor CURROW: As I have indicated—

The Hon. WALT SECORD: You have used the plural. You said "cases". How many?

The Hon. TREVOR KHAN: Let him answer the question. You are cutting him off before he gets two words out.

The Hon. WALT SECORD: No, I am not.

The CHAIR: Order! Allow the witness to answer the question.

Professor CURROW: As I have indicated, that is not quantified in the inquiry because it was not within the expert reference group's advice to the inquiry, Mr Secord.

The Hon. WALT SECORD: Were there a dozen? Where there two dozen? Were there many or was there but one? Last night I met a family who have concerns about this and they drew this case to my attention. They have had two meetings with St Vincent's Hospital about this and St Vincent's has apologised. I want to know how many other cases fall into this, and have those families been notified?

Professor CURROW: Again, this was not a finding of the inquiry because palliative chemotherapy was considered outside the bounds of the inquiry to actually comment on dose.

The Hon. WALT SECORD: So you just ignored all those cases?

Professor CURROW: No, we did not ignore them, Mr Secord. Again, if I can return to an explanation of how a protocol is developed—because if we understand that, we get to the bottom of the question I believe that you are asking.

The Hon. WALT SECORD: Okay.

Professor CURROW: The protocol seeks to use the best available evidence that is extant anywhere in the world. This evidence in New South Wales is brought together by more than 700 clinicians for clinicians. Importantly, what happens in that process is that that process develops consensus. It also, however, puts parameters around that particular combination or medication in order to convey clearly to clinicians how to vary the dose. Importantly, that variation is part of personalising the dose for individual patients. There does come a point where that variation is so great that you would have to say it is off protocol. Now, in the case of temozolomide, in the palliative setting it is very hard to draw a line across that grey zone. This is not black and white. This is not white, good; black, bad. This is a continuum and individual clinician judgement is crucial to personalising the medication and the choice of medication and the choice of dose of that medication. These cases were not ignored. What happened was—

The Hon. WALT SECORD: But they are not in your report.

Professor CURROW: That does not mean that they were ignored, Mr Secord. They were not ignored. The advice from the panel was that a clinical determination could not be made that this was either on- or off-protocol and, as such, they do not appear in the final report.

The Hon. WALT SECORD: Professor, who determined not to include those cases in the report?

Professor CURROW: That was on the expert evidence of a panel predominantly of interstate experts in medical and radiation oncology, in oncology pharmacy and in clinical pharmacology.

The Hon. WALT SECORD: You seem to be familiar with this area. Can you quantify how many cases we are talking about that you decided not to put in the report?

Professor CURROW: A handful of cases.

The Hon. WALT SECORD: A handful? Is that 12?

Professor CURROW: No. It is fewer than that. There were a handful of cases relating to temozolomide, Mr Secord. I do not have a number. I am happy to take that on notice.

The Hon. WALT SECORD: I would appreciate that.

The CHAIR: We will move on and then we can come back. I am mindful that members want to ask questions.

Mr JEREMY BUCKINGHAM: Professor, when was the issue of flat dosing of carboplatin first raised by clinicians?

Professor CURROW: The inquiry's findings are that that was first raised in June or July 2015.

Mr JEREMY BUCKINGHAM: Your report states, "Staff interviewed indicate that the flat dosing of carboplatin was raised with Dr Grygiel on many occasions from at least 2005."

Professor CURROW: Absolutely.

Mr JEREMY BUCKINGHAM: But you said it was 2015.

Professor CURROW: In terms of being formally raised—that is, raised beyond a conversation between Dr Grygiel and a member of staff—the advice to the—

Mr JEREMY BUCKINGHAM: I did not say "formally raised". I said "raised".

Professor CURROW: Right. Then, as you have seen in the report, 2005.

Mr JEREMY BUCKINGHAM: How was that raised?

Professor CURROW: My understanding from the interviews that the inquiry undertook was that that was raised between individual staff members and Dr Grygiel; that is, oncology nurses, oncology pharmacists and junior medical staff.

Mr JEREMY BUCKINGHAM: So it was only raised in that 10-year period between junior staff—oncology nurses, oncology pharmacists and junior doctors—on an individual, one-on-one basis with Dr Grygiel?

Professor CURROW: That is the advice that the inquiry received.

Mr JEREMY BUCKINGHAM: Who did the inquiry receive that advice from?

Professor CURROW: From junior pharmacists, oncology nurses and at least one junior doctor.

Mr JEREMY BUCKINGHAM: Do you accept that that is possible, that is credible, that for 10 years junior doctors, junior pharmacists and nurses were raising an issue with Dr Grygiel and that senior staff and management at St Vincent's in particular were unaware? Do you accept that that is a reality? Do you accept that?

Professor CURROW: That is the evidence that has been given to the inquiry, Mr Buckingham. I would hasten to add that there are three patient cohorts identified relating to head and neck cancers in the report. There are those who were administered cisplatin at a personalised dose; those who were administered carboplatin at a personalised dose; and those who were administered carboplatin at a flat dose off-protocol. That is important because, as you think about those staff rotating through in the case of medical staff, who perhaps are on a 10-week rotation, they will have seen patients treated with cisplatin, with carboplatin at a personalised dose and potentially carboplatin at a flat dose. If it was not escalated beyond that, their exposure to that clinically may indeed have been quite limited.

Mr JEREMY BUCKINGHAM: The only evidence you received was that that was the case. It was only raised on an individual basis between junior staff and Dr Grygiel, and in no other way.

Professor CURROW: Dr Grygiel suggested that it had been raised with the head of—

Mr JEREMY BUCKINGHAM: But that is different. You just said that there was no other evidence.

The Hon. TREVOR KHAN: Just let him answer the question.

Mr JEREMY BUCKINGHAM: Excuse me, if you want to raise a point of order then please do so.

The Hon. TREVOR KHAN: Point of order: Instead of jumping on the witness, allow him to answer the question.

The CHAIR: That is not necessarily a point of order. You need to put it through the Chair.

The Hon. TREVOR KHAN: With respect, Chair, the witness is entitled to answer his question and not be cut off before he gets two words out of his mouth.

Mr JEREMY BUCKINGHAM: Professor Currow, you have just said that there was no evidence that there was an alternate view to that, and yet there was. Your report states:

> Dr Grygiel stated that there were others who were aware of the practice but the Inquiry was unable to corroborate the statement.

Who were the "others" that Dr Grygiel is referring to?

Professor CURROW: Firstly, if I may, Mr Buckingham, we are asked as an inquiry to form a balance in what is put before us. If there is conflict in that, then the evidence is where the inquiry concludes that the evidence is strongest. So when you ask about evidence, we are tasked with the process of actually defining where the balance of that evidence sits.

Mr JEREMY BUCKINGHAM: With respect, Professor Currow, you said there was no evidence. That is not entirely true. There was evidence. You have just decided to ignore that evidence, with the weight, as you say—

Professor CURROW: I am sorry, we have not ignored it. We could not find another person to corroborate that, despite asking several people at interview, Mr Buckingham.

Mr JEREMY BUCKINGHAM: Could Dr Grygiel not put forward a single person that corroborated that they were aware of his practice?

Professor CURROW: That is correct.

Mr JEREMY BUCKINGHAM: In the findings of your report you say:

> Failure by staff to recognise this prescribing as a clinical incident resulted in no incidents being reported in the St Vincent's Hospital RiskMan® system.

Did you find no evidence of junior staff or any staff reporting this in any way prior to when it emerged in 2015?

Professor CURROW: Again, Mr Buckingham, there was an entry into the incident information management system which was never actually submitted, so it was not a complete report in 2012.

Mr JEREMY BUCKINGHAM: In 2012?

Professor CURROW: But it was not submitted. So again we cannot take that as evidence. It did not come through the system. Someone had started to enter it and that was never completed.

Mr JEREMY BUCKINGHAM: Professor Currow, your report states:

> The Inquiry was advised that, in June and July 2015, concerns about off-protocol flat dose prescribing of carboplatin were raised in several ways.

Who raised them and how did they raise them in June and July 2015?

Professor CURROW: Again there were several versions of this put to the inquiry. One was that it was a nurse working together in clinic with a medical practitioner. Another was that it was a medical practitioner seeing patients in consultation that raised concerns at that time. The bottom line is that there may well have been several conversations happening at or around that time. None of the accounts given conflict with each other but I think that to say there is a single point at which this started to be raised is a moot point in terms of the inquiry.

Mr JEREMY BUCKINGHAM: And who did they raise them with?

Professor CURROW: Those issues were raised and, as you would see from the timeline in the report, those issues were raised at a level that included the medical clinical stream manager and executive sponsors including the director of clinical governance and chief medical officer by early August 2015.

Mr JEREMY BUCKINGHAM: Do you think it is entirely credible and entirely possible that in St Vincent's Hospital, despite junior clinicians raising this as early as 2005, it never came to the attention of senior clinicians or management?

Professor CURROW: That is the evidence that has been presented to the inquiry.

Mr JEREMY BUCKINGHAM: And are you happy to accept that?

Professor CURROW: That is the evidence that has been presented to the inquiry.

Mr JEREMY BUCKINGHAM: But in your opinion and in terms of your findings, do you think that is credible, that there is no cover-up there?

Professor CURROW: I do not have any evidence of a cover-up.

Mr JEREMY BUCKINGHAM: I will rest there for a moment.

The Hon. COURTNEY HOUSSOS: Professor Currow, how many people declined to participate in your inquiry?

Professor CURROW: In terms of St Vincent's, my recollection is that there were four people who declined. Three of those were junior medical staff who had moved on to other roles, in some cases in other States. In Western NSW there was one person who had retired and was no longer clinically active.

The Hon. COURTNEY HOUSSOS: What processes did you have in place to encourage them to participate in the inquiry?

Professor CURROW: Importantly, people were able to engage with the inquiry. We have not named names throughout the reports and we made it clear that that was an important part of trying to engage with people. I think we went to lengths to ensure that our interviews were at times suitable for interviewees and that people were supported with a support person—

The Hon. COURTNEY HOUSSOS: Sorry, I am going to stop you there. With the people who declined to participate, did they simply decline and then that was it? What follow-up methods were in place for the inquiry to encourage them to participate?

Professor CURROW: One of the people offered to answer some written questions. It was not felt that that would particularly aid the inquiry. Other than that, those people declined. That is their ability under section 122.

The Hon. COURTNEY HOUSSOS: Were any of those junior officers among the people who had raised the initial concerns about Dr Grygiel?

Professor CURROW: I do not know. I have not interviewed them.

The Hon. WALT SECORD: Did that not frustrate you that those four people declined to be interviewed—four people who refused to participate in your inquiry?

Professor CURROW: We had great cooperation from current and former staff at St Vincent's who allowed us to form a very clear picture that there were issues that needed to be dealt with both in clinical governance and in systems. I am confident that the issues raised around culture that are outlined in the report of the inquiry reflect that. If we had found nothing untoward then I would have been very frustrated and we would have needed to look further, but we had a clear picture from the people who participated with the inquiry.

The Hon. WALT SECORD: Can you not see that there is a public perception here? Four doctors refused to participate in the inquiry and you do nothing, you just accept that. Do you not think that that compromises your investigation?

Professor CURROW: Again, as I said, we already had clear patterns relating to culture, to systems, to clinical governance and to the clinical question which the inquiry was asked to answer. Again I stress that if there was nothing untoward found then absolutely we needed to go further, but we had those patterns very clearly outlined by interviewees, by the written responses from St Vincent's, from the clinical records which were explored as part of the inquiry, from the expert clinical input from interstate and from the documents presented by St Vincent's Hospital. So with those sources of information the inquiry was able to respond very clearly to the terms of reference asked of it.

The Hon. WALT SECORD: But do you usually conduct your inquiries and allow people not to participate? They say, "We are not going to participate," and you say, "That is fine." Is that how you conduct investigations? If I refuse to cooperate then that is fine?

Professor CURROW: I am bound by section 122 of the Act.

The CHAIR: Professor Currow, what is your power under section 122? Would you have the ability to summons those people to attend?

Professor CURROW: No, but I would point out that in parallel with this the Health Care Complaints Commission is undertaking an inquiry. That complaint has been lodged with the Health Care Complaints Commission and it does have the ability to subpoena witnesses and to compel provision of data.

The Hon. WALT SECORD: But yours did not.

Professor CURROW: That is happening in parallel. A third process is the Medical Council. A section 122 inquiry does not have such powers.

The CHAIR: The Committee is aware that both are investigating the matter.

The Hon. WALT SECORD: Chair, may I return to one question that arises from this?

The CHAIR: Yes, very quickly.

The Hon. WALT SECORD: The Government has been hanging its hat on these investigations and claiming that it has been open, transparent and thorough. You just told the Committee that there are other cancer patients who were not included in the inquiry and that there are four doctors who did not participate in the inquiry. That must have frustrated you. You were conducting an inquiring. You leave off some cases, you leave off people with brain tumours, brain cancer, and then four doctors refuse to participate. That must have frustrated you.

Professor CURROW: Again, let me state clearly: We did not leave those people off—

The Hon. WALT SECORD: But they are not in your report.

Professor CURROW: We did not leave those people off the inquiry under section 122. Their cases were considered but, as you saw with carboplatin and capecitabine, both at St Vincent's Hospital and in the Western NSW Local Health District, if the intent was palliative it is not possible to draw those black and white lines that you are seeking. It is just not possible.

The Hon. WALT SECORD: When you say "palliative", can you put that in layman's terms?

Professor CURROW: Certainly.

The Hon. WALT SECORD: When you say "palliative care", what do you mean in layman's terms?

Professor CURROW: Palliative chemotherapy or palliative radiotherapy is the setting where it is not expected that the treatment will be curative. Importantly, although that may change life expectancy by a small amount, its primary clinical indication is to improve symptoms and optimise function. It is not about changing life expectancy primarily. It is primarily about symptom control and optimising function in the face of advanced cancer.

The Hon. WALT SECORD: I have one last question. I would like to know—

The CHAIR: Order! We are trying to share the time for questions. We will come back to that question if there is time.

The Hon. WALT SECORD: So palliative care was not included because they were going to die.

Professor CURROW: No, absolutely not.

The CHAIR: Order! Disregard that question at the moment. We may have time for that question later. Dr Currow, are you of the view that those four doctors would have brought forward evidence that was consistent with the finding of your report? Is that what you are saying?

Professor CURROW: Yes.

The CHAIR: How do you know that they would not have provided evidence outside that prediction?

Professor CURROW: The bottom line is that we had constant and consistent feedback from interviewees that corroborated the written evidence from the hospital, that corroborated the documents that were provided to the inquiry by the hospital and certainly backed up what was seen from the clinical records.

The CHAIR: Would you be of the opinion that it would have been better if they had presented to the inquiry?

Professor CURROW: I would have been delighted to interview them, but we had a consistent picture that was systematic and corroborated the evidence.

The CHAIR: Recommendation 10 of the report says:

> That St Vincent's Hospital ensure that Mortality and Morbidity meetings use data beyond individual patients to examine patterns of care and outcomes benchmarked with similar hospitals or health services or, at least, the most recent, relevant peer-reviewed literature.

My understanding is that it is reasonable for mortality and morbidity meetings to be held to discuss cases. How often would St Vincent's Hospital have those meetings?

Professor CURROW: There are two levels, one at a hospital-wide level and one at a unit level. I do not have information on the frequency with me today, but I am happy to take the question on notice and put it to St Vincent's.

The CHAIR: Would that not be something you would have found through your inquiries into those meetings, given that they are where you detect that fatalities have occurred due to overdosing or underdosing? Would that not be a trigger point, where you could pick up on that?

Professor CURROW: That is why the next recommendation took recommendation 10 further. Firstly, we looked at the minutes of the mortality and morbidity meetings that were made available to us. We have a record of those meetings. As you see from recommendation 11, particularly in its amended form, the importance is to start to look at patterns. For Committee members who are not familiar with the function of mortality and morbidity meetings, they are charged with looking at outcomes as a result of death or morbidity that was unanticipated within the hospital setting. You will see that recommendation 11 specifically goes beyond that and asks that the mortality and morbidity meeting look at what we have described as "a random selection of 'expected' deaths rather than relying on the subjective decision that the death was 'unanticipated'". We are asking mortality and morbidity meetings to cast a wider net.

Yes, we did look at the mortality and morbidity meeting minutes as part of the documentation provided to the inquiry. The meetings failed to pick up patterns. Those committees were not set up originally to think about patterns. Again I stress that we have three distinct patterns of prescribing for head and neck cancer patients at St Vincent's. First, there were those who had first-line therapy with cisplatin, the drug of choice, at a personalised dose. Second, there were a group of patients who had carboplatin, arguably the third choice, at a personalised dose. Finally, there were a group of patients who had carboplatin at a flat dose. We are asking mortality and morbidity meetings to think carefully in the future about looking at patterns of care rather than simply looking on a case-by-case basis.

The CHAIR: Given that the initial case was back in January 2006, and given the regular mortality and morbidity meetings, do you not think the issue should have been picked up way before 2016?

Professor CURROW: I expect that those meetings considered unanticipated deaths. The cases would have been seen largely as people with disease progression leading to an expected death, which would not be the subject of a mortality and morbidity meeting. That is specifically why recommendation 11 was included in the inquiry's findings.

The CHAIR: Would you give the Committee a snapshot of what sort of discussion would take place at a meeting like that?

Professor CURROW: That meeting should include a discussion of deaths within the hospital or major events in a set period of time, that is, since the last meeting.

The CHAIR: Would that be a month, two months or weekly?

Professor CURROW: A hospital-wide one may well be weekly. A departmental one may be less frequent because the numbers of patients considered would be smaller. It would often involve a clinician from another part of the hospital doing a thorough case note review. It is a time-consuming process to carefully go through that page by page and to understand whether there were any points in the patient's care where different decisions could or should have been made, where documentation should have been different from the way it was. It is a learning process for the health system, in a very explicit bid to improve care in the future.

The CHAIR: Would that take into consideration nursing notes?

Professor CURROW: It would take into consideration nursing notes, pharmacy notes and notes from other allied health practitioners. It would be the complete clinical record.

The CHAIR: So if a nurse had an issue with dosage, one would think it would show up in the peer assessment and examination of those notes?

Professor CURROW: If that death was signalled as unanticipated and therefore crossed the threshold for consideration in the mortality and morbidity meeting.

The CHAIR: Are you saying that a dosage issue could be masked by the death of a patient with serious stage 4 cancer? It was expected that the person would die and clinicians would therefore not be looking at the dosage.

Professor CURROW: Importantly, there may be several years between chemotherapy at the time of diagnosis and death. That may well happen across more than one institution, and across public and private. Ensuring that the complete picture is there may or may not be there, particularly when disease recurrence was diagnosed months or years after the initial diagnosis and where the disease progressed despite best treatment.

The CHAIR: That brings me to another point: the complete picture you talk about. It seems that the multidisciplinary team assessment is disconnected, dysfunctional. It seems, through the submissions that we are getting, that patient communication between the professionals—whether it be the pharmacist or the oncologist—there is a lot of disconnection. Can you clarify that for us? In what I will call MDT [multidisciplinary team] would it be unusual for a patient to be brought back time and time again for assessment on their ongoing treatment, or is it a one off—how the first dose impacts on the person—and then they are virtually off the radar until something significant happens?

Professor CURROW: The inquiry's report is very careful in its wording here. It talks about the care of people being overseen by a multidisciplinary team. Much of that depends on the maturity of that multidisciplinary team, on how rapidly the evidence in that particular tumour stream is changing and how it adapts to that. Importantly, there are two processes for a multidisciplinary cancer care team. The first of those processes is to determine what is the cancer and what is its extent of disease. That is, in some language in the literature, referred to as a multi-specialist meeting, which is really to make sure that the radiologist and imaging specialists, the pathologist, the surgeon and the medical and radiation oncologist have agreed about the label of cancer. Cancer is many hundreds of diseases. The second, broader discussion is really to contextualise those findings in the light of this patient, their comorbidities, their preferences and the other issues that they face in life.

The CHAIR: Would you expect, in that scenario, that if you were flat dosing patient after patient that that MDT would be aware that this does not add up? Would that not be a benchmark situation to say, "Actually something is not right here," or "The treatment is not right"? Wouldn't peers then add to that scenario to say, "This may not be the best way to be treating this case."

Professor CURROW: As the inquiry found—it came up in the recommendations of the inquiry—in order to deal with those issues there is a real opportunity to ensure that if there is only a single member from a single discipline in multidisciplinary team, that that multidisciplinary cancer care team should join with another one, after major national or international meetings, to look at the updated evidence and how they respond. I think that is where the opportunity is for that cross-fertilisation. There was one medical oncologist for the last three years in this multidisciplinary cancer care team—in the head and neck multidisciplinary cancer care team—so there is a specific recommendation from the inquiry to address that concern.

The CHAIR: My understanding is that St Vincent's Hospital has a 160-year-old history. It is shameful that it has got to 2016 without embracing such a team that could pick up on such measures as flat dosing or situations of mortality.

The Hon. NATASHA MACLAREN-JONES: I want to explore these teams a little bit more and also the role the protocols have in determining the dose. Could you elaborate a little bit more because a number on the committee do not have health backgrounds?

Professor CURROW: The issue of the choice of protocol is dealt with by a number of evidence-based resources around the world, such as the national cancer centres network website. It helps a clinician to decide—having made those important decisions in the multidisciplinary cancer care team about which cancer this is, the extent of the disease and the particular risk factors associated with the cancer in the context of this person—and gives guidance as to which protocol they should use. There is then a resource which was originally developed in south-east Sydney—actually at St Vincent's—that is now available nationally and supported by more than 700 clinicians coming together to ensure that there is a strong and robust review of the evidence and that consensus

is gained in how to provide that care at the bedside, the point of care. That will have a number of factors associated with it.

If we look at a screen dump of one of those protocols, what we see is that there are a number of factors that are canvassed in such advice. Firstly, there is the drug and how a dose should be calculated. Then, importantly—I go back to my introductory remarks—there is an opportunity to think about the particular factors that can help personalise this for a patient. What are the factors that allow you to adjust this to this person's other illnesses? For example, if they have liver dysfunction or kidney dysfunction should the dose be adjusted and, if so, by how much? Or, indeed, should this chemotherapy not be given to someone because of their kidney function? There are a number of guidelines—not only for the initial dose, but also for how to subsequently adjust that dose.

The inquiry has—on the advice of and in collaboration with its experts—focused on that first dose, because after that the variation will be great and will be driven by a number of new clinical factors that are introduced cumulatively as people have chemotherapy. There are a number of medications listed that may interact with that drug or may have interactions as a result of that chemotherapy. That is tremendously important. Then we need to look at how to recognise and deal with side effects. That last aspect is particularly important, because each individual clinical unit will have its approach to dealing with some of those side effects. This is, therefore, a complex issue that is perpetually updated as new evidence becomes available. Some protocols will be superseded. Some will stand the test of time for decades; they will still be in existence and providing clinical care.

The Hon. NATASHA MACLAREN-JONES: In relation to these medications, has it been common for the variation to be great? I note that in your comments you said that where the variation is so great you would use the term off "protocol". Where the dose is not that great, where is that variable? How do you judge that?

Professor CURROW: That variable is really in sitting down with the patient to find their preferences and their other medical conditions and working through that on a case-by-case basis. Personalising therapy has a great deal of air time at the moment, but that has been happening for a long time in something like chemotherapy. You may adjust it on the person's body habitus—their height and weight, for example. You may adjust it by their kidney function. You may adjust it by a number of those factors.

The Hon. TREVOR KHAN: May or must?

Professor CURROW: It would depend on the chemotherapy. For some there would be no guidance around kidney function, for example, because it is not dealt with by the kidneys. So it varies from chemotherapy to chemotherapy. Where it is there then, yes, you must take into account kidney function. But that is not going to be the case for every chemotherapy. The next important point to appreciate is that an increasing proportion of chemotherapy is now administered by tablet or capsule. That is a very big change over the last decade. It means that line of sight to that kind of clinical care is now through different lenses—through the Pharmaceutical Benefit Scheme rather than through hospital dispensing records, for example. What we are seeing is a rapid and continuing change in chemotherapy and how it is considered, and how it will be taken forward into the future.

The Hon. NATASHA MACLAREN-JONES: Can you explain the reporting process? I understand we have moved more to the electronic process.

The Hon. WALT SECORD: Point of order: All these practical issues have already been canvassed in private briefings. Why are we using up valuable time asking Dorothy Dixers?

The CHAIR: The Government has a right to ask questions. It is within their time for questions.

The Hon. WALT SECORD: We have already covered this material.

The CHAIR: You are wasting the time you will get to ask some more questions.

The Hon. NATASHA MACLAREN-JONES: That is my point; I am interested going back over the past 10 years in relation to how doses were reported then as to what happens now where you have a lot more electronics, where if the dose is changed it is quite easy for the pharmacy, for the Cancer Council and other bodies to know exactly why it has been done. What were the processes in the past?

Professor CURROW: This is a process of evolution from entirely paper-based processes, certainly when I was a junior doctor, through to several local health districts having fully implemented electronic prescribing for cancer chemotherapy. By January 2018 all local health districts will have operating oncology medical information systems and by that time an increasing number will have full electronic prescribing as part of that oncology medical information system.

The Hon. NATASHA MACLAREN-JONES: And that will still allow for the varying of doses if required?

Professor CURROW: That variation in dose is absolutely crucial to personalising care. The problem is that we cannot in any way proscribe that or we will be compromising care. It is not only valid; it is essential that such variation is in place and is allowed to continue.

The Hon. BRONNIE TAYLOR: As to terms of reference (d)—and we were talking a lot about MDT—I want to ask you about what you think. There obviously are some gaps and there are obviously things that have happened. What about our primary care interventions in terms of cancer care coordination? You mentioned oral chemotherapy and how in the last decade we have moved steps ahead, and that has been mentioned as well in the depths of this report. But if you are having oral chemotherapy, if you are a rural or regional patient you are not going to have access to that oncologist as much as if you were a metro patient; so you depend on your primary care teams. How much more do we need to involve them in this care to make sure that they are at the centre and then all the people caring for them are brought together, because that just seems to me to be something that is recurring through all of this?

Professor CURROW: It is an important issue that you raise. In terms of primary health engagement, I think we have seen a major shift in oncology services across the State and with the implementation of oncology medical information systems there is the ability to increasingly provide information back to general practitioners and the care team in a more timely way. We have got good examples now where oncology medical information systems are providing letters directly to general practitioners within 48 hours so they are totally across not only what is happening for the patient but what to do in contingency planning for that person's clinical care in the future.

Hand in hand with that, the eviQ website, which is the protocol website, has specific general practitioner information sheets for every protocol. That is being expanded and I expect that we will see a layering of information there—that information that you need in 30 seconds as a general a practitioner between leaving your desk and getting to the door of your consult room through to much more detailed information, which is what is there. I would add that that is complemented by information for patients and their families, again with each protocol, so that there can be a much greater understanding of exactly what is happening, what is likely to happen, so that people can prepare for that and understand that. So I agree that the interface with primary care is crucial. It is fair to say that there has been much greater engagement with primary health networks in recent years with cancer services, and if we are going to continue to see an improvement in cancer outcomes it will be because, in part, of the strong engagement with primary care.

The Hon. BRONNIE TAYLOR: I suppose I am posing that question because I think when you look at what has happened in this particular case with Dr Grygiel and at St Vincent's and you look at all the checks that should have been in place, that something happened at each stage. I am thinking, moving to the future, that we have lots of different specialties involved in a person's treatment, that they need to be at the centre of the care. What I am seeing is that that falls off because there are so many different things and there is not a lot of really good coordination and service coordination. Do we need to look more at a heath clinician, regardless of what specialty, and look more at centring and coordinating the care so that they can then pick up if there seem to be patterns of things happening or if they seem to think that someone is on a dose that is perhaps modified to a low dose and that they have no effects and no benefit?

Professor CURROW: I think there are two parts to that question. The first is better coordination of people diagnosed with cancer. I think it is absolutely crucial that there is a point of contact for every person and every person knows who that point of contact is. It may change as their cancer is treated, and as it changes that they know when to contact and who to contact if something changes between now and their next appointment. So that is one issue, and I agree strongly: I do not think that is a single role but I think it is crucial for coordination of cancer care. The second issue is how do we improve care in the community? To that end, we need to engage with pharmacists in retail pharmacy in a way that was not required 10 years ago as chemotherapy changes.

The Hon. BRONNIE TAYLOR: Because of oral chemotherapy?

Professor CURROW: Because of oral chemotherapy, which can be dispensed on a normal prescription through a retail pharmacist. So we need to skill up a workforce that is already there and ensure that the workforce of tomorrow is also skilled in that area. We need to engage more effectively with practice nurses and with general practitioners from the moment that that person is reasonably suspected of having cancer so that there is coordination of their care, that they reach a diagnosis as quickly as possible, receive a care plan that they physically hold and understand as quickly as possible and that all of the clinicians involved in their care are able to take forward that care as efficiently as possible.

The Hon. WALT SECORD: Professor Currow, I think you were at the press conference with health Minister Jillian Skinner and you said that there was a difficulty in identifying more cases in the Central West and you would contact the Federal Government and determine the extra cases that would emerge in the Central West under the Pharmaceutical Benefits Scheme [PBS] examination. Then this morning the health Minister announced that they are not going to reveal any details on this. How many more cases are we talking about in the Central West?

Professor CURROW: I would be speculating at the moment.

The Hon. WALT SECORD: But did you not attend the press conference and conduct the section 122 inquiry into the Western NSW Local Health District?

Professor CURROW: I indeed did and we indicated in the inquiry report that the number of people is unknown and it would be pure speculation at the moment.

The Hon. WALT SECORD: Have they reported back to you in any form the number of cases involving the PBS?

Professor CURROW: We do not yet have the Pharmaceutical Benefits Scheme data. I have been assured by the Commonwealth that that will be available early in November.

The Hon. WALT SECORD: But there are more cases?

Professor CURROW: That was made very clear in both the report and in that press conference.

The Hon. WALT SECORD: I want to take you back to an earlier answer you gave where you said that four people at St Vincent's declined or refused to participate in your inquiry. You said three were junior doctors. What was the fourth person's status in the organisation?

Professor CURROW: That was a senior clinician.

The Hon. WALT SECORD: A senior clinician? How senior?

Professor CURROW: A senior clinician.

The Hon. WALT SECORD: I do not have a medical background. I would like to know what you mean when you say "a senior clinician".

Professor CURROW: That is someone who on a day-to-day basis sees patients.

The Hon. WALT SECORD: You said that three were junior doctors. So a senior clinician at St Vincent's Hospital refused to participate in your inquiry?

Professor CURROW: Declined to, yes.

The Hon. WALT SECORD: Did you send letters? Did you call them up?

Professor CURROW: We indeed sent letters.

The Hon. WALT SECORD: And they ignored them?

Professor CURROW: They have the right to decline. I have stated that very clearly, Mr Secord.

The Hon. WALT SECORD: Earlier in your evidence in response to the Hon. Paul Green you said in your own words you would have been delighted if they had participated. Do you think there is now a case for a wider inquiry to compel people to give evidence? In your own words you have admitted that four doctors, including a senior clinician, refused to participate in your inquiry.

Professor CURROW: Four doctors declined to participate in the inquiry, that is correct. However, as I have indicated, when we look at the evidence that has been provided to the inquiry through documents from St Vincent's Hospital, through written responses to questions provided to St Vincent's Hospital, through clinical case note audit, through interviews of St Vincent's staff, the picture is absolutely consistent. Again I stress if we did not find any problems then my answer to your question would be yes. But we have found problems which have consistently been reflected through those documents, through the clinical case note reviews and through the interviews. As such, further interviews are not going to change the findings that there are problems in culture, in systems and in clinical governance that need to be addressed.

The Hon. WALT SECORD: I humbly disagree with you. I think interviewing four doctors, including a senior clinician, would have increased or enhanced your investigation. I take you back to something you said earlier. You mentioned the cases you did not include in the report were palliative care cases. Does that mean

those patients were going to die so you determined that you would not investigate them? You said there were palliative care cases and you put them aside and you said you would not investigate them. Is that correct?

Professor CURROW: No, it is not correct.

The Hon. TREVOR KHAN: It borders on offensive.

The CHAIR: Order! There are some people in the inquiry who need a medical understanding. Professor Currow will you just answer that question?

The Hon. WALT SECORD: Why did you not investigate the palliative care cases?

The CHAIR: Please explain why that is so.

Professor CURROW: Back to my earlier answer to you, Mr Secord, when we look at a protocol, that protocol is derived from the best available clinical evidence. Most of those studies are done in relatively well patients where they do not have other comorbidities at the time. As such, very few studies are actually done—sorry, I do not want to interrupt.

The Hon. WALT SECORD: No, I was indicating something to my colleague.

Professor CURROW: Very few of those studies, if any, are done in the patient population about whom we are talking. These are people with multiple comorbidities as their bodies close down, often with kidney and liver dysfunction, and the evidence base is simply not there to inform it. As such, these people were not, as you suggest, ignored because they were dying, the evidence was not there to draw an absolute line and say that that was either on-protocol, a variation of the protocol or off-protocol. There is no single standard against which we can judge that. The committee, therefore, I believe quite rightly on the advice of the expert panel, said that it is unable to determine the breadth of that prescribing because the evidence base is simply not there. It is not that we have not looked for it; it does not exist.

The Hon. WALT SECORD: Professor Currow, the palliative care cases that you did not look at, I have been advised by the families and in two meetings with St Vincent's Hospital, St Vincent's admitted that they were underdosed. So the palliative care cases that you did not put into the report were the subject of underdosing.

Professor CURROW: Again I do not have a standard which says this is dosing in the setting of advanced disease.

Mr JEREMY BUCKINGHAM: Professor, finding No. 65 has peaked my interest for a number of reasons. The first part states, "Pharmacists dispensing the chemotherapy, nurses administering it and doctors who were working under the supervision of specialist medical oncologists at St Vincent's Hospital during these years have either challenged the practice or sought an explanation for it." Were you made aware of any evidence or any indication that these flat dosing issues related only to one doctor at St Vincent's?

Professor CURROW: In terms of therapy being initiated it was under that doctor or people under direction of that doctor.

Mr JEREMY BUCKINGHAM: So other doctors who were under his direction were involved?

Professor CURROW: That is correct.

Mr JEREMY BUCKINGHAM: So other doctors were participating in—

Professor CURROW: Yes, as section 65 makes clear, there were junior doctors. They are under direction of a senior doctor.

Mr JEREMY BUCKINGHAM: I appreciate that. So there were senior and junior doctors involved. Did any of the junior doctors take that practice to any other jurisdictions or any other hospitals? If they were given that direction, I assume because they were under the tutelage of that doctor, did they continue that practice in other hospitals?

Professor CURROW: Again I draw the Committee's attention to the fact that there were three patterns of prescribing for people with head and neck cancer under Dr Grygiel: those who had cisplatin chemotherapy at a personalised dose; those who had carboplatin at a personalised dose; and those who had flat dosing. So even a junior doctor exposed to practice has three options.

Mr JEREMY BUCKINGHAM: They had those three options but in regards to a flat dose that is not at a personalised level, did you investigate whether any of those junior doctors continued that practice in other hospitals?

Professor CURROW: They would have been under supervision of other senior doctors as they move on through the system.

Mr JEREMY BUCKINGHAM: But you did not investigate that.

Professor CURROW: No because they would have been under the supervision of other senior doctors.

Mr JEREMY BUCKINGHAM: But, quite feasibly, in those intervening years between when it was happening at St Vincent's and now they could have been practising in that manner?

Professor CURROW: Again, back to the terms of reference of the inquiry, our terms of reference were to look at the practice of Dr John Grygiel at St Vincent's Hospital and Western NSW. To look at the practice of junior doctors moving beyond St Vincent's or Western NSW was not in our terms of reference.

Mr JEREMY BUCKINGHAM: There could be a cohort of doctors who have adopted this practice operating in the health system across New South Wales or Australia or wherever they have gone? Can you rule that out?

Professor CURROW: I was about to say that I cannot rule that out because that was outside the terms of reference for the inquiry.

The Hon. NATASHA MACLAREN-JONES: Could I just ask following that—

Mr JEREMY BUCKINGHAM: No you cannot. I have very limited time.

The Hon. NATASHA MACLAREN-JONES: Does a junior doctor have the ability to prescribe—

Mr JEREMY BUCKINGHAM: Point of order: The Chair has been allocating time according to a strict regime. I have very limited time. I would appreciate if you ask your dorothy dixers later.

The Hon. NATASHA MACLAREN-JONES: It is not a dorothy dixer. I am just informing you about some facts.

The CHAIR: Order! I suggest Mr Jeremy Buckingham not waste his time if he wants to ask further questions.

Mr JEREMY BUCKINGHAM: The other part of finding 65 that peaked my interest states "Pharmacists dispensing the chemotherapy, nursing administering it and doctors who were working under the supervision of the specialist medical oncologist have either challenged the practice or sought an explanation." How many pharmacists, nurses or doctors did you identify as having challenged this practice?

Professor CURROW: We interviewed a number.

Mr JEREMY BUCKINGHAM: How many?

Professor CURROW: I do not have that number Mr Buckingham but I am happy to take it on notice.

Mr JEREMY BUCKINGHAM: It is an important question. Is it one, two or ten?

The CHAIR: Order! Mr Jeremy Buckingham cannot badger the witness. The witness has answered your question and said he will take it on notice.

Mr JEREMY BUCKINGHAM: So you cannot indicate to this inquiry how many people raised this practice with Dr Grygiel?

Professor CURROW: I have indicated in the report here from the inquiry that each of these three disciplines raised that issue with the inquiry.

Mr JEREMY BUCKINGHAM: You cannot tell us how many?

Professor CURROW: I do not have that number with me, Mr Buckingham.

Mr JEREMY BUCKINGHAM: But it is not in the report either.

Professor CURROW: But I am happy to take it on notice.

Mr JEREMY BUCKINGHAM: One would think it is fundamental if it was only one—

The CHAIR: Order! Do not badger the witness. If you have a question, ask it.

Mr JEREMY BUCKINGHAM: Do you not think it is fundamental to the integrity of this inquiry that there is an indication of how many people raised these concerns?

Professor CURROW: It is very important, Mr Buckingham, that we gain a balance in the reporting of the findings to ensure that individuals are not identified in the report and, as such, I will take that on notice.

Mr JEREMY BUCKINGHAM: Are you confident that you interviewed all of the people who raised those concerns over the years?

Professor CURROW: Again, the inquiry's findings are consistent, so this is not a witch-hunt to find every person who has raised it. It is ensuring that we have a consistent view of the information that the inquiry was asked to deal with.

Mr JEREMY BUCKINGHAM: Why would you characterise it as a witch-hunt of people who are trying to raise a concern about the proper therapy that people should or should not be using?

Professor CURROW: Mr Buckingham, the inquiry's report is very clear. There is a problem. So to interview more people is not going to help us determine there is a problem. There is a problem in culture, there is a problem in systems, there is a problem in clinical governance.

Mr JEREMY BUCKINGHAM: I put to you there is a problem with this report. That is, it has characterised the problem as junior doctors, junior staff and pharmacists not doing their job to inform senior management and other people as part of the MDT. Is it not the case that this report actually lays the blame or the fault in this process at the junior staff and absolves senior staff and St Vincent's and those people who are really accountable of any blame?

Professor CURROW: Firstly, if I may, paragraph no. 65 is a section to which you have drawn my attention, Mr Buckingham. The last sentence says:

> The practice was widely known, and senior pharmacy and nursing staff … should have known, it was occurring.

Mr JEREMY BUCKINGHAM: They did know. Can you see—

The Hon. TREVOR KHAN: Let him answer.

Mr JEREMY BUCKINGHAM: This is very important.

The Hon. TREVOR KHAN: So let him answer the question.

Mr JEREMY BUCKINGHAM: The practice was widely known. That is the first part. Can you see the contradiction in this sentence:

> The practice was widely known, and senior pharmacy and nursing … staff should have known, it was occurring."

Professor CURROW: So—

Mr JEREMY BUCKINGHAM: So I put it to you—

The CHAIR: Order!

Mr JEREMY BUCKINGHAM: I had not finished the question.

The CHAIR: I think you did.

Mr JEREMY BUCKINGHAM: No. It says:

> The practice was widely known, and senior pharmacy and nursing staff … should have known, it was occurring."

They did know. I put it to you they did know. It was widely known and they told senior management, who ignored them.

Professor CURROW: I do not have any evidence provided to the inquiry that supports that assertion, Mr Buckingham.

Mr JEREMY BUCKINGHAM: How can you say the practice was widely known and they should have known it was occurring?

Professor CURROW: I have indicated to you, Mr Buckingham, this was not laying the blame at the feet of junior staff. We have been very clear, and Mr Gavel may want to talk to the culture of the organisation. It was very clear in the findings of this and in the recommendations to St Vincent's that the culture of the organisation, that problems with clinical governance and problems with systems were clearly and explicitly identified. Paul, do you want to take that?

Mr GAVEL: To add to that, I would say that in our paragraphs around 149 through to 157 we clearly talk about the responsibility that various people or teams within the hospital—St Vincent's Hospital—had, and we went through medical oncology, pharmacy, Dr Grygiel himself, clinical governance, cancer services, the

clinical leaders, the executive, the people responsible for media statements within St Vincent's, and we have gone, "This was their responsibility."

Mr JEREMY BUCKINGHAM: Every single time. We do not know how many people challenged it and when; we only know that some time between 2005 and 2015 some people challenged it. Paragraph 150 says:

> In the medical oncology unit, when treatment was challenged, it seems there was always acceptance of the explanation provided by Dr Grygiel instead of escalation to an appropriate clinical expert.

How is it that people can continue to raise it again and again and again and again, and yet it be always accepted?

Professor CURROW: Again, if I may—

Mr JEREMY BUCKINGHAM: Clearly that is contradictory.

Professor CURROW: If I may draw the Committee's attention to the fact that junior staff in general are on rotation.

Mr JEREMY BUCKINGHAM: Are you saying that there were no staff—

The Hon. TREVOR KHAN: Let him answer, for heaven's sake, Jeremy.

Mr JEREMY BUCKINGHAM: We have heard that before. Are you saying that there were no staff who were there for a long period who raised it more than once? Were there any staff who raised these concerns with Dr Grygiel more than once?

Professor CURROW: I think that is a question that you should put to St Vincent's, Mr Buckingham. What I am saying—

Mr JEREMY BUCKINGHAM: You do not know?

Professor CURROW: What I am saying very clearly is that paragraphs 150 through to 161 is very clear that there were levels of accountability right across the organisation, that this inquiry does not lay this, as you have suggested, at the feet of junior nursing, junior pharmacy and junior medical staff. It is very explicit in the inquiry's findings, and I draw your attention to paragraph 152:

> Dr Grygiel had a proactive responsibility to let the multidisciplinary team know he was prescribing off-protocol and familiarise them with the implications of what he was doing so they were empowered to endorse it as a team, or seek further information or expert input.

Mr JEREMY BUCKINGHAM: Thank you, Professor.

The CHAIR: Order!

Professor CURROW: And 157,"The hospital and clinical leaders had a proactive responsibility..." This is not about junior staff. This is about saying there were system-wide issues with clinical governance problems and cultural problems, and the inquiry has been very clear about that, Mr Buckingham.

Mr JEREMY BUCKINGHAM: I accept that.

The CHAIR: Order! The Hon. Jeremy Buckingham, it is my turn to ask some questions.

Mr JEREMY BUCKINGHAM: I have one very brief question. It is very important.

The CHAIR: If it is very important make it count.

Mr JEREMY BUCKINGHAM: Professor, were there any clinicians that you interviewed who gave evidence to indicate that they had raised these concerns on more than one occasion or multiple occasions?

Professor CURROW: Not to my recollection, Mr Buckingham.

The CHAIR: Professor Currow, you have quoted the systemic failures of clinical governance. I propose to you that culture is built from the top down, not the bottom up. What confidence do you have, through your report, that St Vincent's is able to provide a culture that will be able to stop these events happening in the future?

Mr GAVEL: Maybe I will answer that and say that there is one recommendation that deals with that issue and the issue of culture.

The CHAIR: Mr Gavel, with all due respect, I have looked through the recommendations, the Health department's report and everything else. It is one thing to have it on paper and another to change culture in an organisation.

Mr GAVEL: I am working towards that. We wrote that in a deliberately constructive manner, talking about needing to build a constructive culture, needing to be inclusive of the people involved at St Vincent's and cancer services, needing for it to be people centred, the importance of leadership in that, and the recommendation was around needing to do that through a facilitated arrangement that involves all of the people. It will take a number of years. We did not say that in the report, but if you want to read any of the literature on culture, cultures are not built in one moment. It is a thing that takes—

The CHAIR: They have had 160 years.

Mr GAVEL: That is probably a question for St Vincent's, not me. They, if you notice in their response to the inquiry, indicated how they have started to progress that recommendation. We have put it deliberately into that constructive context. We have talked about what we want to see and they have made a commitment to deliver that.

The CHAIR: I understand that.

Mr GAVEL: Leadership is central to that and they have acknowledged that.

The CHAIR: This is the issue. If culture is built from the top down and you have got doctors who have a God complex that no-one can question their authority and expertise, how do you change that culture?

Mr GAVEL: You change it through the arrangements that you want to put in place for governance. You change it through—

The CHAIR: Through peer assessment?

Mr GAVEL: You change it through the leadership direction that you choose to take.

The CHAIR: Through a multidisciplinary team?

Mr GAVEL: That is an executive and a board. You change it—

The CHAIR: All these things fail. This is the point.

Mr GAVEL: Yes, we have acknowledged that.

The CHAIR: I am not looking at you. The very things you have recommended have failed. We have evidence that a family suggests that the multidiscipline team was dysfunctional.

Mr GAVEL: We have noted the failings and we have talked about the responsibility, as we have just said in answer to the previous question. We deliberately, as I said, framed that recommendation in terms of looking forward to building a positive culture that is inclusive, patient-centred and people-centred. On the one hand we are acknowledging the failings, correctly, and on the other hand we are saying, "This is how you go about fixing that."

The CHAIR: Professor Currow, I note from a journal of clinical oncology of December 2008 an article on the self-reported practices and attitudes of the United States oncologists regarding off-protocol therapy. It seems in that article that it is not unusual for a variance of opinions, whether you do or you do not use off-protocol treatments. Most actually agree that it should be an opportunity to use it. I know your report is about Dr Grygiel, but did you have any input of how many oncologists are maybe using off-protocol chemotherapy across New South Wales?

Professor CURROW: Again, I think it is important to come back to the definition of "off-protocol". We are not talking about variation here.

The CHAIR: Modification?

Professor CURROW: And modification may well be really important. Again, there are two levels: There is the level of making the clinical recommendation to the patient and the family and having that discussion so that they can make an informed choice, and we need both of those to be in place. You can vary anything if you sit down with the patient and family and explain what normal practice would be, what you are recommending, and why the variance. Again I stress this is not simply about the protocol. This is about what is communicated, what is understood, and what is documented. You can, as a clinician, sit down with patients and explain that variance and, with their fully informed consent, move forward. That was the missing piece of this puzzle consistently in both the documentation provided to the inquiry and in the interviews with patients.

The CHAIR: My question remains then: If your inquiry was put together to critique Dr Grygiel's issues, how many other oncologists are using that particular treatment as an option for chemotherapy across New South Wales?

Professor CURROW: Again, we can only go to the expert panel there because that is—

The CHAIR: I am happy to go to anyone. Can you indicate?

Professor CURROW: Their view was very simply and consistently that this was off-protocol. This was so divorced, from the evidence—

The CHAIR: This was off the radar?

Professor CURROW: This was off the radar, so their expert evidence—advice—in working with the inquiry was very clear, as was the advice to St Vincent's itself when it engaged an external medical oncologist. So this is off the radar and, at the end of the day, we do not have line of sight to other practice.

The Hon. NATASHA MACLAREN-JONES: I have only one issue, as I am mindful of the time. I want to follow on from a comment made by a colleague in relation to junior doctors who work at St Vincent's and I want you to clarify whether or not a junior doctor has the ability to prescribe any dose, whether it is chemotherapy or any other area of medicine, without any supervision.

Dr CURTIS: Junior doctors work closely under the supervision of their senior doctors and they would be expected to follow the protocols and prescribing patterns of their senior doctors. There is very little latitude, really, for them to change that without the express permission because, at the end of the day, the consultant doctor is in charge of the patient and responsible for that patient's care and the junior doctor is working on behalf of that consultant. That is why, in relation to answering your question earlier, when the junior doctors move to another location, they will adopt the pattern of care that their senior doctor is prescribing at that site. They would not have the option of carrying forward an off-protocol prescribing in this way in another site working as a junior doctor.

The Hon. BRONNIE TAYLOR: In regards to No. 73, when you spoke about annual performance reviews, only one performance review had been done, or had there been some done but they did not have documentation?

Professor CURROW: We only had documentation from one.

Dr CURTIS: St Vincent's was only able to provide us with documentation of one event.

The Hon. BRONNIE TAYLOR: In your experience of governance and what you sort of do, would you consider that very unusual that there was only one annual performance review?

Dr CURTIS: The policy around staff specialists—and Dr Grygiel was working as a staff specialist at St Vincent's—is that they are supposed to have annual performance reviews.

The Hon. TREVOR KHAN: So the answer is that it is unusual.

Dr CURTIS: Correct.

The Hon. TREVOR KHAN: And the answer is that it is deficient.

Dr CURTIS: Correct.

The CHAIR: We will conclude this session of the inquiry. Gentlemen, I thank you for fronting up to the inquiry. It is tremendously helpful that you have been able to come.

(The witnesses withdrew)

(Luncheon adjournment)

KAREN CRAWSHAW, Deputy Secretary, Governance, Workforce and Corporate, NSW Ministry of Health, sworn and examined

SUSAN PEARCE, Deputy Secretary, System Purchasing and Performance, NSW Ministry of Health, sworn and examined

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

The CHAIR: Before we start with a new group of witnesses, I want to advise that care be taken when using individual names during the hearing in order to avoid unnecessary harm to people's reputations. Please ensure your comments are relevant to the terms of reference. I also remind participants to respect the privacy of individual patients. It is important to remember that parliamentary privilege does not apply to what witnesses may say outside of their evidence at the hearing. I urge all witnesses to be careful about any comments they make to the media or to others after they complete their evidence as such comments are not protected by parliamentary privilege and they may be taken for defamation. Ms Crawshaw and Ms Pearce, as neither of you have given evidence to the inquiry yet today, would either of you like to make an opening statement?

Ms CRAWSHAW: I will make a statement about the capacities in which we appear. We obviously appear on behalf of NSW Health. We have made a submission that you have with you. Professor Currow is here this afternoon in his capacity as the Chief Executive of the Cancer Institute NSW and the chief cancer officer able to talk about cancer services, policy, clinical policy and broader service developments and the functions of the Cancer Institute. I am here as Deputy Secretary, Governance, Workforce and Corporate. I am able to talk to the terms of reference around the code of conduct and issues arising around governance. Susan Pearce, my colleague Deputy Secretary Health, System Purchasing and Performance, is able to talk to the issues around the performance of the health system, particularly having regard to the outcomes from the various inquiries that have been going on.

The CHAIR: Thank you. The Hon. Walt Secord of the Opposition will start with questions.

The Hon. WALT SECORD: I would like to start with Ms Susan Pearce. Earlier today Professor David Currow said that he was no longer in charge of follow-up investigations into the chemotherapy underdosings in New South Wales. Who in NSW Health now has carriage of this matter?

Ms PEARCE: At a Ministry of Health level, is that what you are asking?

The Hon. WALT SECORD: Yes.

Ms PEARCE: That would be me and my team. We have taken responsibility—working with other colleagues, of course, in the ministry—to work with the relevant network or district as the case may be in regard to the recommendations from the inquiry and to ensure that those recommendations are actioned in a timely fashion. We will continue to monitor those.

The Hon. WALT SECORD: So you have responsibility for implementation of commitments by the Minister and things like that—public commitments involving health?

Ms PEARCE: The implementation at a local health district or a network level is obviously incumbent upon the chief executives. There are other statewide recommendations that are the responsibility of the ministry. Then there were further recommendations, as you would be aware, in regard to the Cancer Institute and so on. So there is a shared responsibility. But in terms of the follow-up of the application and implementation of recommendations associated with the inquiry we have undertaken to continue following that up.

The Hon. WALT SECORD: Can I take you through the various things? How many patients are we referring to at St George, Sutherland, St Vincent's, Macquarie University private hospital and the Central West? Can you take me through how many patients we are talking about in those institutions?

Ms PEARCE: I am sorry, Mr Secord, I am not sure I understand your question. Do you mean how many patients they see in each of those organisations?

The Hon. WALT SECORD: No. How many have been impacted by the activity that we are inquiring into today?

Ms PEARCE: The report from Professor Currow and the team detailed, as you would be aware, the number of patients that were found to have received the flat dosing et cetera both at St Vincent's—

The Hon. WALT SECORD: He was very specific this morning. He only said St Vincent's and the Central West. He said 129 and five for the Central West. So I am trying to get an indication of the numbers in the other institutions.

Ms PEARCE: Regarding the south-eastern Sydney question, that organisation obviously has undertaken the investigation in regard to circumstances that came to light there. We are not directly involved with south-eastern Sydney in that regard because its recommendations are separate and that is part of an internal process. That is not to say that we will not, of course, follow up with the chief executive to ensure that we have an ongoing understanding of what is happening in regard to patients in south-eastern Sydney.

The Hon. WALT SECORD: Do you have an indication of the number of patients?

Ms PEARCE: No, I do not. I am aware that it is a small number of patients that have been identified during the look-back process that went on there. But you would have to direct those questions to the south-eastern Sydney chief executive.

The Hon. WALT SECORD: But they are not here. I will ask you another question then. I understand there are 28 patients at Macquarie University private hospital. What is happening with them?

Ms PEARCE: Macquarie University private hospital is not a hospital under the auspices of the New South Wales public health system and accordingly our performance framework does not extend to that organisation.

The Hon. WALT SECORD: So are those 28 patients at Macquarie University private hospital who were previously under the care of Dr John Grygiel now on their own?

Ms CRAWSHAW: Can I take that question, Mr Secord?

The Hon. WALT SECORD: Yes.

Ms CRAWSHAW: Obviously we regulate private facilities. He was only credentialed to work at the facility between 2010 and 2012. Macquarie reported underdosing of 21 patients—

The Hon. WALT SECORD: Oh, 21.

Ms CRAWSHAW: —to the ministry, as their regulator. They provided a detailed report on 9 March 2016.

The assessment at the time indicated that the facility, when we last looked at it, had a medical advisory committee. The Committee would appreciate that that is the main regulatory mechanism under which the clinical issues that might arise in a private health facility for which we do not have direct operational responsibility are managed and handled, and we have that assurance. It had a reasonably functioning medical advisory committee at the last inspection, in 2015. The private healthcare branch has advised us that it is monitoring the compliance of Macquarie University hospital with our regulation. The branch has advised that any patient cases are reportable incidents under section 20L of the Health Administration Act 1982. As the incident related to the performance and conduct of a registered medical practitioner, the private healthcare branch has also advised Macquarie University hospital to report it to the Health Care Complaints Commission [HCCC].

Macquarie University hospital provided advice on 21 April this year, referring to the inquiry under section 122 of the Health Services Act 1997. On 3 June the Chief Health Officer advised Macquarie University hospital to refer the particular patients to the HCCC, which, as the Committee is aware, is undertaking a detailed investigation into the practice of Dr Grygiel. That involves looking directly at all the patient complaints and issues. On 29 August the private healthcare unit requested an update on investigations into the 21 patients identified in the report from Macquarie. The private healthcare unit has continued to monitor that. On 24 October Macquarie provided a detailed response. Macquarie has spoken to 13 patients and offered follow-up support. Macquarie University hospital is unable to contact eight patients, despite repeated attempts. Macquarie University hospital continues to cooperate with and provide information to the HCCC, which is undertaking an active investigation.

The Hon. WALT SECORD: What has happened to those eight patients? Have they passed away? Is the HCCC unable to find them?

Ms CRAWSHAW: They have been unable to contact them.

The Hon. WALT SECORD: They have been unable to find them?

Ms CRAWSHAW: That is correct. That is the advice from Macquarie University hospital.

The Hon. WALT SECORD: So there are eight patients or their families in New South Wales who are unaware that they were underdosed at Macquarie University hospital.

Ms CRAWSHAW: The latest information is from 24 October. It is now 31 October. We will follow this up to see whether we can provide any assistance in locating the eight patients.

The Hon. WALT SECORD: So eight patients still have not been contacted?

Ms CRAWSHAW: That is correct. Of the 21, 13 have been contacted.

The Hon. WALT SECORD: Professor Currow, this morning you revealed to the Committee that three junior doctors and a senior clinician declined, in your words, to participate in your inquiry. Did all doctors, clinicians, nurses and other people in the health system participate in the Western NSW Local Health District investigation?

Professor CURROW: As I indicated this morning, one nurse who has retired did not participate.

The Hon. WALT SECORD: One nurse did not.

Professor CURROW: I did indicate that this morning in my evidence.

The Hon. WALT SECORD: Ms Pearce, what is the Government doing to support the patients and/or their loved ones who were impacted by Dr Phadke and Dr Grygiel?

Ms PEARCE: You would be aware that we have established a 1800 line for patients and/or their loved ones. That number is published on the website of this parliamentary inquiry and on the front page of the website of the Ministry of Health.

The Hon. WALT SECORD: I have called the telephone number. What happens when someone calls that number?

Ms PEARCE: The call goes through to a central point and a series of details are taken. The decision was taken that it was most appropriate that calls then be transferred to the relevant local health district. If a patient was treated at a hospital within the South Eastern Sydney Local Health District, for example, they would be referred there. South Eastern Sydney Local Health District had its own line, as did Western NSW Local Health District and St Vincent's Hospital. That is one of the ways that we can make sure that calls from patients, carers and loved ones go through to the appropriate location.

The Hon. WALT SECORD: Ms Crawshaw, how does the Government contact the eight patients at Macquarie University hospital who still do not know that they have been underdosed and whose family members do not know? What is the mechanism? What do you do? Do you write them a letter? Do you telephone them? How is the Government trying to find those eight people?

Ms CRAWSHAW: How I would go about it would be to firstly —

The Hon. WALT SECORD: I want to know how the Government is doing it, not a hypothetical answer.

Ms CRAWSHAW: I would be one of the people charged with undertaking the exercise.

The Hon. WALT SECORD: So what are you doing?

Ms CRAWSHAW: I would first of all see if we could identify appropriately, making sure that privacy does not inhibit this in any way—

The Hon. WALT SECORD: I think you are not looking very hard. What do you mean by privacy?

Ms CRAWSHAW: There are privacy issues because it is a private hospital. These are private patients. Not every private patient wants their details known.

The Hon. WALT SECORD: I think they would want to be told.

Ms CRAWSHAW: Within those bounds, we would have good grounds for an exemption from normal doctor-patient confidentiality. We would look at whether those patients' names have shown up in any of our records, for example. They may have presented at one of our hospitals for treatment. They may have received ongoing treatment a hospital other than the private hospital. We would look at that.

The Hon. WALT SECORD: On 2 August Minister Skinner gave a commitment at a press conference. I will quote from the press release. The Minister said:

All public cancer patients who have received treatment over the past five years will be reviewed.

What is the status of Mrs Skinner's 2 August commitment that the Government would contact all cancer patients in the last five years?

The Hon. TREVOR KHAN: What does that say?

The Hon. WALT SECORD: It says that all public cancer patients will be reviewed.

Ms CRAWSHAW: Yes, that is public cancer patients.

The Hon. WALT SECORD: Sorry, I apologise. It was a public commitment, and I understand that the AMA has criticised her about that.

Ms CRAWSHAW: I just stress that it was a commitment to public cancer patients.

The Hon. WALT SECORD: How many people are we talking about, and what is the status of that commitment from Mrs Skinner?

Ms PEARCE: The audit of public cancer patients has been progressing since that announcement to the extent that we have convened a steering committee which has a number of representatives on it, including the AMA as well as, importantly, consumers and medical professional groups. We also have some of our LHD chief executives on that steering committee. We have also been having regular discussions with directors of cancer services at local health district levels, and we have developed with those two groups and with their assistance methodology for the audit. That methodology has been finalised and issued to local health districts. Part of that process was also the establishment of the 1800 number. So we have that avenue for patients to come through, as well.

Local health districts have been asked to establish local review teams. So once the audit commences, in terms of patient files they will have audit teams amassed so that they can commence the review of those records. In addition to that, we have a statewide expert panel which will be established. Through the process of the audit there is an algorithm to follow. The algorithm essentially is that care is assessed with regard to what the clinical record shows. If it is within accepted or reasonable norms—the words around this needed to be carefully considered, given the evidence that Professor Currow has given this morning—as to clinical decisions that doctors make for patients—a

The Hon. WALT SECORD: How many patients are we talking about?

Ms PEARCE: At this point in time, the audit sample, it is a randomised sample of all patients—

The Hon. WALT SECORD: It is now randomised?

Ms PEARCE: That is correct.

The Hon. WALT SECORD: That is not the original commitment to review all public cancer patients.

Ms PEARCE: The sample is statistically valid with regard to the care and treatment of cancer patients in New South Wales. The number at this point in time is, at a minimum, 1,800. But there will be more than that who will come through the 1800 inquiry line. As you said, you have contacted that line yourself. One of the avenues for patients who have had cancer and cancer treatment in a New South Wales public hospital, depending on the circumstances that are elicited from them on the phone, is to go through that inquiry line and into the audit.

The Hon. WALT SECORD: Isn't a randomised sample—1,800 people—a big gulf from Mrs Skinner's public commitment that all public cancer patients who have received treatment over the past five years will be reviewed? Don't you think that that is a significant broken promise? There is a big gulf between what she said publicly and what you are doing—a randomised sample.

Ms PEARCE: I will ask Professor Currow to make a comment in a moment. I repeat that the sample size is statistically valid and will provide an accurate assessment of treatment. We also have a secondary process by which, during the course of the audit, if it is found that the care is outside of expected or reasonable norms—and there is no valid reason for that and no consent from the patient—there is a requirement for a further five cases from that clinician and within that modality, to be examined. That will be referred to the statewide expert panel. The other major issue is that there will then be a formal look-back process, which would involve a much larger group of patients. We are combining the process of the audit with policy instruments that we have around formal look-back, open disclosure and so on, all of which will be applied.

The Hon. WALT SECORD: You said that maybe Professor Currow would want to add something to that. Do you have any involvement in this randomised sample that you are conducting?

Professor CURROW: Certainly the Cancer Institute is one of the organisations sitting on that statewide steering committee—one of many organisations that is being consulted in that process.

The Hon. WALT SECORD: How many patients would we be talking about if we said "all public cancer patients in the last five years"? That would be more than 1,800 people.

Professor CURROW: That is correct.

The Hon. WALT SECORD: How many people would that be?

Professor CURROW: New South Wales has 40,000 people diagnosed each year with cancers other than non-melanoma skin cancers.

The Hon. WALT SECORD: So 200,000 people?

Professor CURROW: That is correct.

The Hon. WALT SECORD: Forty thousand times five is 200,000 people. Her commitment was that all of those would be reviewed but she is now doing 1,800.

Professor CURROW: This is a systematic sample. It is a bit like your business, if I may say so. You do not go to every voter in your electorate to know exactly what is going on.

The Hon. WALT SECORD: This is a public commitment that the Government would review all public cancer patients who had received treatment in the last five years.

Professor CURROW: And this is a systematic approach to look at the patterns of care.

Mr JEREMY BUCKINGHAM: Was anyone in the Ministry of Health involved in drafting the initial terms of reference for this inquiry?

Ms CRAWSHAW: Yes, I was.

Mr JEREMY BUCKINGHAM: How were you involved?

Ms CRAWSHAW: The terms of reference generally get drafted for these sorts of things through our legal branch. Legal branch reports to me.

Mr JEREMY BUCKINGHAM: Who initiated the request to draft those terms of reference?

Ms CRAWSHAW: I think it would have been the Secretary. I imagine it would have been the Secretary. I cannot directly remember, to be honest.

Mr JEREMY BUCKINGHAM: The Secretary of the Ministry of Health?

Ms CRAWSHAW: Yes. I think that would have been the—

Mr JEREMY BUCKINGHAM: Why did they do that?

Ms CRAWSHAW: Because of the public information that came to light that suggested that the way in which St Vincent's had managed this issue of a particular doctor was not managed, it would appear on the face of it, in accordance with required policies appropriately.

Mr JEREMY BUCKINGHAM: Just to be sure, when I said "this inquiry", I meant this parliamentary inquiry.

Ms CRAWSHAW: Sorry. God no. No, I was talking about the section 122 inquiry.

Mr JEREMY BUCKINGHAM: With respect to this inquiry now—

Ms CRAWSHAW: I had absolutely nothing to do with it.

Mr JEREMY BUCKINGHAM: You had nothing to do with it?

Ms CRAWSHAW: No.

Mr JEREMY BUCKINGHAM: Are you aware that the Minister has said that she was involved in the drafting of it?

Ms CRAWSHAW: I think there was some discussion of this issue at the estimates hearing that I was at.

Mr JEREMY BUCKINGHAM: Yes?

Ms CRAWSHAW: I know no more than that.

Mr JEREMY BUCKINGHAM: You just said that the ministry had absolutely nothing to do with the drafting—

Ms CRAWSHAW: I had nothing to do with the drafting of the terms of reference of the inquiry. My colleague to my left is indicating that she had nothing to do with the drafting of the inquiry. My colleague to my right, Professor Currow, is indicating that he had nothing to do with the drafting of the terms of reference for the inquiry.

Mr JEREMY BUCKINGHAM: When you said that the ministry had nothing to do with it, you do not know whether or not the ministry had anything to do with the drafting of the terms of reference of this inquiry.

Ms CRAWSHAW: As a senior executive in the ministry and in an area I would normally be involved, if terms of reference of some kind were to be drafted that would normally be something I would be aware of. But, no, I would have to ask directly each of my colleagues to give you a hand-on-heart answer.

Mr JEREMY BUCKINGHAM: Could you take that on notice?

Ms CRAWSHAW: Yes.

Mr JEREMY BUCKINGHAM: Thank you. The section 122 inquiry and the report back said that at St Vincent's:

> There were tensions, unresolved grievances and conflicts within cancer services. Failure to resolve long-standing conflicts constructively and with understanding has contributed to mistrust within parts of the clinical community. This meant that when the incident was identified, the organisation was not able to see and characterise the issue clearly…

Mr JEREMY BUCKINGHAM: Could you expand on who those longstanding unresolved conflicts were between?

Professor CURROW: I think that was a question that probably should have been put to Paul Gavel this morning in that session. He was particularly inquiring into the culture of the organisation and, likewise, I think, there is every opportunity to put that question to St Vincent's later this afternoon.

Mr JEREMY BUCKINGHAM: Why is that not appropriate to ask of you?

Professor CURROW: It is, but the person who was inquiring particularly into the culture of St Vincent's on the inquiry team was Mr Paul Gavel. So I would have thought that that was an opportunity to discuss that with him.

Mr JEREMY BUCKINGHAM: With all respect, Professor, you are chairing the inquiry. You have no view? You cannot provide any more information on that particular element, that there were longstanding—

Professor CURROW: Without identifying individuals, and again I reflect that this is not about identifying individuals at this time.

Mr JEREMY BUCKINGHAM: I respect that. Was that between various senior staff?

Professor CURROW: That is correct.

Mr JEREMY BUCKINGHAM: Was it between senior oncologists and management?

Professor CURROW: It was predominantly between senior oncologists.

Mr JEREMY BUCKINGHAM: How did that manifest itself? Senior oncologists were having, as you say, longstanding conflicts. How did the flat dosing actually intertwine itself into those conflicts? Were other senior oncologists aware of the flat dosing issue?

Professor CURROW: As I pointed out this morning, we have no evidence that other senior oncologists were aware of flat dosing. Where this intersected was in the issue, as the report clearly points out, that no oncology expertise was introduced by the hospital to their review processes as part of their initial response, and that is a concern.

Mr JEREMY BUCKINGHAM: Could you repeat that? There was no—

Professor CURROW: As the report points out, there was no medical oncology input into the hospital's review of flat dosing when that review was commenced. If I can take you to the timelines—

Mr JEREMY BUCKINGHAM: But that is an issue between the management of the hospital and how they conduct a review. I am more interested in how, in the words of the report, there were longstanding

conflicts, and as you said, between senior oncologists and that that contributed to mistrust and meant that when the incident was identified the organisation was not able to see and characterise the issue clearly. Could you expand on that? How does a dispute between senior oncologists mean that there has been a failure in terms of that part of the governance?

Professor CURROW: As I indicated to you a moment ago, the issue is in how the problem was characterised, and the report is very clear in reflecting the way it was characterised at St Vincent's.

Mr JEREMY BUCKINGHAM: But previous evidence suggested that it was between junior staff and particular medical oncologists. You have just said that there was a culture between senior oncologists. A really key point about how this was or was not escalated is because the suggestion there is that there was some dispute between senior oncologists in relation to this issue.

Professor CURROW: No. Again, can I be very clear: you are characterising it as a problem between junior staff and more senior staff. The report very clearly sets out from section 159 onwards that this was far, far broader than simply a medical oncologist using flat dosing. With regard to the characterisation there, I think the report is very clear that this incident, as the terms of reference would have it, was characterised as a variation rather than as a departure from accepted clinical practice. The consequence of that relating directly to the section that you have highlighted is that St Vincent's did not reach out to medical oncologists within the organisations to help characterise the problem, the incident, as it is termed in the terms of reference.

Mr JEREMY BUCKINGHAM: Ms Crawshaw, would you characterise this incident in the following way: that St Vincent's has put its reputation ahead of patient outcomes?

Ms CRAWSHAW: You are asking my personal opinion?

Mr JEREMY BUCKINGHAM: The ministry's opinion. Is that the view of the ministry: that St Vincent's has put its reputation before patient outcomes?

Ms CRAWSHAW: I think it goes back to what Professor Currow was talking about a minute ago, that in the organisation's mind they had not correctly characterised the issue in the first place; they had characterised it as a variation from normal practice but not a variation that constituted an inappropriate departure. As we know, doctors make clinical judgements to vary from a protocol. But this was an issue, and as a consequence of their characterisation of that incident I think a lot of things flowed from that, including the issue of reputation and how they managed the incident.

Mr JEREMY BUCKINGHAM: But one of the things that flowed from that, was it not, was how they then disclosed this issue, how they reached out to patients or not? The report says, "In a cultural context what the inquiry has found lacking is leadership that provided insight, direction and urgency, a patient-centred approach, analytical rigour or the necessary questioning scepticism for an accurate characterisation of the issue, training for clinical leaders in leadership and in policy and processes and a demonstration of the adherence to values at a time when they were most needed". Do you think that we would have had better outcomes if this had been a facility, an operation, wholly owned and operated by NSW Health?

Ms CRAWSHAW: I do not think that is the critical issue, and the reason I do not think that is the critical issue is because much of the policy, practice, regulation—in fact, pretty well all of it—and the compliance regimes, the incident monitoring, it is pretty much the same whether it is a publicly run facility or it is a non-government run facility within NSW Health. It was the same issues around managing complaints or concern about a clinician; we have policy around open disclosure. That all applies to St Vincent's. Pretty well all our clinical policies and the way in which we deal with patients, they apply equally to St Vincent's. The basis upon which they are funded, their clear conditions of funding are that they comply with our policies. They have a performance framework that mirrors that which we have with our own agencies. So I cannot agree with you; I think the nub goes back to the culture of the organisation and the culture of these particular services.

Mr JEREMY BUCKINGHAM: So the disclosure regime in St Vincent's is exactly the same or almost the same as in other publicly funded hospitals?

Ms CRAWSHAW: Yes, the disclosure regime in terms of what is required of them. But, like anywhere, what you put in terms of regulation and compliance regimes and policy has to be dealt with in a way that a good culture engenders that and makes sure it works effectively. What was found here was a culture that mitigated against those policies and regulations working effectively.

Mr JEREMY BUCKINGHAM: One final question to Professor Currow. Was Dr Stephen Cooper one of the four clinicians that declined to give evidence to your inquiry?

Professor CURROW: Again, the basis of this report has not been about identifying individuals.

Ms CRAWSHAW: We would want to take on notice any question that started to stray into the realm of wanting us to name individuals in the report or individual patients in the report.

Mr JEREMY BUCKINGHAM: Will you take that question on notice?

Ms CRAWSHAW: We will take on notice about whether we can stray into that area. My concern would be in an inquiry such as this where people did come forward—and I think much has been made in relation to the vehicle of the section 122 inquiry about whether staff felt they could come forward and talk to the inquiry. One of the reasons that they felt that they could come forward generally and talk to the inquiry was because there was a commitment to respect their confidentiality and there was a commitment to make it clear that this inquiry was not going to be naming names. So my concern would be that that undermines the whole basis of the way in which this particular 122 inquiry went.

Mr JEREMY BUCKINGHAM: We can always ask you at 4.30 p.m.

The CHAIR: Given the systemic failure of this outcome acknowledged by Professor Currow, what will the department do to ensure a culture change? What measurements and key performance indicators will you put in place to ensure that this does not remain systemic?

Ms PEARCE: Are you referring to St Vincent's?

The CHAIR: In this case, yes, but broadly if this has happened at St Vincent's over a 10 year period one would guess that there could be other hospitals across New South Wales where the same systemic breakdown has happened but we just have not unravelled what they may be or where.

Ms PEARCE: As we have noted there is a range of a recommendations associated with the inquiry report and one of those obviously went to the issue of culture. Once a month we meet with St Vincent's to talk to them about the application of our recommendations and their implementation within the facility. One of the programs that they have established there to address the issues of culture is called "It's OK to ask". That program has been put in place to encourage staff to ask questions or to raise issues if they do have concerns. I think it is critically important across the entire health system that our staff all feel that they have the ability to raise issues or concerns. That particular issue, in addition to other recommendations that are relevant to the other Local Health Districts has been discussed with every single chief executive in New South Wales at their regular performance meetings that we have at the Ministry. A number of them do have programs in place to encourage staff to speak up.

The CHAIR: I do not think that is the issue. Having come from nursing it is not hard to speak up, it is whether that goes any further than when you speak. That is the culture.

Ms PEARCE: That is absolutely critical that point that you raise. I probably would disagree with you on one point. I think that on some occasions speaking up can be difficult, depending on the circumstances. However, what happens next is absolutely the critical feature and that is the exact conversation that we have had with Local Health Districts that staff need to understand that if they do raise an issue and they are not met with satisfaction that they understand other avenues to follow.

The CHAIR: Is the department thinking of a way to make it anonymous if a person wishes to speak up, especially from a nurse to a doctor? There is a culture out there and if you spend time in a ward you will find it. There is marginalisation if you speak up. Will there be an implication where the department puts in a representative in the different hospitals so that a person can speak up anonymously and challenge the treatment, dosage or whatever it may be in relation to the treatment of a patient without being persecuted, demoted or marginalised because of their care in that matter?

Ms PEARCE: I have not turned my mind to an anonymous process—and perhaps Karen can comment. There is obviously the ability for staff to make complaints to the Health Care Complaints Commission—

Ms CRAWSHAW: And they do.

Ms PEARCE: And they certainly do do that.

The CHAIR: It should not have to go that far.

Ms PEARCE: No, I agree, and that is what I was going to say.

The CHAIR: That is a breakdown of a culture of "we don't want to be caught" or "you're not important".

Ms PEARCE: Yes, that is exactly where I was headed with that. I think fundamentally at the local level what is important is that people are able to raise issues of concern to them in a non-punitive fashion and to have an avenue to address those concerns if, at first attempt, they do not feel that they have reached a satisfactory response. I think that once you veer into an anonymous situation there is a very significant issue in the culture of an organisation if you do have to go to those lengths. So there is a range of ways people can raise complaints. What we need to be clear about with our staff and continue to educate them about, remembering it is a very significantly large workforce in NSW Health, that all of our staff, no matter where they work in the organisation, have the ability to raise issues of concern to them.

The CHAIR: You tend to find yourself on nightshift if you get in the way.

Ms CRAWSHAW: Can I add to that? Yes, I think we have policies in place that do encourage people to come forward as well as the carrot and stick. I do acknowledge that historically there have been pockets of medicine that have made it difficult for people to come forward. I think junior medical officers were featured to some degree, and I think this has come to somewhat of a head, certainly last year, with the issues around bullying and harassment in the training culture in medicine across the country and across the Western world. We have a particular program going on at the moment where we are engaging with the various learned colleges and we have just put in place a policy that will enable our junior medical officers to come forward confidentially if they have concerns about particular issues in terms of their own environment and those supervising them.

The CHAIR: That is good to hear because from what I hear that is rampant.

Ms CRAWSHAW: Yes, absolutely. There is going to be an advice and a support line around that as well.

The Hon. BRONNIE TAYLOR: I am a previous employee who has had the code of conduct pointed out on a number of occasions. I acknowledge that in the past five years things have definitely improved. Do you think it needs to come from the top? If a person has an issue and they work in a facility that does not have junior medical officers and their next senior person is a nurse delivering something, there needs to be some mechanism if that cannot happen within that facility, that someone is able to go somewhere else. That has to come as a directive from above so that staff underneath feel they can go there.

Ms CRAWSHAW: I would agree with that. I would agree too that when we talk about the top it just cannot be 73 Miller Street, North Sydney because each district is an organisation with its own culture. So when you are talking about culture, absolutely it is critical that the chief executives of those organisations encourage people to speak out and to bring issues forward and to deal with them properly. I think we have some good examples in the recent history of where that has actually happened. We certainly have leadership programs that we are rolling out with the Health Education and Training Institute and a key part of that is and leadership issues around having those conversations and being able to have those communications and being able for staff to come forward. It is critical.

The CHAIR: Will surgeons and oncologists go to this education course? I do not think so with all due respect. Let us understand that these people have got a high set of skills and they are very needed right throughout the State. No-one likes rocking the boat because they might lose them out of their little region, their little rural area so the first person that is expendable is someone at a lower level, the professional health carers. It has got to come from the top.

Ms CRAWSHAW: I am going to draw on my long corporate knowledge in health and say that I believe—

The CHAIR: That is good, I am drawing on mine and as is the Hon. Bronnie Taylor.

Ms CRAWSHAW: I believe in the past few years there has been a change and I do believe, if I see it, that there is a lot more preparedness on the part of management to take on senior clinicians whose behaviour is unacceptable. I think there is much greater appetite for that than there was in the past.

The CHAIR: And there is too.

Ms CRAWSHAW: They can be very litigious, but there is much greater appetite not to tolerate it. As I say, the revelations last year around the issue of endemic bullying, harassment in the medical culture has brought to the fore the need for everybody to do something about it. The then Secretary of Health wrote to every single junior doctor in the State and said, "This is not acceptable. You need to be assured that you can come forward and tell your manager and something will be done about this." She wrote to every senior clinician and said, "I am writing to every junior doctor and this is what I am saying." You say it comes from the top; we really are trying to establish that.

The CHAIR: We note there has been a cultural change in society, and we are going down that path. One of the witnesses, in particular, noted that they contributed to Professor Currow's inquiry in July but they have not been contacted. One of the recommendations is that there is going to be closer consultation with the families and the patients, given the inquiry. Can anyone make a comment on what you are doing to establish contact after the section 122 inquiry?

Professor CURROW: I think St Vincent's and Western NSW have not only open lines of communication but the advice I have is that they are continuing to stay in contact with patients.

The CHAIR: That is my question, Professor Currow. In one of the submissions they have said, "We are deeply concerned. We gave our input and we still have not heard anything back". This is from July and it is the end of October. You can imagine that is concerning, given the fact that we are trying to mend fences and get things back on track.

Professor CURROW: Absolutely. We need to put that to St Vincent's and Western NSW.

The Hon. BRONNIE TAYLOR: The report on its own is transparent and acknowledges the shortcomings.

The Hon. WALT SECORD: No, that is not the view of the Committee.

The Hon. BRONNIE TAYLOR: What I want to go forward with is we have seen that and we have seen this episode with one particular oncologist at St Vincent's. It is there for everyone to see. In respect of moving forward, do you feel confident with the systems in place so that we are not going to be faced with a situation like this again where systemic and repeated breaches of best practice happen?

Ms CRAWSHAW: I will make a general observation and then I will ask Professor Currow to talk about cancer services, in particular, which is what this inquiry is about.

The Hon. BRONNIE TAYLOR: Yes, absolutely.

Ms CRAWSHAW: I have already alluded to the fact that we have, I think, strong and robust systems. We have strong and robust systems in respect of national regulation, in respect of State-based regulation. We are always refining our regulatory systems in response to issues that come up. We are trying to improve the culture in which these systems have to operate. We are always refining the tools that we are giving to our health organisations to make sure that these sorts of issues are addressed. By way of example, we are putting in place a new incident management system. That incident management system, when implemented, will give staff who raise issues through that incident management system a lot better visibility of what has happened to their notification and what action has been taken. It is a constantly evolving and, I hope, constantly improving system generally for the delivery of health services.

Are there going to be times when individual clinicians represent a departure from good practice? Of course there is. Do we constantly try to improve our systems to try to capture that? Of course we do. To say that there is never going to be any problems with the quality or standard of health services would be naive for me to say. All we can do is make sure we have robust systems in place, be vigilant and monitor and respond when we see gaps. In relation to cancer services, I will refer to David, because obviously the Cancer Institute was a big investment in 2002-03 by the then government in relation to supporting this sort of framework—while the Cancer Institute is not a regulator—for good, high-quality cancer services. Over to you, David.

Professor CURROW: Susan may also want to comment in relation to responses from local health districts. There are a range of recommendations here to provide a stronger framework around the individual clinician. The clinician has a professional responsibility for the care that they offer wherever they are in the health system. What this inquiry has recommended are a number of initiatives around each clinician to strengthen the processes that surround them, that support them, and particularly in team-based care. I think it would be fair to say already we have seen some substantial change in reaching out more effectively to oncology nurses and to pharmacists as part of the checking mechanisms that are necessary in this specific example, but I think the generic issue is ensuring that one of team-based care is able to deliver the quality of care, the safety of care, and the sort of outcomes that are being achieved in New South Wales in health care. Each of the chief executives in the local health districts received a letter from the ministry at both the interim report and the final report. I think it would be fair to say, Susan, that there has been a great deal of activity in the system to reflect that the system is committed to improving.

Ms PEARCE: That is right. As David has mentioned, the districts have all received correspondence, particularly with regard to the statewide recommendations. As I mentioned earlier, at performance meetings we also had an opportunity to talk to the chief executives and their teams in more depth with regard to the recommendations. We have established a process by which we will be following up, not obviously with only

St Vincent's network, Western NSW and so on but with the State in general, regarding the implementation and the recommendations arising from the report.

The Hon. BRONNIE TAYLOR: You said you are going to give feedback to people once they have lodged an incident on the information management system?

Ms CRAWSHAW: They will be able to look online and see—

The Hon. BRONNIE TAYLOR: That is a big change.

Ms CRAWSHAW: It is a big change.

The Hon. BRONNIE TAYLOR: When will it be implemented?

Ms CRAWSHAW: We are in the throes of fixing some issues with it, with a view to rolling out—first stop would be Murrumbidgee Local Health District, and I think it is early next year and then obviously a program of rolling it out across the system. It is not just in-patient incidents; it will be workplace safety incidents, because that is another very important area where you need the feedback to staff.

The Hon. TREVOR KHAN: I want to talk about patients and informed consent. In the context of this, a variation of dosage is either from the protocol or a variation of the dosage that is provided over time. How do you ensure that there is ongoing and verified patient consent to those variations in dosage?

Ms CRAWSHAW: I will talk again in general and then refer to David for the specifics. Again, obviously there is the doctor-patient relationship and the primary responsibility of a very well-trained highly regulated doctor to ensure that in any treatment, not just chemotherapy, but, indeed, in any treatment, that they properly inform the patient about the risks, the benefits of the proposed treatment along the way if it is an episode or series of treatments, any changes that might occur. It is well-established legal principle: *Rogers v Whitaker*. I think it was 1992, but do not hold me to that. More than 20 years ago the law became very clear in this country that doctors had to properly inform their patients in all sorts of ways. Generally, I think doctors are pretty across that and generally are pretty active. Again, are there doctors that are behind the times and who do not always acquit their duty of care in a responsible and appropriate way? Of course there are. But, again, the legal system, the regulatory systems, et cetera, are all there to ensure that that occurs.

In NSW Health, because obviously we run a big system, we have a very detailed policy around informed consent and what is required. There is a model consent form. We are in the throes of actually reviewing that and we are actually going to put out a manual rather than just a consent form because we want to give some more practical tools to our staff. It is not just doctors—it is nurses and other allied health professionals as well—around this issue. In terms of monitoring that routinely, it is practice within our organisations to obtain informed consent. There will be spot audits in particular cases and also the requirements around national accreditation. The new national accreditation system has regular three-to-five yearly accreditation visits where they are effectively audits and where the assessors come and require organisations to give clear evidence that they are doing these things. It could be a sample of records, whatever it might be, to demonstrate they are meeting those standards.

Professor CURROW: I think the other aspect of this, Mr Khan, is the issue of empowering patients more effectively and ensuring that they have information at their disposal that can help them to ask informed questions, and providing question prompt lists, which have a good evidence base for improving the interaction between patients and clinicians and between families and clinicians. Again, as with all the issues we have discussed today, there is no single, simple solution.

The Hon. TREVOR KHAN: I agree.

Professor CURROW: A multimodal system that includes patient empowerment is absolutely crucial if we are going to ensure that people are making fully informed decisions.

The Hon. TREVOR KHAN: Do we know whether St Vincent's has actually adopted recommendation 17—new patient information on dose adjustments? I think it is described as "supported by St Vincent's". The question is whether "supported" means actually implemented.

Professor CURROW: I also have "supported by St Vincent's" in front of me. You may care to put that to them this afternoon.

The Hon. TREVOR KHAN: I am not being critical. You do not know where they are up to.

Professor CURROW: No, no. It has been up on the website since July. It is certainly being used. The website is being accessed and I can only take it that their "support", as with other responses, is a genuine move to improve care.

Ms CRAWSHAW: But it is something that the ministry, in relation to every aspect of the implementation by St Vincent's of the recommendations that they have supported, will be monitoring over the course of time. Obviously cultural issues are going to take some time.

The Hon. TREVOR KHAN: Sure.

Ms CRAWSHAW: But there is absolutely no question about active monitoring of St Vincent's for the foreseeable future.

The CHAIR: Do you think there should be mandatory reporting if there is a level of care that is outside the accepted levels?

Ms CRAWSHAW: Mandatory reporting is an interesting issue. I just want to say that New South Wales was the first jurisdiction to introduce the idea of mandatory reporting by colleagues, by fellow clinicians—medical practitioners. We had that built into the national law when it became a national system. There was quite a lot of angst around mandatory reporting and so the mandatory reporting laws at the moment are very much at that pointy end of professional misconduct—you know, under the influence of drugs and alcohol, sexual misconduct, real pointy-end professional misconduct—as opposed to unsatisfactory professional conduct. I think there is a fine line when unsatisfactory professional conduct strays into that really pointy end.

The CHAIR: Fair point, but I guess in the case of this particular inquiry under section 122 there were 10 years of it.

Ms CRAWSHAW: Yes, I do not disagree.

The Hon. WALT SECORD: I am mindful of the time but I have one final question. Earlier you mentioned that there were still eight patients who had not been contacted involving the Macquarie University—

Ms CRAWSHAW: That is my advice from the private healthcare unit.

The Hon. WALT SECORD: How many other patients involving the other hospitals and clinics are there that the State Government is still trying to locate or make contact with, either with their families or them?

Ms CRAWSHAW: You are talking about—

The Hon. WALT SECORD: I am talking about St Vincent's, St George, Sutherland, Orange, Bathurst.

Ms CRAWSHAW: I cannot tell you the precise number. You are aware that there is St Vincent's.

Ms PEARCE: I think St Vincent's certainly has contacted by this stage, according to my advice, any patients that have come to their attention throughout this process. All of those facilities have had a 1800 line as well for people to call in on.

The Hon. WALT SECORD: But my question is—

Ms PEARCE: In Western NSW, as I understand, there was one patient who has been contacted but, due to scheduling difficulties at the last report, had not been met with yet. But I am not aware of any numbers outside of that.

Ms CRAWSHAW: Bear in mind with Western NSW there is this issue of waiting for the Pharmaceutical Benefits Scheme [PBS] data to come through to know fully. In relation to St George and Sutherland, I believe they have contacted, but again you can put this question to them to confirm.

The Hon. WALT SECORD: And when will the PBS material—

Ms CRAWSHAW: But I believe that they have certainly contacted their patients.

The Hon. WALT SECORD: When will the PBS material be back?

Ms CRAWSHAW: This week some time.

The Hon. WALT SECORD: This week?

Professor CURROW: That is what I presented as evidence this morning, early November.

The CHAIR: We will move on to Jeremy Buckingham's last question.

Mr JEREMY BUCKINGHAM: Thank you, it is my very last question. The report said that St Vincent's Hospital management did not appropriately escalate the issue to the Ministry of Health for a reportable incident brief [RIB] as required by the incident management policy. It also says that the incident management

policy under clause 2.5.6 of the Incident Management Policy—St Vincent's Hospital should have consulted the Ministry of Health when they determined to go to an external review, which they did not do.

The Hon. TREVOR KHAN: Is this a brief question?

The Hon. NATASHA MACLAREN-JONES: Is it a question?

Mr JEREMY BUCKINGHAM: It also states that St Vincent's did not activate the NCCC policy. What has been the outcome, other than a recommendation for more education at St Vincent's, of not activating those policies? How is that not a cover-up?

Ms CRAWSHAW: A cover-up by?

Mr JEREMY BUCKINGHAM: By St Vincent's, by not enacting those policies of reporting to the ministry. What is the outcome of that?

The Hon. TREVOR KHAN: We cannot allow you to have the last question again.

Mr JEREMY BUCKINGHAM: It is a pretty important one, Trevor.

The Hon. NATASHA MACLAREN-JONES: Is it a question or a statement?

Mr JEREMY BUCKINGHAM: There are policies in place. They completely ignore them. What is the outcome for them? Are there any punitive measures or any recourse for the ministry?

The Hon. BRONNIE TAYLOR: Take that on notice, that question.

Ms CRAWSHAW: Well—

The Hon. BRONNIE TAYLOR: You can take that on notice.

The CHAIR: You could take that on notice. It was a quite lengthy statement.

Ms CRAWSHAW: Okay. What I will say is that there is no question—and I think the inquiry by Professor Currow et al said very clearly—that they had not complied. You have read it all out. That is why they are now on a significant and serious performance watch—to make sure that they get back on track and that they do comply. They have monthly meetings.

Ms PEARCE: As a result of the recommendations, Mr Buckingham, the St Vincent's network was escalated to a level two on the performance level framework. What that entails, among other things, is a monthly meeting, as I have discussed, to go through all of the recommendations and their implementation at St Vincent's health network. The performance framework is not a matter in terms of where the districts and networks sit. It is something that is dealt with in all seriousness across the system. It has not gone without attention.

The CHAIR: We will conclude this session with a Government question.

The Hon. NATASHA MACLAREN-JONES: In the light of the fact that Mr Buckingham's question was not brief and because I am mindful of the time I am happy to put my question on notice.

The CHAIR: Thank you. In the light of shortness of time, I thank you all once again for attending, particularly Professor Currow, who did a double session—a double shift, so to speak. We do not pay that well anymore.

The Hon. WALT SECORD: Keep coming back. We will have you come back.

The CHAIR: We might have you come back, you were so good. Seriously, thank you for your evidence. We may need to ask you to return for a right-of-reply meeting in the future, but at this point in time we thank you for your evidence.

(The witnesses withdrew)

(Short adjournment)

TOBY HALL, Group Chief Executive Officer, St Vincent's Health Australia, sworn and examined

ASSOCIATE PROFESSOR ANTHONY SCHEMBRI, Chief Executive Officer, St Vincent's Health Network Sydney, sworn and examined

ASSOCIATE PROFESSOR RICHARD GALLAGHER, Director of Cancer Services, St Vincent's Health Network Sydney, sworn and examined

GABRIELLE PREST, Medicine Clinical Stream Manager, St Vincent's Health Network Sydney, sworn and examined

DAVID FAKTOR, Director of Media and Communications, St Vincent's Health Network Sydney, sworn and examined

The CHAIR: I remind witnesses to be careful when using individual names during the hearing in order to avoid unnecessary harm to people's reputation. Please ensure comments are relevant to the terms of reference. I also remind participants to respect the privacy of individual patients, obviously. Evidence given during the hearing is under parliamentary privilege but obviously if a witness makes the same comment after their evidence has concluded they could be open to defamation action, so please be mindful of that. I welcome this afternoon's witnesses to the inquiry. Would anyone like to make an opening statement?

Mr HALL: Yes, I will make an opening statement. The last nine months have been some of the most testing in a long and proud history for St Vincent's Hospital in Sydney and indeed the entire St Vincent's Health organisation. Our hospitals are recognised nationally and internationally as centres of excellence, but in this case across a range of measures we absolutely failed to live up to the high standards we set ourselves. Of course our challenges absolutely pale in comparison to the distress that has been experienced by patients and their families. To them I say again that we are deeply sorry. We are sorry for what we put you through. We are sorry for the pain and distress caused to you and your families.

The hospital in this case failed to appreciate the seriousness of the issue from the outset. Early questions in relation to the doctor's dosage practice should have led to more formal examinations. The hospital's internal and external inquiries should have been more comprehensive and completed more quickly than they were. While very early on a decision was made not to contact patients until all information was available so as not to cause unnecessary distress, we absolutely recognise now that this was a fundamental error on our part. We fully accept the criticisms of the hospital.

Those of us in senior positions take responsibility for what has happened and equally we are taking responsibility for putting things right for the future. The hospital has utilised the whole of St Vincent's Health's organisation to implement the Currow inquiry recommendations. The hospital has followed up with patients and reviewed and changed its processes. We are aggressively addressing the workplace culture that allowed this to happen and aiming to foster a spirit of challenge when it comes to clinical decisions across the whole of our organisation. A new electronic medication system has been introduced, backed up by clinical audits, where if any clinician wants to prescribe medication outside the standard guidelines they must submit their request to their peers and explain their rationale and reasoning.

The hospital's implementation of its response to the inquiry is being independently supervised by Professor Robert Thomas, Chief Advisor on Cancer to the Victorian Government. This is just the beginning of a long-term effort by the hospital and the whole of St Vincent's to make amends for what has been a distressing chapter in our history. We aim to restore the public confidence and trust in us. We are determined to put things right and we do so in the knowledge that there is a deep well of goodwill towards St Vincent's Hospital. However, again we reiterate that we absolutely apologise to the patients and their families who were affected by this terrible situation. It is now up to us to prove that the goodwill that has been placed in us is not misplaced.

The CHAIR: We understand Dr Grygiel will be appearing tomorrow and will have questions to answer. My first question to you before Opposition members ask questions is: Has anyone lost their job over this?

Associate Professor SCHEMBRI: The doctor involved has had his employment terminated.

The CHAIR: That is Dr Grygiel?

Associate Professor SCHEMBRI: That is correct.

The CHAIR: Has there been anyone else apart from him?

Associate Professor SCHEMBRI: No.

The CHAIR: Was it a multidisciplinary team overlooking his treatment?

Associate Professor SCHEMBRI: There was a multidisciplinary team for cancer patients at St Vincent's.

The CHAIR: How many mortality and morbidity [M and M] meetings do you hold there, how often and what is the nature of those meetings?

Associate Professor SCHEMBRI: The M and M meetings at a minimum for each department are held on a quarterly basis. For some larger volume specialties like intensive care M and M is conducted on a monthly basis. There is also the hospital-wide mortality committee which is the peak M and M, and that meets on a monthly basis.

The CHAIR: How come the sorts of issues that we are now dealing with were not triggered off earlier given the history since 2006?

Associate Professor SCHEMBRI: At the time the M and M committees focused on unanticipated deaths and did not focus on patterns of illness. We have since produced new guidelines for the conducting of M and M that also include expected and unexpected deaths as well as looking for patterns of care and benchmarking with other facilities and services.

The Hon. TREVOR KHAN: That is since the section 122 inquiry, I take it.

Associate Professor SCHEMBRI: Yes. We had started that process last year. I established the hospital mortality committee in 2015.

Mr HALL: I add that whilst Dr Grygiel at the moment is the only member of staff who has been dismissed, we have an independent person going through and reviewing the actions of all staff who were part of this process. If that independent review finds that action needs to be taken, we will absolutely take that action.

The CHAIR: Through the evidence we have received it is becoming blatantly obvious that there was a culture breakdown. We would assume that culture breakdown comes from the top, not the bottom.

The Hon. WALT SECORD: You mentioned that Dr Grygiel was the only person to lose their job. Who was Dr Grygiel's immediate supervisor? Who was the person in charge of reviewing or examining the conduct of Dr Grygiel?

Associate Professor SCHEMBRI: The director of clinical governance and the chief medical officer would be the senior person.

The Hon. WALT SECORD: And what are their names? Who are they?

Associate Professor SCHEMBRI: At the time, Dr Brett Gardiner.

The Hon. WALT SECORD: And where does Associate Professor Richard Gallagher fit into that?

Associate Professor SCHEMBRI: He is the campus director of cancer services.

The Hon. WALT SECORD: Was he also an immediate reviewer of Dr Grygiel's work at the time?

Associate Professor SCHEMBRI: Yes.

The Hon. WALT SECORD: So it would be Brett Gardiner and Associate Professor Richard Gallagher?

Associate Professor SCHEMBRI: Yes.

The Hon. WALT SECORD: Mr Faktor, when was the activity of Dr Grygiel brought to your attention, as the official spokesperson for the hospital?

Mr FAKTOR: I believe it was in either August or September of last year that I was first made aware of the issue.

The Hon. WALT SECORD: So it was not when Matt Peacock from *7.30* called? You had knowledge of it prior to February.

Mr FAKTOR: Exactly.

The Hon. WALT SECORD: When you were told about it, how did that communication occur?

The Hon. TREVOR KHAN: Who told you?

The Hon. WALT SECORD: I was going to get to that. Be patient.

Mr FAKTOR: I believe it would have been the Chief Executive Officer, Professor Schembri. That would be in line with procedure for any potential issue that might arise on campus. He would brief me on that.

The Hon. WALT SECORD: Did you at the time recommend disclosure to the community?

Mr FAKTOR: I did not, but it would not be my call.

The Hon. WALT SECORD: Who would have made the decision to disclose to the community that a doctor at St Vincent's Hospital was deviating from protocol and underdosing patients with head and neck cancer who were receiving chemotherapy at the hospital?

Mr FAKTOR: I should make clear that at the time that I was made aware of the issue we were still investigating that issue internally. The scope of that issue or the impact at that point was not clear. Sitting here today we know that it had a very significant impact and that it involved a number of patients. That is something that we are coming to grips with.

The Hon. WALT SECORD: Professor Gallagher, when a clinical error or a mistake occurs in a hospital setting, what is the standard practice in telling a patient or loved one that it has occurred? When do you tell someone that they have been given a incorrect dosage?

Associate Professor GALLAGHER: Immediately you tell the patient and the relatives what has happened? It is open disclosure?

The Hon. WALT SECORD: Is it done immediately or within 24 hours?

Associate Professor GALLAGHER: If it is a surgical incident, if the patient is awake and able to understand what is going on, that would be when it is explained to the patient. Personally I would explain to the relatives at the same time or before the patient was even awake.

The Hon. WALT SECORD: When did Dr Grygiel begin underdosing at St Vincent's Hospital? What year was that?

Associate Professor GALLAGHER: We now know that it was 2006.

The Hon. WALT SECORD: When did it come to your attention?

Associate Professor GALLAGHER: It came to my attention in June last year.

The Hon. WALT SECORD: In June 2015?

Associate Professor GALLAGHER: Yes.

The Hon. WALT SECORD: What did you do when it came to your attention?

Associate Professor GALLAGHER: When it came to my attention I brought it up with the director of clinical governance.

The Hon. WALT SECORD: What is the name of that person?

Associate Professor GALLAGHER: Brett Gardiner.

The Hon. WALT SECORD: What transpired after that?

Associate Professor GALLAGHER: I brought it up with him on several different occasions. Then he made the decision that there would be an internal review.

The Hon. WALT SECORD: It came to your attention in June. In August you told David Faktor.

The Hon. TREVOR KHAN: No, there is another step in that.

The Hon. WALT SECORD: Sorry, take me through the steps.

Associate Professor GALLAGHER: All I can say is that I became aware in June and it was brought up several times. The decision was made to undertake an inquiry. I am not quite sure when David Faktor was informed.

The Hon. WALT SECORD: When did you start to tell patients?

Associate Professor GALLAGHER: We did not start telling patients until February this year.

The Hon. WALT SECORD: That is six or seven months.

Associate Professor GALLAGHER: Yes.

The Hon. WALT SECORD: Mr Faktor, I have seen the *7.30* footage many times. Refresh my memory. Someone said, "Do we really need to tell patients?"

Associate Professor GALLAGHER: I think you are getting—

The Hon. WALT SECORD: I think that was you.

Associate Professor GALLAGHER: Yes. It is not from *7.30*. That is in an email.

The Hon. WALT SECORD: I thought it was broadcast on *7.30*.

Associate Professor GALLAGHER: Would you like me to talk to that?

The Hon. WALT SECORD: Yes, I would.

Associate Professor GALLAGHER: If all the emails from that time were taken into account, put into context and not misconstrued as they have been—

The Hon. WALT SECORD: Where is the ambiguity in "Do we really need to tell patients"?

Associate Professor GALLAGHER: I am talking about the other emails from around that time, what the rest of the email said and the implications. My major concern in my practice and throughout my career has been the welfare of my patients. I was extremely concerned about the welfare of this group of patients. I was acutely aware that this would cause distress for not only the patients but their relatives. I was trying to get a conversation going about how we would address that. If you look at all of my emails and put them into context that is what those questions were about.

The Hon. WALT SECORD: Did you continue to refer patients to Dr Grygiel when it came to your attention in June 2015?

Associate Professor GALLAGHER: Several things happened. Dr Grygiel changed his practice when it was brought to his attention that we were aware that he was treating patients differently.

The Hon. WALT SECORD: I will restate the question: Did you continue to refer patients to Dr Grygiel after you knew in June 2015 that he was underdosing patients?

Associate Professor GALLAGHER: Yes.

The Hon. WALT SECORD: You did?

Associate Professor GALLAGHER: Yes.

The Hon. WALT SECORD: Why did you not stop? If it was greatly concerning you, why did you continue to refer patients to him?

Associate Professor GALLAGHER: Unfortunately for me we had no other medical oncologist.

The Hon. WALT SECORD: But we are in Sydney; we are not in a remote country town. So why did you continue?

Associate Professor GALLAGHER: We continued to treat patients on our campus.

The Hon. WALT SECORD: Do you have oncologists other than Dr Grygiel?

Associate Professor GALLAGHER: Not with any great knowledge of treating head and neck cancer.

The Hon. WALT SECORD: There was no-one else in Sydney? He was the only one?

Associate Professor GALLAGHER: No, I said on our campus.

The Hon. WALT SECORD: It did not occur to you to stop, given that his practice warranted the sending of an email by you saying, "Do we really need to tell patients"? How many patients did you send to Dr Grygiel after you knew there were concerns about his performance?

Associate Professor GALLAGHER: There would have been a small number of patients.

The Hon. WALT SECORD: Would it have been 20 or 30?

Associate Professor GALLAGHER: Fewer than that, I think. I would have to take that on notice and look it up for you.

The Hon. WALT SECORD: Thank you. Did you consult your colleagues about this?

Associate Professor GALLAGHER: The only colleague who has direct input into this is Dr Stephen Cooper. He is a radiation oncologist who I believe will be talking to the Committee later this afternoon. Radiation and chemotherapy often run in tandem, so a lot of the decision-making process is based on discussions between those two individuals.

The Hon. TREVOR KHAN: When was Dr Cooper told?

Mr HALL: Dr Cooper was aware in June 2015, because the issue was raised, as I understand it, at one of the multidisciplinary team [MDT] meetings that Dr Cooper was part of.

The Hon. WALT SECORD: Dr Gallagher, you had concerns about Dr Grygiel's performance and you were still sending patients to him. At least then did you think, "What processes should I put in place if I am continuing to send patients to this man?"

Associate Professor GALLAGHER: At that point in time there was an inquiry going on within the hospital that I felt was going to address these issues. He changed his prescribing practice. I am aware of that.

The Hon. WALT SECORD: Are you sure?

Associate Professor GALLAGHER: Yes, I am sure that he changed his prescribing practice.

The CHAIR: At that point in time?

Associate Professor GALLAGHER: Yes.

The CHAIR: Do you have evidence on that that you could submit to the Committee?

Associate Professor GALLAGHER: Yes. I would have to take that on notice.

The CHAIR: Take that on notice.

The Hon. WALT SECORD: So, Professor Gallagher, you continued to monitor him. For how long did you allow him to continue to see patients before you said, "Let us stop"? How long after June 2015? You began to monitor him but you kept referring patients to him.

The Hon. TREVOR KHAN: I do not think he said he monitored him.

The Hon. WALT SECORD: Professor Gallagher, I do not want to verbal you. So you did not monitor him?

Associate Professor GALLAGHER: I did not say that I monitored him.

The Hon. WALT SECORD: What did you do, then? You did not monitor him. You continued to send patients to him.

Associate Professor SCHEMBRI: If I could clarify—

The Hon. WALT SECORD: No, the question was to Professor Gallagher.

Associate Professor GALLAGHER: I am happy to answer that. I could tell by carefully going through the letters that I received at that point in time that his prescribing habit had changed. So I knew it had changed. I questioned my patients who were having treatment about what treatment they were having, so I knew it had changed.

The CHAIR: Just to clarify this, because Professor Currow gave us some evidence earlier that Dr Grygiel had three categories. There was cisplatin and then carboplatin which were personally tailored—

Associate Professor GALLAGHER: Yes.

The CHAIR: The third part was carboplatin flat dosing.

Associate Professor GALLAGHER: Yes.

The CHAIR: You are saying to this inquiry—I read this between the lines—that his practice changed from the third party of that procedure and he probably operated within the previous two.

Associate Professor GALLAGHER: Correct.

The Hon. COURTNEY HOUSSOS: I would like to come back to the question of what monitoring was in place. You mentioned letters. Did you rely on letters to come back from patients and questioning individual patients?

Associate Professor GALLAGHER: I would rely on the letters that came back from him or from medical oncology on those patients. They were usually dictated by the registrars. They had information about dosing in those letters.

The Hon. COURTNEY HOUSSOS: That was the only monitoring that was put in place?

Associate Professor GALLAGHER: That is the only monitoring I could do other than asking my patients.

The Hon. COURTNEY HOUSSOS: There was no other supervision or other provisions put in place?

Associate Professor GALLAGHER: He was asked, he was told to change his practice.

Associate Professor SCHEMBRI: At the time, in August 2015, we implemented the MOSAIQ prescription electronic record, in which the eviQ protocols were preloaded into the system.

The Hon. COURTNEY HOUSSOS: Was there specific monitoring of Dr Grygiel's patients within the electronic prescription process?

Associate Professor SCHEMBRI: With MOSAIQ if you were to prescribe outside of the eviQ guidelines that would trigger an alert to the pharmacist. So there was that additional monitoring step put in place.

The Hon. COURTNEY HOUSSOS: So it was the pharmacist who was then monitoring Dr Grygiel?

Associate Professor SCHEMBRI: The pharmacists were monitoring the prescription to ensure that it complied with the eviQ guidelines.

The Hon. COURTNEY HOUSSOS: Were the pharmacists then alerted to the broader concerns about Dr Grygiel or were they just told to monitor him as if they were monitoring any additional doctor?

Associate Professor SCHEMBRI: It was raised at the head and neck MDT, the standard practice, and it was ceased back in June or July of 2015. So there was discussion at the MDT that that practice would cease. So the broader team were aware.

The Hon. COURTNEY HOUSSOS: Sorry, Dr Grygiel's practice would cease in July 2015?

Associate Professor SCHEMBRI: Yes, with off-protocol.

The Hon. TREVOR KHAN: How many people were at that meeting?

Associate Professor SCHEMBRI: The MDT is usually a very large group.

The Hon. TREVOR KHAN: I am guessing that. How many people found out this pearl in June of 2015?

Associate Professor SCHEMBRI: There can be up to 20 or more.

The Hon. WALT SECORD: Twenty?

Associate Professor SCHEMBRI: Yes.

The CHAIR: Could you take that on notice and supply the inquiry.

Associate Professor SCHEMBRI: Yes.

The Hon. COURTNEY HOUSSOS: I have one follow-up question. Were there any provisions, any requirements put on the people at that meeting to keep the concerns about Dr Grygiel confidential?

Associate Professor SCHEMBRI: No, it was not discussed, I believe.

Mr JEREMY BUCKINGHAM: My question is to Associate Professor Gallagher. How did it come to your attention that Dr Grygiel may be prescribing an off-protocol dosage of carboplatin?

Associate Professor GALLAGHER: It was brought up to me by Dr Stephen Cooper, radiation oncologist.

Mr JEREMY BUCKINGHAM: Dr Cooper raised it with you?

Associate Professor GALLAGHER: Yes.

Mr JEREMY BUCKINGHAM: When did he raise that with you?

Associate Professor GALLAGHER: He raised it with me at some time in June. I have to be honest, I cannot tell you the exact date but it was during June.

Mr JEREMY BUCKINGHAM: That was the first time it had been raised with you?

Associate Professor GALLAGHER: Yes. It had never been discussed with me previously. It was raised on several occasions. It was brought up, we had a discussion, and then—

Mr JEREMY BUCKINGHAM: I am interested in that. Why was it raised on several occasions?

Associate Professor GALLAGHER: The first time it was raised I said, "You need to be sure of what you are saying."

Mr JEREMY BUCKINGHAM: You did not believe what he was saying?

Associate Professor GALLAGHER: No, I just said, "If you make allegations you have to have an idea about where it came from." So he found that information.

Mr JEREMY BUCKINGHAM: You asked him to investigate that?

Associate Professor GALLAGHER: I did not ask him to investigate. I implied to him that he needed to provide more information so that I could realistically alert the Director of Clinical Governance.

Mr JEREMY BUCKINGHAM: Other than Dr Cooper at that time—we will talk to him later—there had been no-one in management or senior clinician role who was aware of this off-protocol dosing prior to June 2015?

Associate Professor GALLAGHER: I am unaware of anybody who knew.

Mr JEREMY BUCKINGHAM: That is a question to everyone. Was there anyone in the organisation other than junior clinicians, junior doctors or pharmacists, who was aware that this was an issue? Were there any oncologists or management made aware of off-protocol flat dosing prior to June 2015?

Mr HALL: To be clear, the only evidence we had prior to June 2015 was an entry in 2012 in the RiskMan system, which should have been elevated to management, and it was not. That was covered in the Currow inquiry. My investigations and the Currow investigations have found no evidence that senior management or clinicians knew. If anybody has that evidence they should come forward. As yet I have not been given that evidence from anyone.

Mr JEREMY BUCKINGHAM: When the hospital said in a public statement, "No patients appear to have suffered any negative impact as a result of the dosage," that was not accurate, was it?

Mr HALL: I think that that was a poor phrase. We should not have used it. We have acknowledged that the media releases were not as good as they should have been. We should have said at that time, "We do not know what the impact is on patients." In fact, we will not know the true impact on patients for several years to come. We have committed to following up on those patients and see what happens in their particular circumstances. Absolutely, that statement should not have been used.

Mr JEREMY BUCKINGHAM: A statement was also made that Dr Grygiel was immediately counselled and placed under strict supervision. That is not accurate either.

Mr HALL: To be clear, what happened with Dr Grygiel was that in June 2015 the issue was discovered. He agreed, as I understand it, at the MDT, to stop that treatment regime and to start prescribing in line with the eviQ protocol guidelines. Further to that, we implemented an electronic system in August to ensure that he practised within those guidelines. My understanding is that if Dr Grygiel wanted to go outside those guidelines he committed to talking to the MDT. Plus, the pharmacy team would have highlighted to the MDT and I think also Professor Gallagher, any attempt by Dr Grygiel to go outside those treatment regimes. His treatment regime from that point onwards was monitored by the system, by the MDT and also by the pharmacy team. That regime was put in place for Dr Grygiel and for all the other doctors. His treatment regime was, though, monitored from that point onwards.

Mr JEREMY BUCKINGHAM: Why did the hospital not implement either the RIB or IMP policies and protocols? Was that a conscious and proactive decision?

Associate Professor SCHEMBRI: Unfortunately, the incident was not characterised as an incident, and so it did not trigger the enacting of the ministry's incident policy. We recognise that that was an error and we have put in place new systems to ensure that that does not happen again.

Mr JEREMY BUCKINGHAM: You said that it was not characterised as an incident. Whose job is it to assess something and decide whether or not it is an incident?

Associate Professor SCHEMBRI: Under our new policy it is the Director of Clinical Governance.

Mr JEREMY BUCKINGHAM: Under the policy that was in place at the time.

Associate Professor SCHEMBRI: It was a team decision. We have clarified that now it is the role of the Director of Clinical Governance to assess whether a matter that has been brought forward—

Mr JEREMY BUCKINGHAM: It was a team decision not to characterise it as an incident?

Associate Professor SCHEMBRI: It was not characterised as an incident; that is correct.

Mr JEREMY BUCKINGHAM: To be clear, it was a team decision to do that?

Mr HALL: It was—

Mr JEREMY BUCKINGHAM: The question is to Associate Professor Schembri. Was it a team decision not to characterise it as an incident?

Associate Professor SCHEMBRI: It was not a conscious decision to do that.

Mr JEREMY BUCKINGHAM: At no stage did you consider as an organisation, whether or not at any of your team meetings or various get togethers, characterising it as an incident?

Associate Professor SCHEMBRI: The view was that because patients had received their correct surgery, they had received their correct dose of radiation and that this was a radiosensitising—so an adjuvant therapy—that it was not characterised as being a clinical incident at the time.

Mr JEREMY BUCKINGHAM: But you consciously made the decision not to categorise it as an incident because of those reasons that you have just put?

Associate Professor SCHEMBRI: There was no direct decision; it was an omission. It should have been categorised as a clinical incident; we acknowledge that.

Mr JEREMY BUCKINGHAM: Why did the organisation not activate the MCCC policy?

Associate Professor SCHEMBRI: At the time there was the investigation, the internal review. There was then the external review and it was to be determined whether or not any patients had been harmed or whether this was outside of usual practice. So at the time we did not have all the information.

Mr JEREMY BUCKINGHAM: But there was a clear indication that was the case.

Associate Professor SCHEMBRI: At the time we did not have all the information. We were still conducting the reviews.

Mr JEREMY BUCKINGHAM: At the time that you were considering whether or not there was an issue and whether to activate the MCCC policy you did not think that you had an issue, you did not think that there was anything to trigger that?

Associate Professor SCHEMBRI: We did not have sufficient information.

Mr JEREMY BUCKINGHAM: What would sufficient information look like?

Associate Professor SCHEMBRI: One of the things is we went to an external review, an expert in oncology, to assess the doctor's practice.

Mr JEREMY BUCKINGHAM: So you did not tell the ministry, you did not implement the MCCC, you did not tell any patients. Was this not just a stone cold cover-up by your organisation?

Associate Professor SCHEMBRI: No, it was not.

Mr JEREMY BUCKINGHAM: Why was it not a cover-up? Why did you not go to an external reviewer? Why did you not go to the ministry? Why did you deny that there had been any adverse health implications at the outset?

Associate Professor SCHEMBRI: We went to an external review in December of 2015 to assess the doctor's practice. We have cooperated with Professor Currow's inquiry.

The Hon. TREVOR KHAN: But you really had no choice there.

Associate Professor SCHEMBRI: We have done our very best to cooperate. Over 1,500 documents have been submitted to Professor Currow's inquiry.

The Hon. TREVOR KHAN: You really had no choice there either, did you?

Associate Professor SCHEMBRI: And all our staff who were invited to meet with Professor Currow did meet with Professor Currow.

Mr JEREMY BUCKINGHAM: So clearly there is a conflict of interest with your internal review and then appointing an external review of it, really not telling anyone about it. There is a clear conflict of interest there, is there not?

Associate Professor SCHEMBRI: We went to an expert in another State, who was completely independent of the hospital, to provide us with advice.

Mr JEREMY BUCKINGHAM: How many patients had you called by the time this became a public matter? How many patients had you notified prior to becoming aware that this was a matter that was going to be in the media?

Associate Professor SCHEMBRI: Patients were notified in February this year.

Mr JEREMY BUCKINGHAM: That was prior to the media becoming aware of it?

Associate Professor SCHEMBRI: We had started the process, correct.

Mr JEREMY BUCKINGHAM: How many patients had you contacted?

Associate Professor SCHEMBRI: I believe there was a group of patients who had recurrent disease. They were the first patients; they were given priority in the open disclosure process.

Mr JEREMY BUCKINGHAM: The report from Professor Currow says that St Vincent's put its reputation ahead of patient outcomes. That is a damning indictment of the organisation, is it not? How are you going to ensure you can restore the public's confidence in your organisation?

Associate Professor SCHEMBRI: We have put in place a working party who are working very hard to implement all of the recommendations from Professor Currow's inquiry. We have invited Professor Bob Thomas, who is the chief cancer adviser for Victoria, to provide independent oversight over the recommendations and the implementation that we are working hard to prioritise, and we have put a whole range of systems in place, such as the electronic prescribing system; we have put in our new morbidity mortality committee review, a hospital-wide process as well. So we are working very hard to ensure that all of the recommendations are implemented.

The CHAIR: I just want to come back to Dr Gallagher. There is a report from the Journal of Clinical Oncology, December 20, 2008. There were 146 respondents out of 471 oncologists and the conclusion of that particular looking into off-protocol treatments said, "US oncologists report common discussion and use of off-protocol treatment but attitudes and practices may vary substantially. There is need for greater debate regarding the off-protocol treatment in oncology. Further definition of ethical and clinical issues at stake and development of guidelines in this area". I imagine you are well-travelled, well-read. Dr Gallagher, I think you were on the multidisciplinary team, is that right?

Associate Professor GALLAGHER: Yes.

The CHAIR: How many meetings, roughly, would you have been part of and for how many years?

Associate Professor GALLAGHER: About 40 meetings a year over the past 19 years.

The CHAIR: One of the conclusions, "common discussion", I note a lot of health care professionals have not been a part of that area, and they have regular discussions. Are you saying that you did not know that Dr Grygiel was flat dosing?

Associate Professor GALLAGHER: Absolutely.

The CHAIR: No conversations over dinner, at professional events, travelling around? You did not know, yet you were part of 40 meetings a year.

Associate Professor GALLAGHER: Yes. I think that the multidisciplinary meeting is a valuable meeting that we run and the subgroup of head and neck is actually the oldest group that has run a multidisciplinary meeting in Sydney, Australia and the world because it is a complex area. What happens is that each of the people who are part of that bring their own information to the table. As a surgeon I bring my surgical

expertise and knowledge of how people have responded over time. The radiation oncologist brings their expertise, and the medical oncologist brings their expertise, along with all the other people who are involved.

The CHAIR: And the reason they do that is for a holistic approach, is it not?

Associate Professor GALLAGHER: Correct.

The CHAIR: So it is very important that you know what your colleagues are doing in that area of treatment for the best outcomes for the patient.

Associate Professor GALLAGHER: Correct.

The CHAIR: Yet you did not know that.

Associate Professor GALLAGHER: No, because I am not a medical oncologist, I am a surgical oncologist, and I understood what drugs Dr Grygiel has used over time, but I did not know the dosing, and nobody else knew the dosing.

The CHAIR: I understand what you are saying, but you are surgical so your interest would be if there is liver failure, renal impairment, other breakdown in the gut tissue and all sorts of things, and you are saying that you would not look at a drug therapy that the other doctor was referring to or using in the treatment of that patient before you go to surgery on that patient.

Associate Professor GALLAGHER: All my patients receive their drug therapy after surgery.

The CHAIR: So in Dr Grygiel's case you would only see one of his patients once in the MDT setting and not talk about post-op outcomes.

Associate Professor GALLAGHER: The way the MDT works is that the bulk of the patients are referred via the surgeon and also by the radiation oncologist. But by far the most come in via the surgeons. Just about none come in via the medical oncologists; it is not the primary referral as with some other cancers for head and neck surgery.

The CHAIR: In that MDT, the family and the patient are included in that?

Associate Professor GALLAGHER: Yes, they are, for head and neck cancer.

The CHAIR: So would they not indicate the dosage and what Dr Grygiel would have been prescribing?

Associate Professor GALLAGHER: The head and neck MDT is different to other MDTs.

The CHAIR: In what way?

Associate Professor GALLAGHER: A lot of other MDTs—say, for breast or colorectal cancer—those patients have had operations done by surgeons who are then bringing the results of that surgery to the MDT to then discuss treatment. That is never what happens with head and neck cancer. We bring our patients along, make a decision about their treatment which will not include the exact dosages of chemotherapeutic agents. So what happens is that the patient will come along and generally they may go down a surgical pathway and then once we have got some results after surgery we would proceed down the adjuvant treatment with radiotherapy with or without chemotherapy.

Mr JEREMY BUCKINGHAM: In that time you never took an interest; never then followed up with the surgeon and the chemotherapy and then went and visited patients during their chemotherapy?

Associate Professor GALLAGHER: Fortunately I pride myself in my patients, who are many, also come back to me because I follow my patients up forever. Yes, I saw all my patients and I have seen all these patients and the person who does not see all the patients is the medical oncologist. A follow-up is done by myself and the radiation oncologist.

Mr JEREMY BUCKINGHAM: But with that follow-up did you become aware that they were just getting the flat dose—

Associate Professor GALLAGHER: No, and there was nothing in the behaviour of any of my patients over time with recall to incidence of disease recurrence that would indicate that there was anything of concern.

Mr JEREMY BUCKINGHAM: They never said to you, "I am getting 100 milligrams of carboplatin?

Associate Professor GALLAGHER: No.

Mr JEREMY BUCKINGHAM: Not at any stage?

Associate Professor GALLAGHER: Never.

Mr JEREMY BUCKINGHAM: Never once?

Associate Professor GALLAGHER: No. The patients did not even know they were getting the dose.

Mr JEREMY BUCKINGHAM: What do you mean the patients did not know they were getting that dose.

Associate Professor GALLAGHER: The patients don't—I mean, you will have to ask Dr Grygiel. I am aware—

The CHAIR: Doctor, with all due respect, in the evidence it notes you and it notes you in the MDT. That is all I will say and it notes that you were present in their situation. So I think they are fair questions—

Associate Professor GALLAGHER: Yes, for sure. I am happy to answer it.

The Hon. BRONNIE TAYLOR: I want to go back to the time line that you implemented MOSAIQ. Was that in 2015?

Associate Professor SCHEMBRI: Yes, August 2015.

The Hon. BRONNIE TAYLOR: For a centre like St Vincent's, that is, a big major treatment facility, is that quite late on in the timeline to be using an electronic system for medical oncology?

Ms PREST: The decision to introduce the electronic medical records was made probably about 2012. The system actually first started off in our outpatient areas, if you like, for a booking or billings process. So we actually implemented it earlier on in the year but we only turned on the functionality of the e-prescribing in August. You would be surprised to hear that other major treatment centres throughout Sydney, indeed, do not yet have an electronic records system in them yet. For example, two other major treatment centres have been to visit us to see what we are putting in place with that system and, indeed, some of the extra recommendations coming out of the inquiry to actually make the processes safer for our patients so monitoring variation to protocol and so on we are now building into the MOSAIQ system but we have had at least two centres from Sydney come to visit us to see the system in place as they are considering what system they are putting place.

The Hon. BRONNIE TAYLOR: I am indeed a bit surprised. Having been a rural practitioner I would have assumed the major city hospitals would have it. The Committee has heard about drop-down boxes if it is not within the therapeutic guidelines and then the alert would go to pharmacy. I presume at St Vincent's you mix your own drugs on site? Do you?

Associate Professor SCHEMBRI: Yes.

The Hon. BRONNIE TAYLOR: Now you will have numerous alerts that will happen with the implementation of MOSAIQ?

Ms PREST: Yes. If I can describe the process. If the order is made on the system, the order then goes to the pharmacist to review and approve. If the doctors are ordering a drug dose where they consider that they need to make a variation which is a normal clinical variation because the patient may be slightly unwell, or perhaps slightly frail, we consider that some modifications to the treatment doses may be necessary, for example, if the patient has a low white cell count, what we are monitoring now through MOSAIQ is any dose that we consider to be significantly beyond the guidelines of eviQ. So they are the New South Wales Cancer Institute guidelines.

The pharmacist monitors and orders that and brings it to the other new process that we have instituted which is the Protocol Review Committee. So on a monthly basis we will review all of the prescriptions to see where the protocols that have been ordered are either off slightly from the point of view of just normal clinical variation or where the doctor is wanting to make a different component of the protocol, say change one drug or change the dose significantly, and we have the heads of the department on that committee now who review every new protocol that is prescribed or every major or minor variation.

The Hon. BRONNIE TAYLOR: With the implementation of MOSAIQ since August 2015, and those things in place and your Protocol Review Committee, should a situation, God forbid, arise like this again would you have multiple points of evidence that point to the fact that something was not quite right? Is that a fair enough comment?

Associate Professor SCHEMBRI: Yes.

Ms PREST: Correct, it would not get past the first prescribing process.

The Hon. TREVOR KHAN: Professor Gallagher, you have indicated that you were informed in June and your first point of call was who, in terms of once you were satisfied that there was a problem?

Associate Professor GALLAGHER: With the Director of the Clinical Governance who is Dr Gardiner.

The Hon. TREVOR KHAN: Anyone else?

Associate Professor GALLAGHER: No, because he is the Director of Clinical Governance so that is who I reported to.

The Hon. TREVOR KHAN: Professor Schembri, when did you become aware?

Associate Professor SCHEMBRI: The afternoon of 5 August.

The Hon. TREVOR KHAN: And Ms Prest, when did you become aware?

Ms PREST: In that week in June[1] when it had been raised with the Director of Clinical Governance the then ripple-out conversation happened with the Manager for Safety and Quality and so on and within that week of those meetings happening that is when we—

The Hon. TREVOR KHAN: So you were alive in June and when you talk in terms of ripple out, to whom did it ripple out apart from Dr Gardiner and yourself? Who else was involved?

Ms PREST: The Chief Operating Officer, the Manager for Safety and Quality, the Director of Pharmacy Services, the Senior Oncology Pharmacist—

The Hon. TREVOR KHAN: It was sufficiently alive as an issue, do I take it, in June—I am not trying to hold you to a particular date? You knew you had a significant problem developing. Would that be fair?

Ms PREST: Absolutely, and that is when we first met to formulate a plan as to how to begin to investigate and to see the scope of the problem.

The Hon. TREVOR KHAN: Was it at that point in time when Dr Grygiel was told to stop flat dosing?

Ms PREST: I was not involved in that.

The Hon. TREVOR KHAN: Can somebody tell me? I just want to be clear on the dates, was it as early as June that you realised not only that you had a problem but that Dr Grygiel had to stop what he was doing?

Associate Professor SCHEMBRI: So there was discussion at the MDT in June and the doctor undertook at that point to cease the practice.

The Hon. TREVOR KHAN: That agreement by him to cease the practice was as a result of an expressed concern that what was happening was wrong? Is that fair?

Associate Professor SCHEMBRI: It was raised with the doctor that it was out of the ordinary practice and he agreed to stop at that point.

The Hon. TREVOR KHAN: Are you saying that it was put to him, "Look, this is out of the ordinary, you should stop" or "You've got to stop, this is wrong."?

Associate Professor SCHEMBRI: I was not there at the time but I believe that it was discussed that it was outside normal practice and he agreed to cease.

The Hon. TREVOR KHAN: I am left with this impression that by sometime in June senior management at St Vincent's knew it had a ticking time bomb on its hands and you did not tell the Ministry for Health.

Associate Professor SCHEMBRI: We did not understand the seriousness of the problem and that did not trigger the escalation to the ministry. We recognised that that was an error. One of the things that we have done to ensure that it does not happen again, is over 150 of our senior managers have undergone a comprehensive training program around the Ministry's incident management policy and protocols, as well as

[1] In correspondence to the committee dated 15 February 2017, Ms Prest subsequently advised that the month she referred to should be August, not June.

how you recognise an incident, the open disclosure process, and we will repeat that on an ongoing basis to ensure that all of our staff are familiar with the expectations around incident management.

The Hon. TREVOR KHAN: Mr Hall can comment in due course, but I am interested to get a clearer picture as to why at this stage St Vincent's was not seeking to bury a problem that they knew they had?

The Hon. NATASHA MACLAREN-JONES: Following on from my colleague's questions regarding the MDT meetings in June 2015, at any stage did anyone ask Dr Grygiel why he was doing this?

Mr HALL: I have spoken to Dr Grygiel to understand his treatment regime once this came to light and his explanation to me—and I have to believe that this is the case—was that he was doing this in the best interests of his patients. The cohort of patients that we are talking about are incredibly frail and carboplatin is poisonous to the body. All oncologists have to make a judgement about treatment in respect of "How much should I give a very frail patient" and essentially help them be cured versus damaging them. Now, that is quite an appropriate thing to think through from an oncology point of view. My question then was can you explain the evidence behind that because as an organisation we absolutely rely on having evidence-based treatment protocols. Dr Grygiel, at that point, explained that he believed he had read researched evidence that supported flat-dosing carboplatin for this type of head and neck patient, and he felt that that was the best treatment regime to avoid harm to these patients.

Subsequently, I have yet to have provided any evidence that there are research clinical trials which would show that that was the case. In that case, for this type of treatment regime, what absolutely should have happened, if Dr Grygiel wanted to do this type of work, he should have gone through a research process, he should have gone through an ethics committee and that would have been allowable within our system, and all patients should have been consented. That did not happen. One can only assume that he has taken the decision on his own to carry out that treatment regime, but I do believe he felt that was in the best interests of those patients.

The Hon. NATASHA MACLAREN-JONES: Is it fair to say that when it was raised by other clinicians or staff that there was underdosing that he gave that answer, that he believed it was in their best interests?

Mr HALL: I personally sat down and asked exactly those questions. The answer was compelling. I would have come away saying certainly he generally has an interest in the patient, but he absolutely believes himself that there is research behind this treatment regime. I am sure he would have given that same explanation to junior nurses and to people in oncology. In fact, Professor Gallagher probably would have got the same answer.

Mr JEREMY BUCKINGHAM: Professor Gallagher did not know.

Associate Professor GALLAGHER: No, not until we asked him at that point in time.

The Hon. NATASHA MACLAREN-JONES: Following on from that, as a result of the section 122 inquiry, you have implemented "It's OK to ask". If people were already asking questions and they were getting an answer at the time that they believed was satisfactory, what is going to change in this program to prevent this happening?

Mr HALL: Firstly, beyond "It's OK to ask", I have spoken to senior clinicians at St Vincent's Hospital and also across our group to say very clearly that any clinician who wants to go outside standard treatment protocols has to do so in a research-based project and they have to tell their peers and they have to tell the MDT. That did not happen in this case. The senior clinicians in the hospitals have had that discussion to ensure they are following through, and I believe they have a good understanding of that. Certainly our Medical Advisory Council supports that proposition. I will let Dr Gallagher talk about "It's OK to ask". The goal of "It's OK to ask" is to ensure that all of our people feel it is safe to raise a concern. The risk is, unfortunately, at times, people will listen. What we are saying to people is, yes, you need to listen, but you need to get the evidence, and if you are not comfortable, you need to question and question again, but Professor Schembri should answer that as well.

Associate Professor SCHEMBRI: We have put in place "It's OK to ask", which is a hospital-wide program, to encourage all of our staff to raise any clinical concerns with their peers.

The Hon. NATASHA MACLAREN-JONES: Did not the previous section 122 inquiry show that people had actually raised it?

Associate Professor SCHEMBRI: Yes.

The Hon. NATASHA MACLAREN-JONES: How will this be different?

Associate Professor SCHEMBRI: What we have also put in place is a system whereby staff can escalate outside of their department to members of the executive, to our clinical leaders, to myself, to Mr Hall, and so we have made it very clear to our staff that there is not just the culture of challenge and peer review that we are wanting to develop at St Vincent's, but that staff feel comfortable to raise concerns with me and with other senior leaders.

The CHAIR: Is that anonymously on occasion when they may feel marginalised?

Associate Professor SCHEMBRI: We have an email address where staff can bring any concerns they have to our attention, and so they can do it anonymously or, if they feel comfortable, to raise it directly with us. We will certainly listen to their concerns.

The Hon. TREVOR KHAN: Mr Faktor, you were told in August or September, I think you said, about this matter. Are you able to be more precise as to whether it was August or September that you were told?

Mr FAKTOR: I could check. It was either late August or early September?

The Hon. TREVOR KHAN: Who told you?

Mr FAKTOR: I think I mentioned it. Professor Schembri, chief executive officer.

The Hon. TREVOR KHAN: It may be for Professor Schembri. The patients have not been told, the Ministry of Health has not been told, but your communications officer is being told. Why is he being told what is going on? Were you expecting a problem?

Associate Professor SCHEMBRI: As a matter of course I would communicate with David around a whole range of issues.

The Hon. TREVOR KHAN: This was not as a matter of course, was it?

Associate Professor SCHEMBRI: As I said, I communicate with the director of media and communications around a whole range of issues. It is not unusual that I would have a conversation with that role.

The Hon. TREVOR KHAN: I accept that. Would you agree with me that this was not a normal issue that you were discussing with him?

Associate Professor SCHEMBRI: No, it was a developing issue. We were undertaking an internal review to better understand the problem, to better determine whether this was an issue of concern, and I would have had a conversation with the director of media and communications about the fact that there was an internal review.

The Hon. TREVOR KHAN: Because it would be fair to say you had to be alive to the possibility that this was going to break in the media. Would that be right?

Associate Professor SCHEMBRI: At the time I was not concerned about that because we did not have sufficient information. We were trying to understand what was the nature of the problem.

The Hon. TREVOR KHAN: Let me put this to you. If you felt that it was of sufficient weight, however much that weight is, to tell your communications fellow, why did you not tell the Ministry of Health?

Associate Professor SCHEMBRI: Because, as I said previously, we incorrectly did not characterise this matter as an incident and it did not trigger the usual Ministry response. That was an error and we have acknowledged that.

The Hon. BRONNIE TAYLOR: Can I follow on from that. You talk about triggers and that it was not triggered. What triggers have you got in place now to ensure that this is not going to happen again?

Associate Professor SCHEMBRI: A fundamental change now is we have a subject expert assess the issue to provide that clinical input. Had we had an oncologist at the time provide that review, then it would have been a very different scenario because we would have realised the seriousness of the issue back in August. So we put in place a new system where we have a subject expert provide that input.

The Hon. BRONNIE TAYLOR: One last question for Professor Gallagher. In relation to the MDT, when someone is discussed in the MDT—I do not know because I have not been to a head and neck one, but obviously patients come and you do your plan of care.

Associate Professor GALLAGHER: Yes.

The Hon. BRONNIE TAYLOR: In a head and neck MDT, is a dosage of chemotherapy, regardless of what that chemotherapy agent is, discussed in terms of the dosage?

Associate Professor GALLAGHER: No, never. It has never, ever been raised until June-July last year.

The Hon. BRONNIE TAYLOR: So the assumption is that you are asked and you know that they will be treated with a platinum, or whatever it is, but the dosage is not discussed although the drug and the treatment regime are.

Associate Professor GALLAGHER: Correct.

The Hon. WALT SECORD: Associate Professor Richard Gallagher, in June 2015 it came to your attention, and 20 other of your colleagues knew about this. When did you stop sending patients to Dr Grygiel? When did you say, "That's it. No more patients."

Associate Professor GALLAGHER: For me it was November of last year.

The Hon. WALT SECORD: July, August September—five months.

Associate Professor GALLAGHER: Yes.

The Hon. WALT SECORD: How many patients do you think you referred?

Associate Professor GALLAGHER: As I said, I would have to go and look it up. I would have to take that on notice, really, to give you an honest answer. But I guesstimate it would be somewhere around 10.

The Hon. WALT SECORD: Ten patients. Your colleague Associate Professor Anthony Joshua said that these were frail, very frail, patients.

Associate Professor GALLAGHER: No, I think—

The Hon. WALT SECORD: Sorry—it was Mr Hall.

Associate Professor GALLAGHER: I think Mr Hall probably was alluding to the fact that these patients all had advanced cancer.

The Hon. WALT SECORD: The ones that you referred to Dr Grygiel?

Associate Professor GALLAGHER: Yes. Anybody who requires chemotherapy as part of their management has advanced cancer.

The Hon. WALT SECORD: How many patients would have passed away between 2015 and February 2016?

Associate Professor GALLAGHER: Are you talking about the cohort or are you talking about my personal group of patients?

The Hon. WALT SECORD: Both, if you would like to tell us.

Associate Professor GALLAGHER: I had probably about three or four patients die over the past six months but a lot of them have not had any chemotherapy.

The Hon. WALT SECORD: When did St Vincent's decide to tell the Ministry of Health?

Associate Professor GALLAGHER: This internal review process—I am a little bit conflicted because a lot of these patients are my patients. I was not part of the decision-making process so I cannot in all honesty give you a proper answer to that.

Associate Professor SCHEMBRI: I can advise. We formally notified the Ministry in February of this year.

The Hon. WALT SECORD: February?

Associate Professor SCHEMBRI: Yes.

The Hon. WALT SECORD: What made you decide to tell the Ministry of Health? Was it Matt Peacock calling from the *7.30 Report*?

Associate Professor SCHEMBRI: No. We had the external report from the doctor in South Australia and we were making preparations to inform patients. It was at that point that we notified the Ministry.

The Hon. WALT SECORD: In your submission on page 20 you talk about the new leadership and changes to key personnel. In December 2015 it says here, "We appointed a new head of medical oncology and a new medical oncologist. We also have a new Director of Cancer Services."

Associate Professor SCHEMBRI: Yes.

The Hon. WALT SECORD: What was that appointment?

Associate Professor SCHEMBRI: We appointed Associate Professor Anthony Joshua, following an international search, following, to the role of head of medical oncology. We have appointed five new medical oncologists to the hospital and Dr Gallagher was also appointed the Director of Cancer Services.

The Hon. WALT SECORD: So the man who was in charge of monitoring Dr Grygiel and who was still sending patients to him—and firstly you had discussions that knew about him in June 2015—you decide to appoint him Director of Cancer Services.

Associate Professor SCHEMBRI: Dr Gallagher was appointed the new Director of Cancer Services in February of 2015.

The Hon. WALT SECORD: Was there internal discussions saying, "Well, isn't this a bit unusual that the person who was in charge of Dr John Grygiel"—as part of this new culture you want to create—"is the person who is now the new cancer director"?

Associate Professor SCHEMBRI: When I joined the organisation in 2014 I put in place new clinical governance arrangements. Some of those arrangements were the creation of new clinical streams in which those clinical streams are headed up by a senior nurse and a senior doctor to provide clinical input into the running of the health service. As part of that process there was the appointment of a new Director of Cancer Services in February of 2015.

The Hon. WALT SECORD: Let me get this straight: Dr John Grygiel is sacked, gets pushed into retirement, and Richard Gallagher gets promoted.

Associate Professor SCHEMBRI: Dr Gallagher was appointed, in February of 2015, the Director of Cancer Services.

The Hon. WALT SECORD: Do you still stand by the description on 19 February 2016 that this was human error?

Associate Professor SCHEMBRI: Clearly—

The Hon. WALT SECORD: I am quoting from the review.

Associate Professor SCHEMBRI: We accept—

The Hon. WALT SECORD: It was not human error.

Associate Professor SCHEMBRI: We accept Professor Currow's inquiry report, which found that there were systems issues. There were system concerns. We acknowledge that. We are putting in place a process to ensure that all of the recommendations are implemented.

The Hon. WALT SECORD: So it was not human error.

Associate Professor SCHEMBRI: It was a systems error, correct.

The Hon. COURTNEY HOUSSOS: Associate Professor Schembri, you have outlined that there were a range of protocols that you changed after becoming aware of the allegations in June 2015. There were new morbidity and mortality [M and M] conferences; there were changes in the multidisciplinary teams; there was a range of things that occurred, but at no point was the phone picked up to call patients themselves. At what point did you consider it appropriate to actually pick up the phone to patients? When you were implementing these hospital-wide changes to practice, you did not see fit to call either the patients or, as we previously discussed, the Ministry for Health. At what point did you think it was appropriate to start calling patients?

Associate Professor SCHEMBRI: We wanted to have as much information as we could have to be able to communicate with patients openly and we wanted to have the feedback from the external report to be able to then talk openly with patients about what had happened. We were waiting on the external advice.

The Hon. COURTNEY HOUSSOS: But earlier Associate Professor Gallagher said that if something happens with a patient who is in surgery, they are told immediately—as soon as they are awake and are able to be told—but there was this delay of, it appears, seven or eight months before patients were actually informed

about this treatment that was life-changing. You did not think to flag something with the patients initially to say, "There is a concern and we're investigating this"?

Associate Professor SCHEMBRI: As Professor Currow's report has found, we did not appreciate the seriousness of the issue and we did not appreciate the urgency of the issue. If I had my time over, we would communicate with patients much earlier in the process but, unfortunately, we did not feel that we had sufficient information at the time to communicate with patients. It was always our intention to do so. To go back to the very first meeting when this was first raised with senior staff, it was always the intention to communicate with patients. We wanted to have as much information as we could. But we now understand that that was an error and we are very, very sorry to the relatives and our patients. We are putting in place steps to make sure that our open disclosure process is more timely in the future.

The Hon. WALT SECORD: Earlier this morning we heard evidence involving a patient who had a brain tumour and who was treated by Dr Grygiel and who was underdosed.

The Hon. TREVOR KHAN: Wait a minute. Is this in the context of—

The Hon. WALT SECORD: This morning.

The Hon. TREVOR KHAN: Was this in camera stuff?

The Hon. WALT SECORD: No. It was not in camera.

The CHAIR: We have not taken evidence in camera.

The Hon. TREVOR KHAN: I am sorry. I was protecting everyone.

The Hon. WALT SECORD: I understand your motive. This morning we heard about a brain tumour, a person with cancer in 2008, who was underdosed by Dr Grygiel, but it was not caught up in the New South Wales Government's investigation into St Vincent's.

There was also concern that other patients who they said were—I am not sure of the correct medical term, but the palliative care stream—is that the correct term?

The CHAIR: Yes.

The Hon. WALT SECORD: So there were patients who were not collected in the head and neck cancers category. How many other patients of Dr Grygiel were not scooped up by the State Government internal investigation of Dr Grygiel's patients?

Associate Professor SCHEMBRI: I can answer that. There were two patients that contacted the 1800 number that we established with a request from relatives that we conduct a review into their treatment. In the first patient they were treated with a drug called capecitabine for oesophageal cancer and it was found that that dose was a lower than expected dose so we communicated with the family and provided that feedback and provided support to that family. We also notified Professor Currow for his inquiry and we also notified the Ministry of Health. There was a second patient who was also very sick. They were treated with a different chemotherapy drug. Again it was found that there was a lower than expected dose. However, the patient was very, very sick at the time so it was difficult to determine the dose variation outside of what would be usual practice. Again with that patient we communicated with the family, we provided support, we notified Professor Currow and we also notified the Ministry of Health.

The Hon. WALT SECORD: But with these two patients they were only referred to, examined, or their families made contact with because they called the 1800 number—it was not due to your organisation contacting them.

Associate Professor SCHEMBRI: We were not aware of these particular patients. We participated in Professor Currow's inquiry where we focused on patients that had been treated with carboplatin. But we went and did some of our own reviews. For example—

The Hon. WALT SECORD: How many other patients?

Associate Professor SCHEMBRI: At the request of Professor Currow we reviewed patients that had received capecitabine which is an oral chemotherapy for colorectal patients. There were 38 patients that we were able to identify and there was no evidence of—

The Hon. WALT SECORD: So those 38 are not included in the State Government's report—these are 38 extra patients.

Associate Professor SCHEMBRI: These are patients that we at St Vincent's have undertaken a review of and there was no evidence of any off-protocol dosing. There was no evidence that these patients received anything other than the correct dose.

The Hon. WALT SECORD: What about the other group of patients who received temozolomide, such as the patient and the family that I met? Are there other patients in this person's category?

Associate Professor SCHEMBRI: We were able to identify 11 patients that had received this drug. Only one of those patients was found to have a lower than expected—

The Hon. WALT SECORD: This man was significantly underdosed.

Associate Professor SCHEMBRI: The gentleman was also very, very sick. In very sick patients it is not unusual that there be a dose variation to reduce side effects. There were 11 patients in this group that we were able to identify. Ten had what you would expect to be a correct dose and there was the one patient that you are referring to who received a lower dose.

The Hon. WALT SECORD: But there were 49 in total on top of the 129?

The Hon. TREVOR KHAN: No. You cannot—

Associate Professor SCHEMBRI: That is incorrect.

The Hon. WALT SECORD: I just want to get the numbers correct here.

Associate Professor SCHEMBRI: We have only been able to identify two patients who received a lower than expected dose of chemotherapy.

The Hon. WALT SECORD: Have you assessed the treatment regimes of all of Dr Grygiel's patients through St Vincent's Hospital?

Associate Professor SCHEMBRI: We are participating in the ministry's review of cancer patients. As part of that we will cooperate with the State audit whereby patients will be reviewed.

The Hon. WALT SECORD: We were just told half an hour ago that that State audit comprises 1,800 patients, a random sample, and is no longer the 200,000 patients.

Associate Professor SCHEMBRI: As I said, we will cooperate with the ministry's review.

The CHAIR: Order! We will have to move on.

Mr JEREMY BUCKINGHAM: To be clear, Associate Professor Schembri, in or around June Associate Professor Gallagher was made aware of this issue. Sometime around August you were made aware. Your organisation deemed it significant enough to launch an internal investigation. That investigation reported back in October 2015 and subsequent to that you stopped referring patients to Dr Grygiel. Is that correct?

Associate Professor SCHEMBRI: Yes.

Mr JEREMY BUCKINGHAM: At that juncture, even though you had deemed it serious enough to stop sending patients to a doctor because of off-protocol dosing, you did not notify the ministry?

Associate Professor SCHEMBRI: As I have said, that was an error.

Mr JEREMY BUCKINGHAM: And some people would be very concerned about whether it was an error or was in fact calculated—a pro-active decision. I think that that is a live question. The question I have is: With that internal investigation, who conducted it and did they go back and talk to junior staff about this issue?

Associate Professor SCHEMBRI: The initial review was conducted by one of our medical officers in the clinical governance unit in partnership with representatives from quality and safety, the clinical stream and pharmacy. They conducted a review of the prescribing but they did not talk with junior doctors at that point.

Mr JEREMY BUCKINGHAM: What did that review of the prescribing reveal? Did it reveal at that point that the flat dosing was something that had been happening for many years?

Associate Professor SCHEMBRI: No, because it was a small subset of patients, so we decided to go to an external expert to provide us with advice.

Mr JEREMY BUCKINGHAM: So that small cohort of patients did not reveal any systemic problems or a pattern of behaviour?

Associate Professor SCHEMBRI: It revealed that there was prescribing of chemotherapy that was outside of the eviQ guidelines.

Mr JEREMY BUCKINGHAM: So it did reveal the flat dosing?

Associate Professor SCHEMBRI: At the time we were not aware that it was flat dosing, back then. It revealed that there was a pattern of—

The Hon. TREVOR KHAN: Sorry, is that consistent with what Associate Professor Gallagher has said?

Associate Professor SCHEMBRI: When we conducted the internal review it identified that there was chemotherapy prescribing that was not against the eviQ guidelines.

The Hon. TREVOR KHAN: Associate Professor Gallagher, is that consistent with your evidence?

Associate Professor GALLAGHER: I think we are probably saying the same thing. My understanding is that at the time the dose was recognised to be not as per a recognised dosing schedule. I do not think the term "flat dosing" was used, but I know that it was recognised.

Mr JEREMY BUCKINGHAM: But in that internal investigation with those various bodies and representatives, you did not go back and talk to pharmacy, junior doctors, other junior staff or other oncologists. Who did you talk to in that regard?

Associate Professor SCHEMBRI: The team reviewed the pattern of prescribing. They reviewed clinical records. They reviewed the eviQ guidelines. So it was a very focused review around the prescribing.

Mr JEREMY BUCKINGHAM: And how far back did it look?

Associate Professor SCHEMBRI: My recollection is it went back a couple of years.

Mr JEREMY BUCKINGHAM: What does a couple of years mean—two years, five years or 10 years?

Associate Professor SCHEMBRI: I will have to take it on notice. I do not have that information in front of me.

Mr JEREMY BUCKINGHAM: Would you be prepared to provide that internal review to the Committee?

Associate Professor SCHEMBRI: We have already provided the documentation to Professor Currow's inquiry.

The Hon. TREVOR KHAN: We know that. That is not what he asked.

Mr JEREMY BUCKINGHAM: We know that, but it has not been presented to this Committee. Would you be prepared to provide that document?

Associate Professor SCHEMBRI: I will have to take that on notice.

Mr JEREMY BUCKINGHAM: You said that the only record you could find anywhere of off-protocol dosing was from 2012.

Mr HALL: Yes.

Mr JEREMY BUCKINGHAM: How is that consistent with what the internal review revealed?

Mr HALL: What happened in 2012 was that there was a risk management notification from a member of staff. That is where a member of staff has a concern. They register it on the RiskMan database. It goes to their manager and their manager looks at it. The system was manual in those days. It was automated very shortly afterwards. There was no escalation process at that time to double-check that the manager responded to it. The manager thought she had responded to it and she had not. That was on the system and noted. The next time anyone heard about it was when flat dosing was raised in June 2015.

The Hon. TREVOR KHAN: We then get the reference to flat dosing in June 2015.

Mr JEREMY BUCKINGHAM: That was revealed in the internal review.

Mr HALL: Yes.

Mr JEREMY BUCKINGHAM: You also said that you formally notified the ministry in February 2015.

The Hon. TREVOR KHAN: No, 2016.

Mr JEREMY BUCKINGHAM: Thank you. Did you make any other representations to government prior to that?

Associate Professor SCHEMBRI: In November 2015 I spoke with the Chief Health Officer.

Mr JEREMY BUCKINGHAM: You spoke with the Chief Health Officer in November 2015?

Associate Professor SCHEMBRI: That is correct.

Mr JEREMY BUCKINGHAM: What about?

Associate Professor SCHEMBRI: I informed her that we were going to have an expert from South Australia review these patients.

Mr JEREMY BUCKINGHAM: So you deemed it serious enough to contact the Chief Health Officer. How did you do that?

Associate Professor SCHEMBRI: By telephone.

Mr JEREMY BUCKINGHAM: You rang her up and said, "We have an issue. We are going to have an external review." But at that point you did not think it triggered the significant incident procedures?

Associate Professor SCHEMBRI: That is correct. As we said, that was an error. It should have triggered a reportable incident brief.

The CHAIR: Dr Gallagher, you said the off-protocol dosing was outside the accepted levels of treatment. What would you say the terminology is for Dr Grygiel's flat dosing? I think "off the radar" was a comment made earlier.

Associate Professor GALLAGHER: The term "flat dosing" came up at one stage but has only really been used this year. I do not think that we used that terminology previously.

The CHAIR: What would a healthcare professional say?

Associate Professor GALLAGHER: Essentially that he was not prescribing the prescribed dose.

The CHAIR: Within the acceptable limits?

Associate Professor GALLAGHER: It was at significant variance with the protocols that are written down at eviQ and the National Comprehensive Cancer Network [NCCN] guidelines, which are the American guidelines. That is all that I can add, really.

The CHAIR: Mr Jeremy Buckingham, are you seeking clarification?

Mr JEREMY BUCKINGHAM: Yes. To be clear for the record, Professor Schembri, you contacted the Chief Health Officer by telephone in November to indicate that you had an issue that you were going to have investigated externally and that involved these matters.

Associate Professor SCHEMBRI: Yes.

Mr JEREMY BUCKINGHAM: At that point had your organisation made a decision to stop referring patients to that doctor?

Associate Professor SCHEMBRI: The doctor had ceased his prescribing practice back in June or July.

The Hon. TREVOR KHAN: We knew that.

Mr JEREMY BUCKINGHAM: We knew that, but had you at that point stopped referring patients to him?

Associate Professor SCHEMBRI: Patients were being referred to Dr Grygiel in 2015, yes.

Mr JEREMY BUCKINGHAM: That is right; they were. But when you informed the Chief Health Officer that you were having an external review into these matters, at that point had you stopped sending patients to Dr Grygiel?

Associate Professor SCHEMBRI: No.

The Hon. COURTNEY HOUSSOS: Had you phoned any of the existing patients?

Associate Professor SCHEMBRI: Not in November of 2015, no. As I said, were waiting for the external expert to provide us with advice.

Mr JEREMY BUCKINGHAM: What did the Chief Health Officer say to you?

Associate Professor SCHEMBRI: She asked me to speak with the chief cancer officer, so two days later I spoke with Professor Currow.

Mr JEREMY BUCKINGHAM: Do you know whether she informed anyone else in the Government?

Associate Professor SCHEMBRI: I would not be able to answer that.

The Hon. WALT SECORD: This changes previous evidence given to the Committee. When did you formally tell the Ministry of Health?

Mr JEREMY BUCKINGHAM: In February.

Associate Professor SCHEMBRI: In February, yes.

The Hon. WALT SECORD: Up until now everyone has said it was February 2016. Now you are telling us that you informally told Dr Kerry Chant in November.

Associate Professor SCHEMBRI: That is correct.

The Hon. WALT SECORD: You said you referred it to Dr David Currow of the Cancer Institute NSW. Therefore, you must have had a discussion about the issue that you had at St Vincent's.

Associate Professor SCHEMBRI: I advised that we were going to an external review for a group of cancer patients.

The Hon. WALT SECORD: Wait. So you were doing an external review on something in your hospital and you did not tell Dr Chant what it was and she did not ask?

Associate Professor SCHEMBRI: No, we spoke about the fact that it involved a group of carboplatin patients.

The Hon. WALT SECORD: How does that reconcile with telling New South Wales Health in 2016? Now we are told it is 2015.

Associate Professor SCHEMBRI: As I said, we formally notified the ministry in February 2016.

The CHAIR: Let us clarify a couple of things.

The Hon. NATASHA MACLAREN-JONES: Can I clarify that you advised in 2015 that you were looking into the cases of a couple of patients?

Associate Professor SCHEMBRI: That is correct.

The Hon. NATASHA MACLAREN-JONES: Is that type of investigation common across all areas of Health?

Associate Professor SCHEMBRI: It would not be unusual to seek an external expert to review patient care.

The CHAIR: Across the Health portfolio?

Associate Professor SCHEMBRI: Yes. That is correct.

The CHAIR: That is a reasonable step.

Associate Professor SCHEMBRI: Yes; it is not unusual.

The Hon. NATASHA MACLAREN-JONES: Before formally advising—

The Hon. WALT SECORD: So you picked up the phone to Kerry Chant and said, "We have a problem. I am telling you this informally"?

Associate Professor SCHEMBRI: As I said, I informed her that there was a group of patients that we were seeking an external review on.

Mr JEREMY BUCKINGHAM: How often do you pick up the phone to Kerry Chant and do that?

Associate Professor SCHEMBRI: I have regular conversations with the Chief Health Officer.

The Hon. COURTNEY HOUSSOS: Since 2014, since starting at St Vincent's Hospital, how many external reviews have you commissioned like this?

The CHAIR: Across the portfolio.

Associate Professor SCHEMBRI: I will have to take that on notice.

The CHAIR: Thank you.

The Hon. COURTNEY HOUSSOS: Can you give a general idea? Is it something that you would do every month?

The CHAIR: Would there be three or five a year?

Associate Professor SCHEMBRI: As I said, I will have to take that on notice.

Mr JEREMY BUCKINGHAM: Surely you would be able to remember, Professor Schembri, how often you ring up the Chief Health Officer of New South Wales and say, "We are conducting an external review of practice in our hospital"? That is a pretty serious issue. That is a serious escalation. How is that part of—

The Hon. TREVOR KHAN: One thing at a time.

Associate Professor SCHEMBRI: As I said, I contacted the Chief Health Officer to advise her that there was a group of patients that we were seeking an external review on.

The CHAIR: That would not be unusual.

Associate Professor SCHEMBRI: That is correct.

The CHAIR: In any other portfolio there is a flowchart showing how to work up through the system. As you noted, this issue failed to trigger the procedure.

The Hon. WALT SECORD: I disagree with that characterisation.

The CHAIR: We know how it works within the health system.

The Hon. WALT SECORD: I disagree—

The CHAIR: Order! It is my time to ask questions.

The Hon. TREVOR KHAN: I think it is mine.

The CHAIR: Would it be fair—

The Hon. WALT SECORD: You are missing the point here.

The CHAIR: I am not missing the point.

The Hon. WALT SECORD: NSW Health knew much earlier than—

The CHAIR: I understand that.

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

The CHAIR: It is on the record.

The Hon. WALT SECORD: NSW Health knew much earlier than everyone was led to believe.

The Hon. NATASHA MACLAREN-JONES: Walt, calm down.

The CHAIR: It is on the record, and it is our time to question.

The Hon. WALT SECORD: It is important.

The CHAIR: It is an important point, and you have got it.

Mr JEREMY BUCKINGHAM: And did the Minister know?

The CHAIR: In terms of progressing it, was it because you are not guilty until proven so, or was it a fact that you were not sure that that treatment protocol was happening? Or did you not have enough evidence to raise it to the level and you were saying, "This is an informal, casual phone call. Just letting you know that we have not been through the investigation so we can't prove that this is happening. I am just letting you know that we are working through this." Was it that type of phone call?

Associate Professor SCHEMBRI: Yes it was. We did not have all the information. The reason we were going to external review was to seek further information. So it was as you said.

The CHAIR: You probably would probably have said, "These are the three options. If it is right we are going this way. If it is not we are doing this."

Associate Professor SCHEMBRI: Correct.

The CHAIR: Is that the sort of phone call it was?

Associate Professor SCHEMBRI: Yes.

The CHAIR: It is not unusual that you would bounce those thoughts off the Chief Health Officer at other times?

Associate Professor SCHEMBRI: Correct.

The CHAIR: There are no further questions; that concludes this section. Thank you very much. The information is much appreciated. At the end of the day this will promote health care for our patients and clients across New South Wales. You may have taken some questions on notice. You will have 21 days to answer those questions on notice. Because of the evidence you have given today you may get some further questions from persons in the inquiry here. We thank you for your time.

(The witnesses withdrew)

STEPHEN COOPER, Radiation Oncologist, Genesis Cancer Care NSW, and Chair, Multi-disciplinary Head and Neck Unit, St Vincent's Hospital, sworn and examined

The CHAIR: Good afternoon. I have a couple of instructions. Please be careful when using individuals' names during the hearing, in order to avoid unnecessary harm to people's reputation. Please ensure that comments are relevant to the terms of reference. I also remind participants to respect the privacy of individual patients. What you say here is covered by parliamentary privilege. What you say outside that door may not be, and you might be caught in an action of defamation. Just be aware of that.

I note that you have an assistant beside you. You can have conversations with him if he is giving you advice, but he will not be giving evidence. I ask him not to answer any of the questions but to feel free to be of assistance to Dr Cooper.

Do you have an opening statement that you would like to make?

Dr COOPER: Not of any great import, except to emphasise that my area of expertise is as a radiation oncologist. I am not a medical oncologist, although I do receive training in medical oncology and clearly work, and have worked for many decades, with a medical oncology team. However, to the fine detail of some of the terms of reference, there would be others better qualified than me to talk to issues around medical oncology.

The CHAIR: When were you made aware that Dr Grygiel's off-protocol dosing was a concern?

Dr COOPER: My recollection is that it was from what you might call a corridor conversation with one of the head and neck care coordinators in the second quarter of 2015. This sort of comment or discussion is an everyday sort of occurrence. It was pointed out to me that for many of his patients, John was using a flat dose of carboplatin. Up until that time I had no idea that that was the case. My initial reaction was not to believe it or disbelieve it but that it warranted clarification, which I went about trying to understand.

The CHAIR: How long did you work with Dr Grygiel and his patients?

Dr COOPER: I first worked with John Grygiel—do not fall off your chairs!—in 1988.

The CHAIR: It was a good year, that.

Dr COOPER: I worked with him for a number of years during my training in Newcastle. I joined St Vincent's Hospital in 1994 as a staff specialist, and he had joined the year before. I worked with John fairly regularly through the next nine years before I took on other roles, and recommenced at St Vincent's in late 2004. I worked with John up until the time of his leaving.

The CHAIR: What is your knowledge of the history of him flat-dosing particular patients?

Dr COOPER: I will answer the question but I would like to say that I have an extremely high regard for Professor Grygiel. I think he has copped a great deal of criticism of his care, some of which is justified, but I know him to be a deeply concerned and caring oncologist, who has always struggled to do the right things by his patients. I have no doubt that what he has done has been, in his belief, the best things for his patients. The characterisation in certain sections of the media of him as a rogue and disgrace is absolutely incorrect. That is not to say that I am defending all aspects of what he has done, but they have been done in error rather than in mischief.

The Hon. TREVOR KHAN: I accept all that Dr Cooper has said but he actually has not answered the question he was asked, and that was what he would know about his flat dosing.

The CHAIR: I guess what I am establishing there is that you had a long time with Dr Grygiel and it is really surprising over a 10-year history that has been found by Professor Currow in his report that that relationship that you would have, given the fact that you are a radiation oncologist, that through holistic care you would not be aware of the dosage of medication. I cannot get it out of my head Dr Gallagher, yourself and other professionals not at least looking over the medicine chart and seeing what history the other doctor or professor is allocating to that patient care. I find it hard that you, working through the treatment of radiation, which is pinpoint accuracy on some occasions, would not be aware of this situation of greater than a year ago, basically.

Dr COOPER: I understand the sentiment of the question but I do not think my not being aware would come as any surprise to anyone practising in oncology. The issue is that as a specialist physician we go through a huge amount of training and there is an expectation in those that are credentialed that they are capable and

doing the right thing to an appropriate level. If Professor Gallagher tells me he has done a neck dissection and let us say it turns out that he was doing something incorrect, is it up to me to be in theatre watching him and examining him and seeing whether or not he is actually doing the neck dissection? If a nuclear physician is not giving the appropriate protocol for their PET scan, is it up to me to be able to detect that they are not doing the right thing?

Professor Grygiel was an appropriately trained, appropriately credentialed medical oncologist with some specialty expertise in head and neck cancer. When he wrote to me saying that he had used a drug that is consistent with the protocol, it is not normal course to specify the doses that he uses—it is just not done—and the expectation is not correct to say that it would be that he would write the dose. I do not go to the charts to see if he is actually giving a dose consistent with standard care. My expectation is that he will be using a schedule that is consistent with best practice.

The CHAIR: I find that really hard to process because, as you know, liver failure, renal failure, all sorts of systems failure can happen with that toxic sort of medication. On top of that, in your position you would have seen the recurrence of head and neck cancers with that type of treatment and it was not resolving them, it was doing quite the contrary, from what I understand.

Dr COOPER: I have spent the afternoon listening to the evidence and listening to the questions and I think there is a gap in understanding what was going on. If we look at the role of medical oncology in head and neck cancer, I hesitate to say it but they are bit players in the grand scheme of things; it is just not the main game. If you carefully read Professor Currow's report he indicates that in the cohort of interest it may have caused a reduction in death of 8 per cent. My own view is that that number is not correct; I think it is closer to 6.5 per cent or less, and the references that are given have not been updated and the update on the meta-analysis suggests that it was 6.5. That cohort—the data series starts in 1965 and the reality is there are many dynamic aspects in our care from diagnosis and treatment and imaging, and it is in a constant state of change on the treatment side. In addition, the patient side is changing. I expect they have alluded to the shift from patients whose disease is mediated from cigarettes and alcohol, which results in a certain outcome, and the development of HPV-mediated head and neck cancer, which is fundamentally a different disease with different outcomes and a much better result.

So you have got multiple variables changing over a period of time. In the entire cohort of some 100 patients over many years, the excess deaths, at worst, will be of the order of five or six because that is the difference if you give no treatment. John's premise was that carboplatin was as good. But let us say it did nothing. Over a five- or six-year period we may pick up five or six excess deaths. Now that is not possible to pick up when the outcomes are random because you cannot pick it up from follow-up.

The Hon. COURTNEY HOUSSOS: You mentioned earlier that you found out in the second quarter of 2015 that there was a potential issue with Dr Grygiel's prescribing. Who did you tell then?

Dr COOPER: I discussed it with Professor Gallagher. Again, just by way of clarification, I think there is a little bit of confusion perhaps on what actually occurs at an MDT. The MDT is fundamentally about providing a construct around the care of patients. The majority of patients are new patients; the other patients will be patients who have had a material change in their condition. It is about carefully assessing and documenting and coming up with a care plan as to what the unit believes is the best way forward. Overwhelmingly, that is what the clinic does. Invariably, when you get that group of involved clinicians together in the one place, other discussions occur at or about the same time and they are part of the multidisciplinary team but not necessarily part of the multidisciplinary meeting. I think part of that goes to this little bit of confusion: Was it the multidisciplinary team or did it occur at the multidisciplinary meeting, when, in fact, some of the discussion occurs in the precinct of the environment where things are being discussed? It would have been in that framework that Richard became aware and some of the senior clinicians became aware, but nobody was getting up and blowing a trumpet saying John Grygiel is giving a certain dose of chemotherapy; it just does not work like that.

The Hon. COURTNEY HOUSSOS: I understand, and I think perhaps some of the recommendations from Professor Currow's report and also some of the other commentary indicated that by increasing the use of MDTs that that would somehow solve this problem from potentially happening again. What we have heard consistently today is that the actual dosage of chemotherapy is not discussed at—

Dr COOPER: It is not discussed at the MDT, and the reason why it is not discussed is that a new patient will come to the clinic, or a patient requiring care, and a program will be plotted out—they need these tests, they need to follow through this thing, we need to organise these things, we will go down this route—and it is likely that they will need these treatments in due course, full stop. Some months later they may get to the

stage of getting their chemotherapy, but we have not attempted to specify a dose predicated on everything that is going to happen over the coming weeks and months.

The Hon. TREVOR KHAN: Because you do not know what is going to happen.

Dr COOPER: We do not know what is going to happen. Essentially, all of these patients are discussed in an MDT. They were all discussed and it did not make a scintilla of difference.

The CHAIR: But the goal of the MDT for sure is to give the best optimal patient outcome. So how can you do that without integrating all your care, treatments and medications? I cannot understand that you set this up so it gives optimal health care and it seems to have broken to a degree that you actually got deaths—an indirect outcome.

Dr COOPER: The last thing I want to appear is to be contradictory or argumentative, but I am fairly certain, if we read Professor Currow's report, he says it is not possible to quantify the outcome. I think that is correct. It is not correct to say that we have got deaths. We do not know that. We may have deaths.

The CHAIR: Let me correct it then. We may have MDTs that contributed to death rather than life?

Dr COOPER: No, it was not the MDT that contributed to the death, if there are any deaths. The issue is not that John gave a dose that is off-protocol. I have sincerely tried to understand what is being said. Are these eviQ guidelines, guidelines, protocols? What is it that people are saying? Are they saying it is okay to give a dose that is different to the guidelines? Yes or no? Everyone says "yes, it is okay to give a dose different to the protocols", which is what John did.

The Hon. TREVOR KHAN: No, he did more than that.

Dr COOPER: Correct, in a systematic way. Our expectation when John said he was going to give a platin-based agent was he would employ those drugs consistent with best standard care. Now it is the same expectation that they have of me when I give radiotherapy that I will give radiotherapy consistent with best standard care. When Professor Gallagher does his surgery that is consistent with best standard care.

The CHAIR: I understand that.

Dr COOPER: We do not sit there saying, "Are you any good?" or "Are you giving the right dose?" We do not specify the type of operational specified dose. There is a level of presumed knowledge and presumed behaviour.

The CHAIR: But that is what the problem was.

The Hon. COURTNEY HOUSSOS: And presumed expertise.

Dr COOPER: And presumed expertise.

The Hon. COURTNEY HOUSSOS: We have very limited time and I have quite a few questions I want to ask. You found out in the second quarter of 2015?

Dr COOPER: Yes.

The Hon. COURTNEY HOUSSOS: You told Professor Gallagher. What was his response when you raised it with him?

Dr COOPER: In the normal course issues come up all the time. Sometimes they have veracity and sometimes they do not. It required some discussion to find out actually what was going on. My reaction was then to go back to John and say, "This is being said, John, what is the case?" John was not universally dosing everybody with 100 milligrams of platin, just about half the patients were getting that dose. He was in his expert opinion making a judgement call that that was the right dose for those patients. Now I am not a medical oncologist. The sin is not to give a dose different to eviQ, but to the extent that there is a sin it is that that dose that is being prescribed is outside of the reasonable bounds of care.

Now that is a highly nuanced question and it goes to the so-called delay of St Vincent's in getting to the bottom of what actually got on. When Professor Gallagher and I decided that there was a question to be answered, that John was agreeing that he was giving large numbers of doses to patients, a fixed dose of carboplatin, we escalated the clinical governance side not because we knew that there was a problem because it was within the bounds of reasonable that John could prescribe a dose different to what was in eviQ.

Mr JEREMY BUCKINGHAM: But it is not supported by the evidence though.

Dr COOPER: Just bear with me.

The Hon. TREVOR KHAN: I want to make an observation. Dr Cooper what seems to be different in your evidence, with respect, from Professor Gallagher's evidence, although I am not being critical, is that you are proceeding on the basis essentially that you knew and communicated that Dr Grygiel was giving a flat dose. It seems to me that the evidence that you and I heard today a matter of half an hour ago was that that knowledge of flat dose came later towards the end of 2015. That does not seem to be what you are communicating to the Committee now.

Dr COOPER: My recollection of events is that we became aware that there may be an issue in June. We confirmed that there was a potential issue. It was raised to the executive of the hospital. The executive of the hospital then undertook an investigation and my own view is that that investigation was not sufficiently robust, rigorous or driven by a clear idea as to what the clinical question was. A considerable period of time was spent trying to identify those patients that were affected, what the numbers were, how many there were and a doctor in administration was going through the records and defining that database.

But the fundamental question was, "Yes". It was clear that some patients were getting a fixed dose of chemotherapy. The problem was, and what was not addressed early enough, was this within the spectrum of reasonable care? That goes to the heart of the matter. The reason why it was not nailed down early by the hospital was, firstly, John was the director of the department so there was nobody above John with clinical expertise that could answer that question, number one. Number two, the sub-specialty expertise in head and neck cancer is somewhat limited. This is not an everyday cancer. It is not breast cancer or bowel cancer. So the number of people who are truly expert who could definitively answer the question—anyone can see he is not giving the same recipe—but is it within the reasonable expectation of care?

I spent a lot of time trying to clarify that question in my own mind because I have a very high regard for John, and John had made a considered judgement that it was. In the course of my investigations I came to the conclusion that it was not within the spectrum of reasonable care.

The Hon. COURTNEY HOUSSOS: After the concerns were raised with you, did you change your treating arrangements? Obviously as a radiation oncologist we understand that you would be treating the patient at the same time as Dr Grygiel. Did you change the way that you treated patients? Did you question them or check in any other way on what was happening?

Dr COOPER: Is the question, did I change the way I was treating my patients?

The Hon. COURTNEY HOUSSOS: Or recommendations that you provided to patients.

Dr COOPER: The answer is I did not change the way I was treating my patients. I understand that John Grygiel—this was my understanding at the time—then modified his behaviour and provided doses in accordance with eviQ from July, that is, shortly after he was being confronted with the concern that there was insufficient evidence to support the strategy that he was using.

The Hon. COURTNEY HOUSSOS: Did you ever recommend that a patient seek a treatment regime different from what Dr Grygiel was recommending his flat dosing of carboplatin?

Dr COOPER: The drug and the dose are entirely the responsibility of the medical oncologist to decide upon.

The Hon. COURTNEY HOUSSOS: So you never provided—

Dr COOPER: If I could finish. So the drug and the dose are entirely the responsibility of the medical oncologists. They take responsibility for what they are doing. In the course of caring for patients, at about the time the concerns about the drug and dose were being raised, I did have cause to say to patients, "Push John on the question of which drug and what dose."

Mr JEREMY BUCKINGHAM: That is the key point, is it not? What emerges from the report of Professor Currow is that the biggest issue for him was not the flat dosing but it was the wrong chemotherapy and that and cisplatin should have been used more frequently and that carboplatin was the third tier option. I am a lay person but why did you not notice when cisplatin or carboplatin are absolutely fundamental to the outcome of radiotherapy? If you have a patient with head and neck cancers and they are being given carboplatin again, is it not just a matter of whether it is the level of care that the doctor may or may not be giving but it is actually the evidence to back up the prescription of that particular medication?

Dr COOPER: The question I think you are asking is, is carboplatin a reasonable choice to use in head and neck cancer?

Mr JEREMY BUCKINGHAM: No, the question is—

The Hon. TREVOR KHAN: I think that is the question you are asking.

Mr JEREMY BUCKINGHAM: Is it a reasonable choice, but is it the best choice? Does the scientific evidence, the medical research back up—

The Hon. TREVOR KHAN: Let him answer.

Dr COOPER: If you look at the eviQ guidelines, carboplatin is there as a reasonable drug to use. Okay, it is there.

The CHAIR: Tailored to the patient?

Dr COOPER: Everything is tailored to the patient.

The CHAIR: Well, flat dosing is not, necessarily.

Dr COOPER: All patients have their treatments tailored to them to try to discern what is the right thing to do. In making those judgements, we interpret evidence, okay.

Mr JEREMY BUCKINGHAM: Yes.

Dr COOPER: The major evidence for the concurrent administration of a platinum schedule comes from the meta-analysis of adjuvant therapies in head and neck cancer. It is referenced in there, eight, nine, 10. It is gives you the number of 8 per cent survival advantage, even though it is only 6½. They group the drugs as platinum agents and others. Within platinum agents they have cisplatin and carboplatin. There are more trials with cisplatin. Therefore, there is more evidence for cisplatin, but there are five trials with carboplatin. The trial referred to in the document that says carboplatin is demonstrably inferior, to my mind, is not sufficiently robust to come to that conclusion. It had 140 patients, it had 40 patients in each arm, and it was not sufficiently powered to say unequivocally that cisplatin is better than carboplatin.

Mr JEREMY BUCKINGHAM: You are saying there is a fundamental flaw in the eviQ protocols?

Dr COOPER: I am not saying it is a fundamental flaw. EviQ gives guidelines and, in giving a guideline, they are going to say, "These are reasonable", and ask to put it down. We would go one, two, three. But three is not unreasonable. It is reasonable. However, on balance, there is more evidence to support one. At the end of the day, the clinicians will interpret that evidence and make a judgement call on the competing cost benefit equation as to which is the right way to go forward.

Mr JEREMY BUCKINGHAM: Do you think the patients might have wanted to be part of that cost benefit analysis, that they may have wanted to err on the side of the one that had, as you say, more evidence?

The CHAIR: The benefit-to-risk ratio?

Dr COOPER: I have to be extremely—clearly what you are saying is correct. All patients want the best decision made for their care, certainly. Most patients do not want to have the burden of trying to work out what is the best thing for their care. Most patients want to be able to choose their clinician, rely on their clinician in whom they have confidence and rely on their judgement that they are doing the right thing by them. They do not say, "Give me the evidence and I will make up my own mind." They rely on the experience and training of the clinician to give them the guidance. When you say should the patients not be able to choose, the evidence suggests that when you sit down opposite me and I tell you you have got cancer, and it is very, very serious, and there is at least a 50 per cent chance you are going to die, your brain then goes to mush. Your ability to make highly discerned judgements on competing risk just is not there. They rely on their clinicians with the training and experience and hopefully the goodwill that they are going to make the right judgement calls for them.

Mr JEREMY BUCKINGHAM: But based on evidence?

Dr COOPER: Based on evidence.

Mr JEREMY BUCKINGHAM: Based on the—

Dr COOPER: And that evidence requires interpretation. I am not here to defend John, but he interpreted that evidence in a way that—

Mr JEREMY BUCKINGHAM: With all due respect—

The Hon. TREVOR KHAN: Let him answer. He is answering very reasonably.

Mr JEREMY BUCKINGHAM: I know. With all due respect, you also brought that evidence into question. You said it was—

Dr COOPER: Correct.

Mr JEREMY BUCKINGHAM: —a small cohort and all the rest.

Dr COOPER: No, choosing cisplatin over carboplatin, that it is unequivocally better.

Mr JEREMY BUCKINGHAM: It is unequivocally better?

Dr COOPER: No, but the quality of the evidence that said it is unequivocally better is not hard; it is reasonable. There is more evidence for cisplatin. It is more active in other diseases. There is one small trial that suggests it is better, but it comes at a cost of more toxicity. It is a more wretched drug and, in a perfect world, you would avoid that and you would go for a less toxic drug. In a situation where the diseases and the treatment paradigms are dynamic, it is possible to say the incremental benefit of going with cis over carbo is not there; it is a judgement call. The problem that John had is that he did not disclose to the MDT that as a matter of course, in a large number of patients, he was flat-dosing or fix-dosing the carboplatin. I think the reason he did not do it is that I think he knows that we would not have supported it, not because the hypothesis is not reasonable, because it is a reasonable hypothesis, but there was insufficient evidence to justify taking it up outside of a clinical trial.

What should have been done is that it should have been prospectively evaluated as a clinical trial. It should have been disclosed to the patients, "We believe this is actually going to be better for you, that you will get the same outcome at lower costs in terms of toxicity", but that was never done, and it should have been done, because the dose was sufficiently different. The drug was the right drug. It was a drug that was well validated. It was the dose that had been changed, and it had been changed for good reasons, but he did not have the evidence to introduce it as standard practice.

The Hon. COURTNEY HOUSSOS: Coming back to that, there seems to be a fundamental problem that there is a lack of clarity around why the dosage was given. You said that it is not your role to be the supervisor, it is not Dr Gallagher's role. Whose role was it to supervise Dr Grygiel, or are patients supposed to trust doctors?

Dr COOPER: To some extent there is a reasonable expectation as an appropriately credentialed and trained specialist, that the treatment that John is giving is reasonable. That is a reasonable expectation from patients and from those who work with him. The point—

The Hon. TREVOR KHAN: As in all professions.

Dr COOPER: The point you make with regard to who should have known, I think, is very valid. I know in my department everybody knows everything about what is going on. The descriptors around how things are defined and specified and done and delivered are extraordinarily tight. There is no way you could give a 5 per cent variance to the best practice, let alone a third of a dose, so I find it surprising that those who worked in the medical oncology department did not have more insight as to what was going on. For me, I do not know how that occurred, but it seems to have occurred. As I say, I am not a medical oncologist. I do not work in that department. I do not work with the nurses, the pharmacists. I do not use their record system. I had no way to monitor what Professor Grygiel was doing. But others must have known what was going on, and people—

The CHAIR: That is a good point, Dr Cooper. Given your bird's eye view of the situation, who should have picked up on it, given the fact, as you say, you rely on the specialist?

Dr COOPER: I find it hard to believe that other clinicians with whom he worked did not have an insight as to what he was doing.

The CHAIR: So do I.

Dr COOPER: But maybe they did not.

The Hon. COURTNEY HOUSSOS: Can you be specific when you say "other clinicians"?

Dr COOPER: He was not the only medical oncologist at St Vincent's. They are all working in the same precinct, with the same staff, with the same nurses and pharmacists, and doing so over many years.

The Hon. COURTNEY HOUSSOS: Can I go back a step. We received evidence earlier he was one of the few, if not the only head and neck medical oncologist.

Dr COOPER: Yes.

The Hon. COURTNEY HOUSSOS: You are saying other medical oncologists within other specialties—

The Hon. TREVOR KHAN: Sub-specialties.

Dr COOPER: Sub-specialties. Yes, because they share registrars, they share pharmacists who are also servicing their patients, they share the nurses. The use of a fixed dose of carboplatin, to me, would have been sufficiently atypical to raise questions, as it did for me, and I am not a medical oncologist. Perhaps they did not, but I find it hard to believe.

The CHAIR: On my understanding of Dr Grygiel's specialties, his was not just oncology; previously, he was pharmaceutical.

Dr COOPER: Correct.

The CHAIR: I guess that would, once again, just put a little thing there—he knows what he is doing.

Dr COOPER: There is no doubt that the issues were raised with John at different times and he confidently states that he believes that it is the best dose, as I am sure he will tell you tomorrow, because I know that he believes that. It is a premise that might be right. It is just that, as of 2016—

The Hon. TREVOR KHAN: It is hard to prove it.

Dr COOPER: —there is not sufficient evidence to roll it out as standard practice.

Mr JEREMY BUCKINGHAM: Is it true to say that there is no evidence because that was what was put in the Currow report—that Dr Grygiel was unable to point to any research.

Dr COOPER: I think it was slightly more nuanced than that. There is evidence that carboplatin is active in head and neck cancer, so the question is the dose. The report continually refers to carboplatin as a radiation sensitising agent. From my own perspective, I have always considered it as more than simply a radiation sensitising agent. I considered it as a cytotoxic agent in its own right, so it conferred some benefit in killing tumour cells over and above anything from the radiotherapy. It was not just relying on the radiation. In addition, it had a component of what we would call geographical cooperation in so far as radiation and surgery treat a field whereas chemotherapy is going throughout the body, so there is a concept of geographical cooperation in sterilising micro-metastatic disease.

If you believe that the major utility of platinum agents in adjuvant therapy is as a radiation sensitiser, then the question of dose is less germane because you are not looking for a systemic cytotoxic effect whereas in other diseases we know dose density is important. If the fundamental mechanism of action is the radiation sensitiser, then it may well be that a dose of 100 milligrams is sufficient to sensitise the radiotherapy when the radiation is the major agent of cell killing. My initial concerns were not from a failure to obtain infield control but in systemic control—that we were seeing patients relapse outside of the target volume in their lungs and liver, et cetera. Radiotherapy was never going to contribute to control of disease outside of the target volume. We were relying on the drugs. If drug density is important, then it is arguable that 100 milligrams was insufficient.

As I have delved deeper and deeper into this and read more articles and counselled with more people in this area, I am of a view that the contribution in systemic control from these platinum agents is small—perhaps 1 or 2 per cent—and that the major effects are in improving local control. So it is possible that that dose is sufficient, but we just do not know.

The Hon. COURTNEY HOUSSOS: Can I just ask you this? You just said then that you delved into this area quite extensively. You read and read articles and consulted other people.

Dr COOPER: Yes.

The Hon. COURTNEY HOUSSOS: Do you feel that, given this is outside your area of expertise, there actually should have been more people within the hospital who had done that?

Dr COOPER: I think that the hospital has conceded on multiple occasions that the rigour with which this issue was investigated was insufficient. A major component of that was a failure to get expert external advice in sooner that could say yes, there was an issue, or no, there was not. As I have said, anybody can see, yes, he has given you a dose lower than eviQ. So what? It is: Is the dose that has been given reasonable, or could it be construed to be within the spectrum of reasonable care? To answer that question, they required much earlier genuine subspecialty expertise input into the question, which they did not get. I think in retrospect they would have gotten it. By the time it was sought, it was initially slow to come back and it took some time before the true nature of the problem became apparent.

The CHAIR: In concluding, I just want to say couple of things. Thank you for your evidence, which has been ever so helpful. We had a presentation this morning. I think that evened out the difficulties of treating people by putting poison in their blood system, not knowing an outcome until you put that first dose in, so we

do appreciate all the treatments that the doctors, professors and nurses in the cancer community must embrace. It is a tough gig. From the point of view of the inquiry, we are trying to get good processes—right things, right way, right order—and I guess at the end of the day, specialists are ministering to people who are at their most vulnerable. You mentioned your world falls apart when you hear that you have got cancer.

Even more so, this inquiry is about setting up the circumstances in which even the experts can be questioned to ensure that optimal health care is achieved for people at their most critical moment. That is what this inquiry is about. I thank you for your presentation. In the light of the evidence that you have given us this afternoon, some members may put questions on notice. You have 21 days in which to answer those. Thank you so much for what you do. We wish you well.

Dr COOPER: Thank you very much. I appreciate very much the opportunity to speak.

(The witness withdrew)

The Committee adjourned at 17.16.