REPORT OF PROCEEDINGS BEFORE

GENERAL PURPOSE STANDING COMMITTEE No. 2

INQUIRY INTO COMPLAINTS HANDLING WITHIN NSW HEALTH

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At Sydney on Friday 30 April 2004

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The Committee met at 9.30 a.m.

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PRESENT

The Hon. Patricia Forsythe (Deputy Chair)

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

DEPUTY CHAIR: Welcome to the seventh, and what may be the final, public hearing of the General Purpose Standing Committee No. 2 inquiry into the complaint handling procedures within NSW Health. I pass on the apologies of the Chair of the Committee, Reverend the Hon. Dr Gordon Moyes, who is unable to attend today's hearing due to illness. My name is Patricia Forsythe and I am the Deputy Chair of the Committee. Before we commence, I will make some comments about aspects of the Committee's inquiry.

This inquiry will raise, and has raised, difficult issues for many participants; the relatives and friends of people who have experienced an adverse event in the health system, health workers who have sought to draw attention to poor practices as well as practitioners and managers whose abilities and professionalism have been challenged. I therefore ask that the media and any other persons in the audience demonstrate sensitivity in any approach made to witnesses during this inquiry, particularly immediately after the giving of evidence. The inquiry's terms of reference require the Committee to examine the system for handling complaints in NSW Health and whether the health system in New South Wales encourages people to reflect on errors. People's individual experiences of this system will help the Committee understand how the complaint handling system works or does not work. I ask everyone who is interacting with the Committee to reflect on the terms of reference and to assist the Committee to use these difficult experiences to improve the health system.

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

While parliamentary privilege applies to these proceedings, the privilege extends only to what people say while they are a witness during the hearings. The privilege does not extend to any further comments that witnesses may make once they complete their evidence and leave the witness table, even if these comments repeat what has already been said as a witness. The Committee cannot protect witnesses from actions taken against them in relation to comments made outside the hearing. I ask that witnesses be mindful of the ethical and legal implications of disclosing personal information about patients. Health practitioners and managers should only discuss personal information about a client or a patient if they are specific to the terms of reference and that person has authorised them to do so. I also ask my fellow Committee members to consider the ethical duties owed by practitioners to patients when pursuing lines of questions. It is likely that some of the matters raised during the hearings may be the subject of legal proceedings elsewhere, such as in the Industrial Relations Commission, a disciplinary tribunal or the special inquiry being conducted by Bret Walker.

The sub judice convention requires the Committee to consider the impact of discussing a matter that is being considered by a court of law. The weight of opinion supports the view that a parliamentary committee may discuss a matter that is being considered by another inquiry. This would include investigations undertaken by the Independent Commission Against Corruption [ICAC]. Nevertheless I remind people today that this inquiry is about systemic issues and not the culpability or otherwise of particular individuals. If people have concerns about any of these issues, they should raise them at any time with the Committee and we will consider those concerns.

The Committee previously resolved to authorise the media to broadcast sound and video excerpts of its public proceedings. Copies of guidelines covering broadcast of the proceedings are available from the table by the door. In accordance with the Legislative Council's guidelines for the broadcast of proceedings, a member of the Committee and witnesses may be filmed or recorded. People in the public calorie should not be the primary focus of any filming or photographs. In reporting the proceedings of this Committee, the media must take responsibility for what they publish or the interpretation that is placed on anything that is said before the Committee. Witnesses, members and their staff are advised that any messages should be delivered through the attendants or Committee clerks. I advise that under the standing orders of the Legislator Council, evidence given before the Committee and any documents presented to the Committee that have not yet been tabled in Parliament may not, except with the permission of the Committee, be disclosed or published by any member of such Committee or by any other persons. Before we commence I ask anybody who has a mobile phone to turn it

off. It is not sufficient for it to be just put in silent mode. I now turn to our first witnesses and welcome Professor Stewart Dunn and Associate Professor John Cartmill.

STEWART MAXWELL DUNN, Professor of Psychological Medicine, Department of Psychological Medicine, and Director of Erromed, University of Sydney, NSW 2006, and

JOHN ANDREW CARTMILL, Associate Professor, Department of Surgery and Director of Erromed, University of Sydney, sworn and examined:

DEPUTY CHAIR: In what capacity are you appearing before the Committee—as a private individual or as a representative of an organisational business?

Professor DUNN: As a representative of an organisation.

DEPUTY CHAIR: Do you wish to make a brief opening statement?

Professor DUNN: May I make my statement after Professor Cartmill?

DEPUTY CHAIR: Sure. Professor Cartmill, in what capacity are you appearing before the Committee—as a private individual or as a representative of an organisation or a business?

Associate Professor CARTMILL: Can I be here as more than one, as an individual and as a representative of an organisation, because I am?

DEPUTY CHAIR: Yes. That is acceptable. Do you wish to make a brief opening statement prior to questioning?

Associate Professor CARTMILL: I do. I have prepared a statement, but it is too long to read and I will table that. The guts of it are that intelligent, highly motivated, will-intentioned health care workers are harming patients. That is really hard for people to understand and it is even harder for them to come to terms with, but in medicine we are coming to terms with this—actively coming to terms with it—and doing something about it, doing a lot about it. A lot has been done and it is improving. We have root cause analyses, we have the Institute of Clinical Excellence [ICE], we have the Safety and Quality Council disclosure guidelines, safety officers as well as some of the work that we have done. NSW Health at the moment is a real live learning culture and it is a very exciting place to be.

We are bringing error management techniques from other industries and believe it or not we are applying them so effectively to medicine that some of these techniques are being exported from medicine back into these industries. You would not know any of this to read the papers, and I guess it has not been explained clearly enough. I sound optimistic. It is hard to be optimistic with the cameras on me, and I am very nervous. But I am optimistic because the solution is already there. It is listed in the NSW Health brief that they have tabled and which I have read, which is a good read. We are working on it. It is working, but it is terribly fragile and it is very cautious at the moment. I have drawn it up on the board as an innovation deffusion curve, if you like. That leading edge is a very delicate thing. It is like the probing edge of an amoeba and it is just waiting to see if it is going to get—and this is a mixed metaphor—its head bitten off. The current atmosphere that we are dealing with and that I am experiencing now—and have experienced already this morning—is one of shame, of blame, of abuse. It feels like harassment, not of me personally but harassment of the entire health service, a health service which is a living, breathing organism, if you like, and it is being hounded and harassed, but not by the Committee—by the politicians out there, by the media out there, with exceptions of course to the people in the room.

But that attitude is making it almost impossible for us to do our best. The solution is so close, I can see it. I get quite worked up about this. We need changes in the culture that only you can help us make happen. We need political nerve, lateral thinking, and I mean all of this at the highest levels of policy. We have done a lot of hard work and we have gone just about as far as we can without some serious help from those of you with goodwill and good intention.

DEPUTY CHAIR: Professor Dunn, do you wish to make an opening statement?

Professor DUNN: Yes, I do. Thank you for the opportunity to speak to this inquiry. I have been working with John Cartmill for many years. As a psychologist, I find it quite interesting to stand on the

periphery of the medical profession and observe the way they work and to interact with them. I believe that this inquiry is taking part in a broader context of cultural change in the Australian culture. At the moment we are dissecting all the relationships based on trust in authority. That is happening in the clergy, in education, with politicians, journalists, sports coaches, business leaders and now health professionals. I think trust is critical in health care because people who enter the health care system are vulnerable and frightened. They need to delegate autonomy for their care to others to make decisions and to take actions of their behalf. Therefore that trust is part of the contract between the patient and the professional.

When you look at the definition of "trust" in the dictionary, it talks about a firm belief in the honesty, veracity, justice and strength of a person and a confident expectation that they will be behave with your best interests in mind. The dictionary definition of trust makes no mention of error-free or absence of mistakes.

The cornerstones of a healthy complaints handling system are trust, accountability and compensation, and all three deserve equal weight. They are actually enshrined in the Health Care Complaints Commission process, which includes conciliation, which could be seen to be rebuilding, maintaining or establishing trust between a damaged patient and the professional. That conciliation is privileged but not mandatory, and I think that is a problem that needs to be addressed. Most of our legal and medical defence processes seem designed to specifically prohibit meetings between patients who have been injured and the professionals who may have contributed to that injury, and I think it is essential to the restoration of trust that all mechanisms find ways of bringing patients and professionals together when there has been harm to a patient.

I will conclude my opening statement by reading briefly from a transcript of a statement by the mother of a child who died as a result of an adverse event in another State. I know this case because it is on the open disclosure educational CD-ROM which is produced by the Australian Council for Safety and Quality in Health Care. I videotaped the mother talking about this event. An 18-month-old child was given an accidental overdose of an anticonvulsant by an inexperienced team in an emergency department. The child arrested and died despite 30 minutes attempted resuscitation, from which the parents were excluded. The hospital management expressly prohibited staff from approaching the parents. This is a brief extract from the statement by the child's mother. She is talking about the Coroner's Court 10 months later:

> We later found out that the doctor wanted to be the one to tell us. He wanted to tell us then and there but the hospital protocol did not allow it. I had to wait 10 months to hear, "I'm sorry".

She goes on to talk about the nurse involved:

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

DEPUTY CHAIR: Associate Professor Cartmill, you referred to "we in medicine are doing something about it", finding out about errors and about dealing with the issue of errors. It seems from what we have heard in the Committee inquiry so far—in fact, we have been told—that nurses are far more likely to report errors or adverse events than doctors. Do you agree with that? If so, why do you think that may be so? What can be done to increase reporting by doctors?

Associate Professor CARTMILL: You may have to remind me of bits and pieces of that. I think that nurses are better at reporting incidents than doctors. Just mechanically, the way they get through the day lends itself to incident reporting much better. There are handovers every shift and incident reports are available to be filled out. At the nursing level, it is a protocol-driven activity and it is done well by nurses. That is not to say that it is not done by doctors but it happens—no, I am getting myself a little bit confused. What can be done—

DEPUTY CHAIR: What can be done to increase reporting by doctors?

Associate Professor CARTMILL: We already do a lot of reporting. I think part of the problem is that it is not always transparent reporting. As a memory prompt here, and it is part of the statement that I will give you, it happens at different levels. I guess, at its most objective, it is the audit of performance, so it is the

surgical audit. Every infection that I have gets audited and it is a tick on the box every time I fail to complete a procedure satisfactorily. In my case, for example, that would be a colonoscopy. If I do not get all the way around, that gets reported. There is no getting away from that factual stuff.

I also attend mortality and morbidity meetings where every adverse event and death is reported. In our hospital those are beginning to be but they are not entirely multidisciplinary meetings. They were on the verge of becoming multidisciplinary meetings and this thing all blew up. I guess I am getting a little bit off the topic but without apology. This afternoon I will be going back to work and an important meeting is the future of our mortality and morbidity meetings and how we will manage particularly the multidisciplinary ones. Those are the ones that have the advantage of doctors being present, nurses being present, ancillary staff being present.

In my ideal world—and this is a little bit out there, almost lunatic fringe, so do not take it too seriously—I think that the patients should be involved in those meetings as well. I have gone off on a tangent again. The point is that I am going to be going to that meeting. If any of you are free—no kidding, I am quite serious—you could come at four o'clock this afternoon to Nepean Hospital. You would see what is troubling our hospital at the moment in relation to this sort of activity and you would get a much better idea of it than you will by talking to me in this very artificial situation. Not just mortality and morbidity meetings; we have clinical pathological meetings. It all happens.

I agree that it is not transparent enough. In the past I think people have not really wanted to know. I have been a surgeon for 10 years. People have not really wanted to know in the past. Certainly, the managers have not wanted to know. That has changed. I am very comfortable discussing these incidents with my managers. I will spontaneously dictate a letter in the middle of the night if there has been a problem. I will write one to my general manager or CEO and say, "Just letting you know …" If it is daylight hours I will ring them up and when they are available I tell them what is happening. I do not know if everybody does that. I know that everybody does not but I am part of that thin line there. The others are watching cautiously in the background. They are the bulk of that innovation diffusion curve: what will happen to that crazy bastard? Is this really going to work or is it not?

DEPUTY CHAIR: Do these multidisciplinary meetings involve as well the hospital's public relations officials?

Associate Professor CARTMILL: No.

DEPUTY CHAIR: Is there ever—

Associate Professor CARTMILL: A mortality and morbidity meeting with a public relations official?

DEPUTY CHAIR: Yes. If we are going to deal with a particular event, how does the message get through so that the hospital has the information about the case?

Associate Professor CARTMILL: I am just talking about run of the mill, day to day. Mistakes happen every minute of the day in hospitals and we are mostly able to manage those, to catch them before they become too much of a problem, to do something about them. It is the same as you guys driving to work . If you veer a little into one lane you correct itself. If there is a disaster then there is a well-rehearsed and often used policy of bringing that to the attention of the general manager or the CEO. In our hospital we have a privileged committee that is privileged precisely so that we can talk frankly and openly about what has happened. I have never had a public relations person present at one of those meetings, although—no, I will not pursue that.

DEPUTY CHAIR: You were a member of the systems review panel convened by the HCCC to investigate the systems issues raised by the complaint against Macarthur health service. Could you discuss your role on the panel and any of the panel's findings that could be extrapolated to other health services across the State?

Associate Professor CARTMILL: This is not a cop-out but it is important for me to say that I actually prepared that report for the former health care complaints commissioner. I am sure that you would have that available to you. If you do not, or if it is not easy for you to get it, I would be very happy to speak to the current commissioner and make sure that it is okay for you to have it. I think the one sentence answer to that was that I was impressed by all that Macarthur health had done to ameliorate the events that had led to the inquiry. They

had really done a heck of a lot of work and they have done more since. I was there over a year ago. This has sort of been happening in waves, the Macarthur thing. I was part of the second wave, I think. The meltdown will probably happen as part of the third or fourth wave. So it happened a long time ago that I was there. I know they have done a lot since, all of it against this currant of shame, blame and harassment, which must be making it almost impossible. I do not know how they managed to turn up at work there, the way they appear to be being treated. This afternoon you can ask Brad Frankum what allows him to go to work.

Professor DUNN: Am I allowed to come back to a previous question?

DEPUTY CHAIR: Yes, sure.

Professor DUNN: The first question you asked was about why doctors are not complaining with the same frequency as nurses and John has answered that from one perspective . I think the other perspective is that I do not think this is anything mysterious about the medical profession; I think it is something about human nature. I am very good at giving my children corrective instructions when they are very young; now that they are teenagers they do not listen to me because it is challenging their competence and their authority. I think in the medical profession, in any profession, we are not good at giving feedback to people when we can see something that can be done more effectively.

A simple example: as a psychologist I was called to see a patient of mine. This lady has had a long and tragic history with a cancer and she went for a procedure. The procedure was very brutally handled—not mismanaged, no negligence but just very brutally handled for a patient who was extraordinarily vulnerable. I went up to see her because she had developed a full-blown panic attack. When I talked to doctors involved, they said, "We know about this person. She's always like that". So I talked to the patient and encouraged her to write down exactly what had happened and to file a formal complaint in the hope that it would go to the doctor and he would have a chance to reconsider the way he communicates with patients. As always, the patient did not want to sit down with the doctor and I suggested that I would be happy to mediate that. She did not wish to do that.

What struck me was that doctors were aware that there was very poor communication by this particular individual but had no way of feeding that back. That is part of human nature; we do not have good ways of feeding back to each other that there is a better way of doing this. We can do it down the chain, when the person below us has a lower authority position; we cannot do it very well up the chain and we find it incredibly difficult to do it to somebody at the same level. I think it is a characteristic of human nature. I do not think this is unique to the medical profession.

The Hon. AMANDA FAZIO: Can I just ask you a question following on from that? We heard yesterday that one of the factors that could inhibit doctors reporting errors was the simple fact that doctors are held financially liable for any errors that they make, whereas people do not tend to sue nurses; they sue doctors. Yesterday we heard that that was a contributing factor in why nurses felt more freely able to report errors and yet doctors tended not to. Do you think that is a valid comment?

Professor DUNN: I have reflected on this as a psychologist and not a doctor. When a lawyer or the medical defence system says, "You may not talk to the patient. If you do we will not support you", then a doctor is looking at: do they talk to the patient because they want to heal the breach of trust and risk losing their home, or do they concede to the medical defence union. I think there are a number of impediments that prevent doctors talking to patients. I think the problem that John alluded to is that there are many reporting mechanisms for doctors but patients never find out about that. The interpretation of all the literature about what patients want when things go wrong is, "Please tell us what is happening?"

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Do you think tort law is an impediment to this? Certainly, as a practising doctor I always had visions of what I had written being cross-examined by a QC and it still gives me nightmares 20 years later. Do you think that that adversarial system is absolutely critical in the covering up of behaviours?

Professor DUNN: I will answer this first and then maybe John. Yes, I think it is a serious impediment. There are other countries and other States, which have used different mechanisms other than tort law. We have mechanisms in New South Wales—the Health Care Complaints Commission has that conciliation pathway, which is available to doctors and patients, to any professional and patient, but it is not mandatory for doctors to go, so if a doctor does not want to actually heal the breach with a patient, that is a privileged meeting—

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Sure, but the reason we are having this inquiry really is because the pressures on the system to not address its problems reached a point where a number of people became whistleblowers and blew the lid off it, and we are part of the response to that explosion, if you want put it that way. One would have to say that a tort lawyer defending the tort system would say that these existing mechanisms had not worked, would they not?

Professor DUNN: They probably would and my answer to that would be that that component of the Health Care Complaints Commission, if a patient wants conciliation, that it should be mandatory for the professional. It should not be an option.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: I have studied all this management and error theory and I think it is very good, but if at the end of the day anything that you discover or admit is then used to beat you around the head, that surely must have a bearing on these things and, as you say, the amoeba is at great risk if there is this sanction in the end. Do you have any comments on that? Perhaps Dr Cartmill might comments on that?

Associate Professor CARTMILL: I would love to comment about all this stuff. The mistake is best analysed quickly while it is still fresh in everybody's mind, not just the events but everything else that is happening around it. A more concrete, immediate example is that down the track people will read the transcript of this evidence and all they will see is the single written line. They will not smell the fear, they will not see the cameras, they will have forgotten what is on the front page of the newspapers this morning. All that context that actually influences my performance today and what I say is lost, it is gone—and the same with medical error that is looked at using the legal system. It happens two or three years down the track. There is one medical record; the medical records of the other 30 people who were in casualty that night, their families, the hopes, aspirations, fears, missed periods of the staff, everything that affects performance—all the parts of the error chain that led up to whatever went wrong in that medical record are all gone.

What that means is that the personal failings of the individual who was on the spot, if you have read the literature, who made the active error—you really have to exaggerate just what a hopeless physician they were to have cocked it up to that extent. How could they have possibly made that mistake? Whereas you and I know that they are smart, they were certainly well-intentioned, they were certainly highly motivated or they would not have been there at three o'clock in the morning; all of the things that led them to be in that position are all missing. So if the patient and family really want to know what happened and why it happened, the legal system is not the way of finding it out.

The way of finding it out is to analyse it then and there. This is the system that is now well established in New South Wales Health. It is called root cause analysis. It is fantastic. What it means is that all of those other events, all of the parts of the error chain, are taken and noted. In a sense, we are looking at the system there. The system is missing from those two- or three-year-down-the-track analyses and the reason I know is because I have been sued. Part of that process—I have always been interested in this stuff, so that when I was sued I was able to say, "Whoa, here is an example of an associative activation error. There was a little bit of task saturation here; I had made a false hypothesis there".

I explained all this to my barrister, who was a sensitive, terrific fellow—also the son of a cardiothoracic surgeon, so we had a bit in common. I explained all this to him—the entire explanation for how I had come to injure this patient and he said, "Look, that is all really interesting but the law has no interest in that." They regard it as an excuse. It was an explanation. It was what had happened and why and yet it was seen as an excuse, as being irrelevant, and in fact it is everything. And if you do not look at that stuff closely—and you cannot look at it closely if it is two or three years down the track—you are not going to be able to fix it.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: I do not dispute what you are saying because I have actually got a masters in safety management so I understand what you are saying—the Piper Alpha disaster—

Associate Professor CARTMILL: Wonderful, herald of free enterprise.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Yes, but the fact is that at the moment people are telling us that tort law does put a sword of Damocles over everybody's head in a non-specific fashion—and

that is very important and we are here largely because the existing mechanisms did not work. My experience when I was in the health system is that you do not ask your boss too embarrassing questions or you will not have a career in medicine, and here I am in politics.

Associate Professor CARTMILL: I think there is a way of asking questions and you are going to do more good in politics.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: That is my opinion. I am sure Walker is also dealing with this question, and he will deal with it from the perspective of a tort lawyer, initially at least. The question is: Can we get a credible system that will not require tort law? People have spoken to me from within the health system to say that at the moment they are informing their bosses but people are spending up to 50 per cent of the time writing analyses of past events and they say they cannot do the work to stop future events because they are effectively passing stuff upwards, which is almost a backside covering exercise for those above them—at least that is how it is often perceived.

Associate Professor CARTMILL: Everything you say is true. Having been in the experience, only the very odd one will end up in court, but when it does, it is all consuming. You are saying that 50 per cent of the time might be spent doing incident analyses. That is better than 100 per cent of the time preparing for a court case—six months of lost sleep, impotence, absolute misery. I stopped teaching because I was unable to. My colleagues supported me. I was devastated. This patient's family, to this day, continues to see me for their health care needs.

If we take the opportunity to look at those incidents at the time that they happen, yes, it is time consuming and disclosing it to the patient is time consuming, but it is not nearly as time consuming as going through the pointless exercise of doing it in front of a judge and a couple of lawyers that do not have the faintest bloody idea what happened and are not interested. They are only interested—I should not say that, but you can see that I have got an opinion about it.

Professor DUNN: In the case John was just citing, it is amazing that whilst the patient was suing, in order to get the compensation they deserved, they were still seeing him because the trust was still there. So we have two parallel processes; the trust remains, the patient still feels that the doctor is the right doctor to go to, but the only way they can access compensation for an error is through the tort law. What strikes me as just bizarre is the fact that there is so much evidence from studies all around the world showing that patients have three things—it is basically EAR: explanation, apology, reassurance—"I want to know what happened; I want to know how you felt about it; I want an apology and I want reassurance that something is going to be changed". If they would get that, they are less likely to resort to the courts.

Unfortunately, in Australia the only way a person can get the compensation they are entitled to is through the courts. The other thing I wanted to say is that it strikes me as bizarre that you have a contract between a doctor and a patient, a nurse and a patient or a psychologist and a patient, which stops the moment a mistake occurs, and that is crazy. What John does and what you see in doctors who actually practise preventive, informed consent—you can practise informed consent by saying, "I need to explain these risks to you to cover my arse. If I don't tell you these things I will be sued". Or you can say, "I need to tell you these risks so that together you and I, as a team, can minimise the possibility of these things happening." And what he does when he consents a patient for the surgery is draw a diagram and tell the patient, "This is a point where this nerve runs. People have cut this nerve. If this nerve is cut you could be impotent, so I need to be very careful around that point. In telling you now it is reminding me to be very careful when I dissect through there. If I make a mistake, then you and I would need to sit down and talk about how we are going to manage that." It is actually treating consent and informed consent as patient and professional working together as a team, but we have to find, I agree with you, some way of getting past this barrier, which is in all doctors I have talked to, that if they give a clear and honest explanation to the patient, the patient will sue them, with all implications that that has.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: And the knowledge they have given them?

Professor DUNN: Yes. The HCCC actually allows that space. The conciliation process is privileged information. It is the patient and professional sitting down and talking about what happened to try and rebuild the trust.

The Hon. ROBYN PARKER: Professor Cartmill, you talked before about Macquarie Health and you do not know how people turn up for work there each day. There are some people who are not able to turn up for work each day. Because of their bravery we are in the position we are in, because they did alert people to deficiencies. Do you think that there is a culture of learning and an environment now in Macquarie Health that allows people to handle complaints efficiently and without blame?

Associate Professor CARTMILL: You are asking me about Macquarie Health?

The Hon. ROBYN PARKER: Yes.

Associate Professor CARTMILL: I do not know.

The Hon. ROBYN PARKER: Macarthur Health. Were you not involved with Macarthur Health?

Associate Professor CARTMILL: Yes, but that was over a year ago. You are asking me what their culture is now. I do not know.

The Hon. ROBYN PARKER: What is your comment on how we treat people who do come forward with complaints?

Associate Professor CARTMILL: That is a complex question. Who is "we"? People who blow the whistle—and I am not an expert on this—often have a pretty bad time doing it. They have usually had a pretty bad time coming up to the point at which they blow the whistle. Perhaps I can explain it by giving a story, almost a story. Modern medicine is complex and we are able to achieve that only by forming teams. Madam Chair, I am sorry, my hearing is not good and I find any peripheral conversations impact on my concentration. It is a performance-shaping factor that I have. But I am aware of it, and I am mitigating it, and I am not afraid to call it and tell people to be quiet.

We form a team, and a team functions only in so far as it freely exchanges information. Stewart was talking about how I like to form a team before a big operation. If it is a big cancer operation I will insist on family members there as well. We all work together as a team, and I say to people, "If you notice something is wrong with your dad, you can tell us. And if no-one will listen, ring me at home." It is all very easy to share information and slap one another on the back when things are going well; when things start going bad, it is very difficult to share information. In the past, instead of having one team when there is a mishap, particularly an unexpected one, a barrier goes up. Suddenly there are two teams, and two teams compete with one another.

I return now to the whistleblower. What if a member of the team has information? We play games at the courses we attend, and in one game we put on headbands. I was a member of a team that had something to offer, I wanted to tell them something, I wanted to give the team feedback to help them do the job. I imagine in the future I will become a whistleblower; perhaps that is what is going through my mind, because I have not been one. In the game, I wanted to get this information across, and every time I tried to get my message across—I did not know that I had a label on my headband that meant they were not going to listen to me—and when I tried to say something it was not heard.

I am sorry, but the people behind me really need to be quiet. They are throwing me off. What I am trying to do is really hard.

DEPUTY CHAIR: I ask everyone to remain quiet, please.

Associate Professor CARTMILL: In the game, I have information that I am trying to get across, but I am not being listened to. Finally, it gets so frustrating that I am no longer a member of that team. If I was, and if they would listen to me, I would not need to be a whistleblower, and there would not be a problem. That is generic, that is how I understand the concept of whistleblowing.

Professor DUNN: I have a view on that which comes from a teaching session we did with third year medical students at Sydney university where we are trying to inculcate the notion that when you see something wrong, bring it to the attention of people. The students fed back to us that in some teaching sessions they had been exposed to behaviour that they though was improper, unprofessional. And what should they do about it? When we examined it, it was clear that when they take that information to the appropriate reporting authorities,

somebody in the Faculty of Medicine for example, there were no guidelines for what they person in senior management did with the information. I think the onus keeps coming back to the person who first raised the issue. Maybe one thing we need to work to in system improvement is finding ways to take the burden of responsibility, once that event has been identified, away from the person who is the whistleblower. They should not be carrying the can for it.

The Hon. CHRISTINE ROBERTSON: Madam Chair, we have only 10 minutes left, and I have not asked a question.

DEPUTY CHAIR: All Committee members will be given an opportunity to ask questions. I will allow Hon. Robyn Parker to finish her series of questions.

The Hon. ROBYN PARKER: Professor Dunn, you talked about third year medicine and training. The Committee heard evidence that there is a lack of training in root cause analysis, complaints handling and communication with the medical profession. Do you have any comments on that?

Professor DUNN: I agree with it. There are now three sessions in the first two years. If you go back three years there were not. As John said, it is the beginning of the creeping curve, it is starting to come in but it is nowhere near adequate.

Associate Professor CARTMILL: Could I answer the education question? I am passionate about that. It is taught in medical schools and hospitals. The medical protection organisations teach that material and the Committee knows that we do, Erromed does. I have always been bowled over by the sincerity of the participants, they are hungry for an understanding of error, an understanding of root cause analysis. We are working on understanding it, but I would really like to see that your level of the system understand it as well, politicians in particular, and the media. They do not have to report it, but they need to understand it. That is one of the things that is making what we do in medicine possible, and we do some amazing things.

We would enthusiastically take up the challenge, if any of you wanted to come to a course. We would love to have you and you would be amazed at what you would learn and what you could apply to your day-to-day work.

The Hon. CHRISTINE ROBERTSON: The Committee has heard evidence about issues with communication. The Committee has heard a considerable amount of evidence about the difficulties with medical practitioners participating in both the quality processes and the open communication processes, fully recognising the extraordinary examples of the opposite. You have given two concrete suggestions today; one in relation to education and the other in relation to the possible introduction of obligatory conciliation, if the patient requests it through the HCCC. From your experience and training do you have any other ideas in relation to communication improvement within the health sector?

Associate Professor CARTMILL: The group Erromed, which we formed, includes surgeons and anaesthetists, myself, a psychologist, and people from aviation. It is the front end of the curve, it is about culture change. We do not have the wherewithal and organisations like ICE, the quality improvement branch of NSW Health, are trying to find ways to implement that. Still, there are huge chunks of NSW Health that have not been exposed to rethinking the whole process of how to deal with harm to a patient or a complaint from a patient. First, we need to find ways of getting some glimmerings of the culture change, and then some substantial infrastructure to support that. That may be the two that the Hon. Christine Robertson has already extracted.

The Hon. CHRISTINE ROBERTSON: There have been examples of exemplars within the area, although I cannot think of the correct expression. Obviously you are becoming that within the utilisation of quality. I come from this background, and I know that means you may well be the only medical practitioner on your quality organisation that is multidisciplinary at the moment.

Associate Professor CARTMILL: I am not, and I will not give the name of the hospital at which I work. The Committee members know where I work. We have been doing this a little bit longer, possibly partly because of my particular interest in it, but it is not me alone. Initially there was a core of us. We have been running courses in our area health service. There is a wonderful awareness of it. I guess we are that little bit further along that curve, so there is just that much more of the organisation that is comfortable with this stuff. No, I am not the only one. It has a peculiar effect, this is a learning experience for me. I start off thinking that it

is just me, and I used to give talks. I gave a talk going around my training hospital when I was just a registrar. I called it "Surgical Error". You can imagine how everyone in the audience sat through that.

I gave the same talk to the physicians and called it "Medical Error", and it was exactly the same. Years afterwards, when I got into adult education techniques, I realised that the trick was that I had to stop challenging people. So I called it "Human Error" and they all came along with their eyes wide open. We would talk about famous disasters, the Piper Alpha, the *Herald of Free Enterprise*, Teneriffe, Ketchikan, Mount Erebus, and others. There is a wonderful, rich area of literature. The people who came to the courses, doctors and nurses, listened with their mouths wide open, and the message went in. At the end they would say, "You know this happens in medicine and nursing too?" The adult learning technique is called “linking”. I used to think that I was the only person who could teach this, but through Erromed, particularly in Queensland, we have started.

We have a program there which goes right across the State, in which we have trained people. There will always be a few people who particularly get the bug, although everybody can take away a positive message. But some are so enthused about this. Human factors engage those of us who work with people. We are sensitive people, and it engages that side of them. We take the people who are particularly enthused by it and teach them how to give the course. Now, in Queensland, today while we are talking, probably there are two or three human factors courses running that Stewart and I helped to two or three years ago. Hey, and we are nowhere near it! It is self-perpetuating because it is a good idea, it really works, it makes a difference. It is that self-repairing organism, like DNA reverse, the one that runs up and down the chromosome repairing itself.

The Hon. AMANDA FAZIO: Following on from that, Bret Walker, in his special commission of inquiry, made the point that he believes there should be individual accountability within the broader health system where people learn from errors and improve their practices. Do you consider that that would be a human factor approach?

Associate Professor CARTMILL: Certainly human factors helps us to address individuals, way we perform to get through the day. At its simplest, it is the individual, it is me. I have a big day ahead, so I get up and have breakfast, make sure I am not hungry, I make sure I am not angry, I try not to be late or tired. That is it: hungry, angry, late and tired. Halt! I do not have a night on the grog. Little things that I know will improve my performance. I am aware of those in my co-workers, so if I see that one of them is not quite on their game I can talk to them and support them. This is not new, it is new to medicine but not to aviation, where people actually get points for asking after one another. You are meant to check on one another's wellbeing and ability to be a useful member of the team. If one is not quite up there, they are prepared to look out for one another. You might use a few less sarcastic jokes. No kidding.

Human factors will help the individual perform better. It will help teams work better together. Because I am such an enthusiast for this stuff, I think the same principles that act on the individual and team level—and probably the reason I am talking to you so openly and naively—and I imagine that is sharing of communication makes us a team that will work together to solve the problem. I see Madam Chair is nodding, and I believe in that.

Also, we use human factors to look at the context in which people perform. There is not a jackhammer in the background. I have consulted with a jackhammer in the background. You would not hear about that in the inquest three years down the track. It impacts on performance. Rostering does. We are always very tough on ourselves in medicine. We blame ourselves. We are feeling blame. We are our harshest critics and we are always blaming ourselves and it makes us blind to the systems issues. If you are blind to them you cannot draw the attention of management to them. So, human factors also make people become aware of those things that influence their performance in the system.

Bret Walker has said—and I have a little Bret Walker line here if I can read it—Bret Walker wondered whether the two approaches, the system-oriented approach and the person-oriented approach, could ever be married successfully. I think that is one of his lines. The answer in yes, but as with all marriages only through goodwill, trust and a lot of hard work.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: The most salient example of the failure of inclusiveness and warm and fuzzy systems approach is the factor that the whistleblowers could not do it without blowing the whistle. Effectively they were accused of disloyalty as a greater crime then any mitigation of

discovering error might have been a good thing to do. They are now outside the system and very alienated from it. Is there any chance they can be reintegrated? What would that take and what effect would it have on the system? If they are not integrated they are still there as a salient example that, despite all the rhetoric, if you blow the whistle you are kicked out and some of the people who you criticise may be kicked out but some may not. That is the end point, is it not?

Associate Professor CARTMILL: I am answering not about whistleblowers initially but to say there are a lot of ways to raise awareness of concerns with the system, at least in the hospital I work at, short of whistleblowing. Presumably those avenues were not open to the people who had to blow the whistle. I am not a psychologist, and we would have to ask Stewart what would be required to have those absolutely-at-loggerheads parties to come to understand one another. We are talking about walking in another person's shoes. I do not know how frustrated they were to become whistleblowers. I do not know how angered by the revelations those at Macarthur have been to treat them the way they have. I do not know.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: They are end stage, from a psychological review, are they not, in that they now totally distrust the system and the system totally distrusts them? How do you get any restitution for that, and if you do not it is probably a huge stumbling block for the incremental stages you are making in that you have this symbolic breach in the paper everyday?

Associate Professor CARTMILL: Perhaps Stewart could answer that.

Professor DUNN: What John normally does, his brain goes in all different directions. I try to follow him and when he gets to a question he cannot answer he dumps it on me. I come back to conciliation. I think those people have to be brought back into the system. Trust has to be restored, otherwise they remain there as living proof, as you say, that if you blow the whistle you will be excluded. So, it is essential to find some way of getting them back into the system and talking to people. That is very hard and I do not have a clever answer right now. One thing that has occurred to me lately, and I know of no data on this other than what is supported by a research interest I have, which is professional burnout. We know from the literature that there are characteristics about health professionals, there are characteristics about individuals and there are characteristics of the workplace that lead to higher rates of professional burnout.

One of the things that characterises health professionals is that I as a health professional trust myself to provide a high quality of care to my patients. I am not quite sure, if I refer my patients to somebody else, that I can trust them to give the same high quality care. I think as all health professionals we care so passionately about our patients that deep down we do not trust each other enough, and where the most safety problems arise is in the handovers. It is most often not in the one-to-one clinical situations. It is in the handovers. It is where teams start to develop that the problems occur. I think there is the core issue that we have never addressed in health care which is precisely that. We really have to learn to trust each other.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: How do we fix the whistleblowers? You did stray from that. Is the answer that you do not really know?

Professor DUNN: The answer is that I do not really know. It is a very important question. I will go away and think about it and I am happy to come back to you and tell you what the fruit of my thoughts are. As I said, you have a basic contract based on trust between a professional and a patient. The people who are whistleblowers are now victims of the system. In just the same way as a patient has to be brought back together and talk to the people who were the source of the problem, they have to be brought back in and there has to be a process of conciliation. If they stay there remote, removed, it is a disaster.

DEPUTY CHAIR: Professor Dunn, I think we cut you off earlier from making a comment on individual accountability.

Professor DUNN: It was that. I managed to sneak it in there.

DEPUTY CHAIR: Professor Cartmill, in your opening statement you referred to NSW Health as being a live learning culture. How do you reconcile that with the evidence we have had from the nurses in particular, the people who had to become whistleblowers, to use the expression, in order to bring to the attention of officials their concerns about what they had seen inside the health system?

Associate Professor CARTMILL: I think NSW Health is so big that I cannot see the entire organisation. I have also got funny-coloured spectacles and I tend to be an optimist. That is what enables me to be a surgeon, I suspect. That is not a throw-away line. I tend to see the good. You can see that in the way I am addressing you today. I think the part of NSW Health that I see—and I talking about the department, the Miller Street department—I have people who know who I mean, they know who they are, who have made the work that we do possible. It is that leading edge. There is some real good stuff there and it will filter down. They are the thought leaders. If you have the labels on that curve, at the extreme edge it is called the lunatic fringe. Then there are the thought leaders. The thought leaders are the ones that people listen to, and within NSW Health there are thought leaders who are world leaders in this work.

There is a considerable lag time as well. Imagine a living thing that is as big as NSW Health. It is not going to have very fast reflexes. We are responding now to things that happened at hospitals many, many, years ago. In the meantime we are cleaning up the act. The thing that makes that a bit difficult is that that cleaning up of the act is being mistaken for the system that led to those problems in the first place. I do not know if I have expressed that very well. It is a bit like jerking your hand away from—no, I do not have a good example except that it is not as bad as it looks.

The Hon. CHRISTINE ROBERTSON: Also in your opening statement you talked about problems that were occurring for health professionals because of the feeling of external blame that was being flung at them. It has obviously created some sort of bunkering type processes out there. How long do you think it will take for that to settle?

Associate Professor CARTMILL: It has not even begun to get bad yet. No kidding, you have to be really worried about what is happening as a result of the lack of leadership. Again, we talk about this big, living breathing thing that is NSW Health. Take any one of you and harass you—I do not know whether any of you have experienced harassment in the workplace. I have, although it was in another country where I was working as a doctor. I was harassed. I was not the same person. I was depressed. I would wake up early. I just could not do my best. It became a self-fulfilling prophecy. That is what has happened to NSW Health. When I extended my invitation for one of you, any one of you, to come to this evening's meeting—and it is no special meeting, we are just talking about what to do about the mortality and morbidity meetings in the current climate—it is a real problem. It is coming not from within. The problem is not within NSW Health and within the doctors and nurses; the problem is from without. It is the way it is being perceived. We really need you to help us with, I do not know, the lateral thoughts, the novel politics. I am not sure.

DEPUTY CHAIR: What did you mean by the expression "lack of leadership"?

Associate Professor CARTMILL: I may have been a little harsh. I do not like giving feedback. I am not good at it. I like to encourage what people do well—and my children would not necessarily agree with me. My perspective is that things are being made worse by the way politicians—and it is not you, it is politicians out there—

The Hon. CHRISTINE ROBERTSON: Of course it is us, we are playing there.

Associate Professor CARTMILL: You would not be in this Committee if you were not well intentioned and wanting to make some sense of it. I believe that. I have completely lost my thought. It is called a lapse. Just having a name for it helps me to cope with it.

DEPUTY CHAIR: I was interested in leadership.

Associate Professor CARTMILL: What is happening is it appears to me that the politicians are falling over themselves to make it seem that we are worse than we are. One side will call for crucifixion and the other side says that is not nearly good enough, hang, draw and quarter them. That is the perception. Robyn, you seem disturbed by that. Because you agree or because you disagree?

DEPUTY CHAIR: I think you are going to have to answer the questions and the Committee will ask them.

Associate Professor CARTMILL: But will we truly be exchanging information two ways? Again, it is part of the artificial—

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Certainly the leadership as we have had it described to us was the antithesis of what you are advocating.

Associate Professor CARTMILL: I am sorry, I am talking about you as the leaders.

The Hon. CHRISTINE ROBERTSON: Yes, he is not talking about public servants, he is talking about politicians, and the game that has been going on.

Associate Professor CARTMILL: I am talking about you as the leaders. Sorry, that may be why we are at cross-purposes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: I would argue that I was on the extreme end of the future curve, but that is another question.

The Hon. AMANDA FAZIO: Perhaps the appropriate analogy would be that in the past we had law and order options. At present we seem to have the kick the health system options. Is that what you are alluding to?

Professor DUNN: To bring it back to the opening statement I made, there is a whole context in Australia of questioning authority. We are doing that with everybody who has been given authority in our society—clergy, educators, politicians, journalists, sports coaches, business leaders and health professionals. It is part of the difference between years ago when you would walk to your corner store and the grocer would give you the fruit because you would have a relationship. These days you go in the supermarket and you are responsible for your own decisions. I think society is coming to terms with the changes that began in the 1960s and part of it is questioning every authority we have set there. There is a huge context of driving us forward and to some degree—unlike John, who is the eternal optimist—I feel we are probably pawns in a very huge movement.

The Hon. ROBYN PARKER: Professor Cartmill, in relation to your comments about thinkers in NSW Health, I am encouraged that there are those people out there who are putting their minds to this.

Associate Professor CARTMILL: Thought leaders.

The Hon. ROBYN PARKER: A lot of evidence that has been presented to us is that there is a good culture of information flowing upwards but there is a lot of pressure from those leaders, and I would think leaders in the health profession managing that information because of political ramifications. If people say there is a lack of resources, that has to be managed rather than the truth get out there. I am wondering if those thought leaders are at the level they need to be at and if they are being stifled. What is your view on that?

Associate Professor CARTMILL: They may not be being stifled. They may be a victim of their own system, of this system that we have been talking about. I have no doubt at all that the way of improving health care, the way of making it safer, has to come from the shop floor and lead up. What I have been encouraged to see is just how far up into the system it has got. I cannot really see it coming from above because above does not really have the faintest idea what happens in the middle of the night in the casualty department at the other side of the city.

The Hon. ROBYN PARKER: Therein lies the problem.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: It should, should it not?

Associate Professor CARTMILL: Yes, unless the leaders listen carefully. I have in my notes "Health care workers are well intentioned, highly motivated" and we have said that before. Treat them that way. In the past I have worked with a surgeon who imagine, used to say whenever there was a complication "The turkeys have done it again". Arthur smiles because he knows that. When I hear about these incidents I say to myself, "Hang on, the intelligent well-intentioned highly motivated health care professionals have done it again. How come?" The reason I do that—and it is really important that it is on the slides behind the committee—is that I prefer to work with intelligent, motivated people rather than turkeys. If you treat somebody like a turkey they will act like one. If you treat them as if they know what is going on then they are intelligent and they can give

you some insight into what is happening, and I treat them like that and they will act like that. They will tell you what is happening because nobody has got a better idea than they do.

The same is happening, I guess, at all levels of the organisation. I listen to how my team performed over the weekend and what happened. If they need something I will endeavour to get it for them. If there is a problem I will take that up to my managers. I am very comfortable discussing safety matters with my managers. I like to think that they are very comfortable discussing them at the next level above them and so on. At some point it is fizzling out. How can it be otherwise? This is a learning process. It is that innovation diffusion curve and it is not all the way there yet, but it is coming. It has to be. It is too important.

The Hon. AMANDA FAZIO: Dr. Cartmill, in a lot of your answers you have alluded to the fact that the system is so hierarchical within Health. You said that information will flow up but not down.

Associate Professor CARTMILL: No, sorry, I did not say that information would flow up but will not flow down. I think that came from one of the others.

The Hon. AMANDA FAZIO: An impression I have got from hearing evidence from other people and from some of the comments that you have made today is that one of the things that would inhibit good team building within medical professionals working together across all sorts of disciplines is that there is this hierarchical structure. Do you have any good ideas on how to work around that or break it down?

Associate Professor CARTMILL: Yes, I do. But for me it stems from the basic interaction between two humans. It is this human factor thing again, I guess. We talk about an authority gradient. For example, right now I am using an example of an authority gradient existing between two individuals but that can also exist between the department and a hospital, between the department and the politicians or between the politicians and the media. There is an authority gradient. It can be very difficult to get information across an authority gradient. That is one of the things that probably ultimately drove the whistleblowers. They may not have had the techniques to get a message up an authority gradient. The people up that authority gradient may not have had the experience, techniques, wisdom, life experience to say "Hey, hang on. Somebody who knows what is going on is trying to tell me something here."

What aviation does is it has a very well defined set of rules that relate to getting messages across an authority gradient. It is called graded assertion that is teachable. I do not know if now is the time to give the committee a lecture on it, but come to a course.

Professor DUNN: That is a really important question. I think what we have not yet come to terms within Health is the hierarchy is based on the military model that came into medicine eons ago which is excellent for acute care. It is absolutely outstanding for acute care. You must have a chain of command but we have an ageing population. Chronic illness is the biggest demand and that is where the errors are happening because we do not have team models that actually meet the demands of community-based care, of diffuse care where you have a nurse practitioner who is actually the obvious leader in many situations. So we need to do a lot of new team models that address the changing patterns of health care in the State.

Document tabled.

(The witnesses withdrew)

(Short adjournment)

GREGORY JOHN ROCHFORD, Chief Executive Officer, Ambulance Service of New South Wales, and

LOUISE MARIE ASHELFORD, Acting Manager, Professional Conduct and Standards Unit, Ambulance Service of New South Wales, affirmed and examined:

CHAIR: Do you wish to make a brief opening statement prior to questioning?

Ms ASHELFORD: No, I do not.

Mr ROCHFORD: Yes. The Ambulance Service is the emergency part of our New South Wales health system, and the ambulance officers who serve the community and patients as part of their jobs are similar in many ways to other health professionals but operate in an environment that is significantly different from the hospital environment. The way we structure our complaints management processes, our processes for reviewing clinical interactions, quality improvement and the cultural environment of the service is somewhat different from that of the average hospital.

However, we believe that the systems we have established, particularly over the last five years, have gone a long way to developing a culture of openness, lifelong learning, professional reflection, and a culture that patients, staff and the community can view with some confidence in terms of how we manage the clinical practice we deliver and the variations to that clinical practice that inevitably arise in the complex, largely unsupervised, unstructured and unpredictable environment in which ambulance officers deliver clinical care to patients.

Our complaint rate is relatively low—fewer than 400 complaints in the last annual reporting period, as against some 900,000 cases attended by ambulance officers, which is less than one complaint for every 2,000 incidents. The way we manage those complaints is akin to both the role of an employer and also the role of a professional registration board that other health professionals report under, so the service has that dual responsibility if you like.

We moved to substantially renovate our complaints management system five years ago. At that time a large number of matters were subject to complaints, many of which were through external organisations such as the Health Care Complaints Commission and the Independent Commission Against Corruption [ICAC]. The service was heavily reliant on external analysis and advice in dealing with those complaints, and in many ways that external reliance served to undermine the confidence and capacity of both staff and managers in dealing with these important issues.

In response to that environment we established the Professional Conduct and Standards Unit, of which Ms Ashelford is the Acting Manager. The unit was staffed at that time, and continues to be staffed, by a senior solicitor, an investigator experienced in health investigations, and an ambulance officer who is selected from the staff and rotates through the unit on a two-year rotation basis. The unit reports to me, and particularly in the early days of its existence it started with a clear role to investigate and advise me on how to manage the serious matters of inappropriate conduct and poor clinical outcomes.

The unit has a significant role in liaising with external agencies, and also with complaints management roles, and has been established as a body that provides me and others in the service, as well as external agencies, with independent, impartial and authoritative advice on conduct matters. The unit also assists managers in the way they deal with complaints at the local level, and increasingly the unit is becoming a place where staff go to seek advice on how to deal with particular concerns they may have.

As the number of complaints on foot and the level of investigations has gradually reduced over the years, the unit has been able to take on a greater role in building organisational systems for supporting and guiding conduct matters within the service. This includes producing and regularly revising the service's code of conduct and providing staff with training and orientation in relation to those matters. So far the unit has been able to directly train two-thirds of our work force in the code of conduct and the matters that flow from it.

The unit also supports building capacity for investigation procedures and training, and investigation techniques across the service, so that wherever possible issues can be dealt with as close as possible to the point of care, rather than at a statewide level. A matter we are pleased to report on is the corruption resistance

framework that the unit has been able to build within the service over that time. We asked the ICAC to review that framework two years ago now. We received a positive report from the ICAC as a result of that review, and we are quite confident that the systems we have in place provide a sound base for dealing with complaints, adverse clinical outcomes and matters of professional and ethical conduct across our work force.

The system we have set up started very much at the end of dealing with the spectrum of conduct that would be categorised as being of a serious nature. However, we know very clearly that many unsatisfactory outcomes in clinical practice do not arise from conduct that would be classed as serious or culpable. More recently we have used that base to pick up the safety improvement program developed across the New South Wales health system, and the conduct unit has provided an important platform for rolling out the tools and training that go with that program.

We have been able to make clear and consistent statements across the service that we realise that the majority of adverse events and unsatisfactory outcomes that arise are not because of personal or individual culpability, but because of some weakness in our systems that would allow natural human error to go right through the system and result in an unsatisfactory outcome for a patient.

We acknowledge very clearly that in our organisation there is no place for the "no blame" culture, that if an individual conducts himself or herself in an unsatisfactory way, or fails to display the level of care and diligence expected of any of our staff, mainly ambulance officers, they will be dealt with through the procedures of the conduct unit. But with those matters put to one side, and our quiet confidence that we will deal with a very small number of those matters when they arise, we are now left with the task of rolling out the process of a safety improvement program.

Our staff have enthusiastically embraced the process of reporting incidents, assessing those incidents under the severity assessment code score and, for incidents that have serious outcomes for the patient, reviewing those incidents initially by the root cause analysis [RCA] process. This whole system is now supported by a subcommittee of the board, the Clinical Governance Committee, which we have set up with the view that it will take on the same sort of authoritative role in the service for clinical matters that our finance and audit committees take on for financial matters. Our level of clinical governance and scrutiny, and our expectations of compliance and quality, will be consistent across both financial and clinical matters.

At the moment our system is in its early stages. Reportable incidents are all collected centrally, their severity is ranked centrally, and all matters that may be suitable for an RCA are brought to my attention and root cause analysis teams are authorised on my approval. We are finding that the majority of matters that come to our attention are suitable for either the root cause analysis process or a clinical review. We have established a clinical review process that allows staff to self-report matters where they may feel that they should seek advice on the clinical care they have delivered, or where colleagues raise a matter, or where matters are raised by external agencies.

At the moment we have reviewed about 70 matters as a matter of clinical review. We have found that one-third of those matters arose from self-reports from staff, one-third from external agencies and one-third from reports from colleagues within the service. We are finding that that process of openness and open reflection is building a great deal of confidence amongst staff and our systems for managing complaints, and we are quite pleased with the processes there.

We are still toying with the difficult question of, when a matter is first received—whether it is a complaint, an incident report of a clinical review, a reportable incident because of an adverse outcome, or a query from an external agency—initially assessing the matter and determining what is the best method for dealing with it: whether it should be the subject of an RCA, or an investigation through Ms Ashelford's unit, or whether another form of review should come about. We are taking the approach that initially, unless there is evidence to the contrary, we treat all matters as suitable for root cause analysis. Should information arise that suggests a purposefully unsafe act, the delivery of patient harm, criminality of any kind, or the involvement of drugs or alcohol in the provision of care, those matters would then be referred to the investigatory route.

DEPUTY CHAIR: I apologise: I also should have indicated before you commenced your statement that if you consider at any stage during your evidence that certain evidence or documents you may should wish to present should be heard or seen in private by the Committee, the Committee will consider your request.

However, the Committee or the Legislative Council itself may subsequently published the evidence if they decide it to be in the public interest.

The Hon. ROBYN PARKER: We have had evidence presented to us about a code red system of ambulances. I wonder if you could explain to us your understanding of how that system works.

Mr ROCHFORD: Yes. The emergency department network access [EDNA] system has been in operation for a couple of years now. It is growing in its capacity and complexity with every year. The fundamental idea of the system is not new; it has been with modern ambulances services for more than 10 years now. It started with the notion that a seriously injured patient or a patient that is likely to have serious injuries from, say, a major motor vehicle accident, or a patient that is likely to need care at a major teaching hospital with specialist facilities and certain conditions, it is better in terms of patient care and patient outcomes if that patient is taken directly to a major hospital where they can receive definitive care. If necessary, that might involve bypassing a district hospital that may not have all the equipment or specialists available at the time that they are needed. So the idea of bypassing a hospital to get the patient to the best point of care has been with ambulances for a long time, as has been the idea that when hospitals are particularly busy—for example, through a major event and the last one that springs to mind was the Waterfall train incident—we need to make decisions at the scene about where is the best place to take the patients.

There is no point in overcrowding one hospital so that people do not get timely care. So we tend to liaise with the hospitals and the senior clinicians in the hospitals to make those decisions about where to take the patients, and occasionally that will mean taking a patient a good distance. I think some of the Waterfall patients ended up at the Westmead and Nepean hospitals. That is a risk management value assessment that is taken by the officers with clinical advice, depending on circumstances. That same theory of providing safe patient care also pertains to the situation where a hospital is busy, for example, in the wintertime from an influx of patients with flu symptoms. We have extrapolated that thinking to say that in certain conditions we should take patients to the hospitals that will provide the most appropriate and prompt care for that patient, and that may not necessarily be the closest hospital. So the emergency department network access [EDNA] system is a shorthand way of indicating to ambulance officers the status of the hospital and where might be the most appropriate destination for a patient that they are collecting, either from an emergency call or for another reason.

The Hon. ROBYN PARKER: Who would make those requests, those code red requests, within the hospital system?

Mr ROCHFORD: There is a system that each hospital goes through in terms of assessing a range of factors. I probably will not be able to list them exhaustively, but they include factors like the number of people waiting in the emergency department, the severity of the condition of those patients and how much of the clinical resources they will consume, the number of beds in the hospital, the likely number of discharges that will be going out of those beds in the foreseeable future, particularly for example if those patients are likely to require a period in an intensive care unit. So assessment is made of the available resources and the likely demand in the short term and that will guide the hospital in indicating its status as being normal, becoming very busy, or going through a period of peak activity, and officers will take that information and make a decision about which hospital would be the best for their patient at a particular time.

The Hon. ROBYN PARKER: Just walk me through that. Who is the person in the hospital that makes the decision to activate a code red? Can you just run me through the path of where that travels?

Mr ROCHFORD: It varies. There are a number of components to be considered in the hospital. It is not to just what is happening in the emergency department: It is also what is happening in the rest of the hospital. Each hospital has its own arrangements for advising that and then for making the call about this status. They do that depending on the size and nature of the hospital and indeed according to the time of the day, depending on what people are on duty. The information is collected centrally at our Sydney operations centre which co-ordinates the dispatch of all ambulances, and crews and ambulance officers are able to communicate with the operations centre to ascertain the status of hospitals in the area. I might just say at this point that ambulance officers of the Ambulance Service like the EDNA system. It helps us to make the best decision for our patients as to which hospital is going to be appropriate from time to time, and that decision will change from the time of day, depending on the nature of the patient, and for a whole range of factors—traffic conditions, for example. So it is not a simple matter of saying, "This hospital is red. It cannot accept any patients." A hospital that is on code red will always accept life-threatened patients. It may also be appropriate to take other patients

there—for example, people with chronic conditions that are receiving ongoing care, such as renal dialysis, where they can go to hospital and get care more efficiently than going to a new hospital and having to have the clinical condition assessed from scratch.

The Hon. ROBYN PARKER: Would it be your assessment that those working in the system, such as the doctors and nurses, would be in a better position to assess the code red status than those in the management of the hospital?

Mr ROCHFORD: I do not think it is as simple as saying who is in the better position. The person who is in the best position is the person who has access to information, and that will include access to how many nurses are on, what they are doing, and what patients are waiting to be attended to; how many doctors are on, what they are doing, and when they are likely to become free; what is happening in the hospital with beds; and even going to the point at an ambulance slant, what is likely to come to that hospital in the near future. If there has been a major multi-victim motor vehicle accident down the road, the hospital may have to make provision for those patients to come in. So the person who is in the best position to make the call is the one who has access to all those pieces of information in a reliable form, and that will vary. It is not necessarily a doctor, a nurse or a manager.

The Hon. ROBYN PARKER: Is it common for a code red request to be denied?

Mr ROCHFORD: No. Code red is not denied; code red is an indication of status. As I have indicated, it does not necessarily mean that ambulances will not go to that hospital. They will still go in appropriate circumstances but it makes it easier for an ambulance officer to work out what those appropriate circumstances are to make the best call for the patient in their care.

The Hon. ROBYN PARKER: But it is not common within a hospital where a request is made by doctors or nurses for code red that that is denied by management?

Mr ROCHFORD: I could not comment on that because, as I have said, an individual in one ward, dealing with one patient even, may feel that they are very busy and that it is time to put a hand up and say "We need a bit of a rest if that is possible", but when you look at the whole hospital, it may be clear that a ward is going to discharge three patients shortly and that period will pass, so it is not simple. We would not want to rely on the opinion of any one individual in the hospital in order to make that call because it is far too complex for that and we would end up by making mistakes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You have a hierarchical system of urgency in terms of which patients are urgent and which ones are not. Is that correct?

Mr ROCHFORD: Yes. We endeavour to give priority to the most urgent patients, yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: There have been criticisms of the time taken to transfer patients from Camden to Campbelltown hospitals. Are you aware of those criticisms?

Mr ROCHFORD: I am not aware of the specific criticisms that you might have in mind.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Some of the cases looked at by the Health Care Complaints Commission [HCCC] showed there was a long waiting time for transfer.

Mr ROCHFORD: Yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: It would seem that those patients at Camden were not covered by surgical registrars. They had been seen by a doctor who was not surgically trained and who thought they should be assessed by a surgical registrar. It seems the problem was that they then were not very high in the hierarchy of transfers because it was an inter-hospital transfer and they were not urgent because their problem had not been recognised. In that situation it would seem that there was something wrong with the hierarchical system perhaps; an unassessed patient could be far sicker than they were perceived to be, if you see what I am saying.

Mr ROCHFORD: Yes. It can be a difficult puzzle because not only do we have at times patients in hospital who are needing transfer to a larger hospital for a higher level of care, we also have patients in the larger hospitals who can be transferred down to a lower level of care, thereby freeing up an acute bed at a major hospital, if that hospital is becoming busy. Most importantly from the ambulance perspective we also have patients waiting on the end of a 000 call who have had very little assessment other than what we have been able to do on the telephone. For a patient in care compared to a patient complaining of priority symptoms on the other end of the telephone, we will generally do a weighting to the patient on the telephone and ask the patient in the hospital to wait. So to comment on individual cases you have to know all those details that were in place at the particular time, but what we try to do in the operations centre is balance the information we have about the individual requests and the status of the ambulance system and the hospital system at the time in order to allocate appropriate priorities.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: If Camden hospital did not have surgical registrar cover and thus could not assess certain types of cases, would they come to you and say, "Look, we cannot assess these cases because we have not got trained staff. All we know is that it is a referral to a surgeon to look at." That would suggest a greater degree of urgency than a simple inter-hospital transfer, would it not? If they are seen by a doctor who said, "This person needs to see a surgeon", I am saying that that, in a sense, is an upping of the ante of the urgency.

Mr ROCHFORD: Yes, but we would still rely on the level of urgency from the doctor referring, whether the doctor was a specialist or a general practitioner, and they also contact us directly to move their patients. We would rely on information coming from the doctor to assist us to gauge urgency. If we are very busy, we might have a conversation with the referring doctor and say, "We can't do it within the next two hours. Is that going to be okay? Can you tell me some more?" At the end of the day, we are very reliant on that clinical assessment of the medical practitioner, of whatever level of qualification, to guide us in setting our priorities.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Assuming the doctor knew that—although he did not know in the sense that he knew that it had to go to a surgeon—but he had not recognised it as being an acute problem, he would actually fail because you would not have been asked to come as an urgent item by that individual case, and you were not asked as part of the strategic approach that all cases have to be referred and seen by a specialist should be transferred quickly on the assumption that the doctors who were there could not deal with their problem. In other words they were a relatively acute hospital transfer, but were not classified as such. You can either classify all of them administratively, or you can classify them one by one, depending on the clinical assessment of the patient, could you?

Mr ROCHFORD: Yes, but I would not like to see us classify them all administratively. We do really have to deal with the instant situation that faces each operator in front of them. The call is made. The balancing process is the here and now of what are the immediate clinical needs of a whole range of patients. When the patient has had the benefit of medical assessment, they are in a slightly different category from the patient who is complaining of chest pain or uncontrolled bleeding and has had no medical assessment. We will always try to balance that. At the end of the day, the patient in care generally has a greater chance of getting care than the patient who is not in care. The exception to that of course is in the critical situations where we are doing an emergency transfer to an intensive care bed or a paediatric retrieval—situations of that nature. Of course they get the highest level of priority, but it is really up to the doctor at the end of the phone to indicate the condition of the patients so that we can make that assessment.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: So that if the initial doctor recognises that a surgeon is needed but does not realise that the surgeon is needed urgently, they are falling between two stools, in a sense. They are not being transferred quickly because they are not recognised as urgent and therefore they are in hospital but are not getting to where the help is. I mean, there were deaths; there was at least one death in this situation.

Mr ROCHFORD: Yes, but I can only repeat that we rely on that information that is presented to us in order for us to make a decision about the relative urgency for the competing demands on our resources.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Sure. When hospitals go code red—for example when Campbelltown goes code red—would you then revert to Camden? Would that put an immense strain on a little hospital like Camden that has very little in the way of facilities? Your choice is either to go to a

little hospital with few facilities, or to drive for a very long time up the freeway. That is the realistic situation you are put in.

Mr ROCHFORD: Yes. We are mindful of not overloading, particularly the smaller hospitals. I am not referring to any particular hospital here. Officers and people in the control centre are quite aware of the capacity of different hospitals and will try to spread peaks and workloads as evenly as possible, as appropriate to the capacity of an individual hospital. To get to your particular point, these days it is very unlikely that we would divert a patient destined for Campbelltown to Camden. They would be going down a level of care in terms of the capacity of the hospital. The capacity of Camden is quite limited.

Our experience is that many emergency presentations to Camden end up by requiring transfer to Campbelltown or Liverpool in any event so then you are occasioning another journey and that requires more resources.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: If all the hospitals are making independent decisions about their capacity to receive patients, you could potentially, in a flu epidemic or in a busy time, effectively have most of the hospitals on code red and your ambulances all driving around in little circles wondering which one to go through, could you not?

Mr ROCHFORD: That would not arise. When a number of code reds are appearing or they are coming or we suspect they are coming, there is a process of consulting with senior clinicians at the hospital and more often at the area level to manage the situation. I go back to the Waterfall example again. Each area health service has a known senior clinician who can advise us of their capacity, their availability to move resources and balance priorities. In times of a major event such as Waterfall there is a well-established and easily accessible network that we can use to ensure that we do not get into the situation that each hospital and each area health service is aware of the relevant demand being placed on the network, neighbouring hospitals, and that balanced decisions can be made about priorities.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: How often do you get people stuck in ambulances in the sense that you cannot offload them? Is that a frequent situation? How much time per year would you spend in the situation of ambulance block, if you like, where you cannot offload your ambulance?

Mr ROCHFORD: Certainly, I could not answer for an annual figure but our average times for unloading a patient at a hospital are in the 20-minute to 30-minute range, depending on seasonal factors and time of day. We would certainly like to work with the hospitals to improve that. But when I talk about the averages and in those terms, it is also clear to us that those people who are in dire need of instant or urgent attention, the life-threatening cases and the cases that are nearly life threatening, tend not to wait that long. They go straight through. It is the patients who are less urgent who tend to occupy, to lengthen that average. We would like to get the average down.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: The average can be quite deceptive, though, if it takes 15 minutes to offload the average patient, then the ones who take three hours or so would be lost; the average would not go up very much because of the few who waited a very long time.

The Hon. CHRISTINE ROBERTSON: Or the urgents who did not wait at all.

Mr ROCHFORD: There is an average. There are extremes at either end of the scale.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Could you give us a breakdown of those waiting times? Obviously the ones that are blocked will have very long waiting times and could be swallowed in an average.

Mr ROCHFORD: Yes. I would have to take that on notice but we could give some analysis of turnaround.

The Hon. ROBYN PARKER: What contact have you had with Roger Wilkins, the Director General of the Cabinet Office, regarding this inquiry?

Mr ROCHFORD: Regarding this inquiry, none.

The Hon. ROBYN PARKER: Have you had contact with the Minister's office regarding this inquiry?

Mr ROCHFORD: Very little. I was working in the Health Department in February on secondment, and I provided some assistance in co-ordinating preparations but that was the extent of my contact.

The Hon. ROBYN PARKER: Could you elaborate on that involvement?

Mr ROCHFORD: It was administrative processes to collect information that was being sought for a number of inquiries in relation to Macarthur.

The Hon. ROBYN PARKER: Have you been to any training sessions run by the Minister's office or the Cabinet Office before coming to appear today?

Mr ROCHFORD: In relation to this inquiry, no.

The Hon. ROBYN PARKER: Have you had any advice in terms of answering questions at all?

Mr ROCHFORD: No. I am aware of the standing circular. I have been in the public sector for some time. I am aware of the advice for all public servants coming to parliamentary inquiries. I think it started in about 1984, the circular, and it was reissued by the Fahey Government in about 1992. It remains largely unchanged to this day so I am conversant with that material and that would be the extent of my preparations.

The Hon. ROBYN PARKER: In terms of your preparation of materials and collecting information, can you elaborate on what you mean specifically?

Mr ROCHFORD: This inquiry and other inquiries asked for a range of briefing documents to be prepared, background information. I understand you have had a briefing document from the ambulance service as well, for example. So it is just a process of requesting and collating those.

The Hon. ROBYN PARKER: And specifically related to the Camden and Campbelltown hospitals?

Mr ROCHFORD: Specifically related to the requests of the Committee. There is more than one Committee going on on that topic.

The Hon. ROBYN PARKER: What sort of information were you preparing?

Mr ROCHFORD: Complaints handling procedures, the current policies and guidelines that are in place, the safety improvement program—

The Hon. CHRISTINE ROBERTSON: Did you have this lovely booklet?

Mr ROCHFORD: Yes.

DEPUTY CHAIR: What about specific cases?

Mr ROCHFORD: No, I was not involved in that.

The Hon. ROBYN PARKER: Any incidents at all?

Mr ROCHFORD: No, I was not involved in those matters.

The Hon. AMANDA FAZIO: Mr Rochford, I was interested in getting your comments on the issue of transfer of protocols. That is the one issue that has been raised in previous evidence given to this inquiry in relation to the ambulance service and its interaction with Macarthur area health service. Are you confident that the transfer protocols that have now been put in place will overcome any of the difficulties that were highlighted in the past?

Mr ROCHFORD: Yes. The transfer protocols that are in place, constantly evolve—we are improving them all the time—are good protocols. They work effectively the majority of the time. As I am sure at the core, at the heart of the proceedings of this Committee, humans being humans, clinical practice being clinical practice, there are always opportunities to learn from errors that arise in any procedural system and we are confident that we will continue to revise and improve protocols for transferring patients, for treating patients, for responding ambulances as a regular part of our business as delivering an ambulance service.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: I would ask that the breakdown of ambulance waiting times be also by area. Can you do that in your question on notice?

Mr ROCHFORD: I will take that on notice, yes.

The Hon. CHRISTINE ROBERTSON: And then crossed with statistical analysis about the number of people who live there, so that we can have some balance in your report?

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: No. That is facetious.

The Hon. CHRISTINE ROBERTSON: If not, I will provide it.

The Hon. AMANDA FAZIO: It is not facetious; it is honest.

The Hon. ROBYN PARKER: Have you ever had discussions with Deborah Picone or Robyn Kruk in relation to Jennifer Collins, Camden and Campbelltown hospitals, the whistleblower nurses, any of the incidents that have been in the public arena recently?

The Hon. AMANDA FAZIO: Why don't we just ask about the rugby league world cup as well?

DEPUTY CHAIR: No, thank you. The question has been asked. The witness can answer it.

Mr ROCHFORD: I have had a number of discussions with both Robyn Kruk and Deborah Picone about a number of matters. I think the one I picked out of the list you just ran through is the one relating to Camden and Campbelltown hospitals and ambulances taking patients in particular to Camden hospital. They tend not to do that any more to reduce the double transfers that I referred to in my earlier answer and that would be the extent of my discussions with Deborah Picone, if I can remember your list correctly.

DEPUTY CHAIR: Was that in the context of this inquiry?

Mr ROCHFORD: No. It was in the context of managing emergency patients in the Macarthur area.

(The witnesses withdrew)

ROBYN KRUK, Director General, New South Wales Health,

ROBERT McGREGOR, Deputy Director General, New South Wales Health, and

LIZ JAKUBOWSKI, Director, Communications, New South Wales Health, on former oath:

DEPUTY CHAIR: I remind each witness that you are still under oath. Do any of the witnesses wish to make an opening statement?

Ms KRUK: I welcome the opportunity to make a brief opening statement. I am aware that allegations have been made of pressure being applied to witnesses giving evidence to this inquiry. I want to make it very clear from the outset that the department has aimed to play a supportive role for staff called to give evidence—a role that I believe is totally appropriate. For a number of witnesses—and I discussed this with the chair of the Committee in the lead-up to the public hearings—this is the first time they have given evidence to an inquiry of this nature. It can be a stressful experience. This is particularly so for those who are questioned on their actions and experiences in the workplace, as opposed to witnesses called as experts in their field.

The chair of the Committee was very understanding and appreciative of some of the anxieties of witnesses appearing before the Committee and the potential impact on their reputations. I met with the chair, as I indicated, of this inquiry and the secretariat staff on 9 March. I gave an assurance that staff would not be obstructed from providing information in giving evidence to this inquiry. I also asked to be notified if the chair became aware of any member of New South Wales Health staff thinking that they were under any pressure from making a submission.

The department did not see any of the submissions sent to this inquiry by individual staff members prior to those submissions being sent or afterwards, unless they were being made publicly available. Members of the Committee would be aware that your Committee called for submissions and a wide range of media, and the public was certainly aware of the conduct of this inquiry. I also make it clear that the department has not vetted any submissions, nor has it given any instructions to staff about what they may or may not say before this inquiry.

I also indicated at that meeting with the Chair that I had told the area chief executive officers, initially on 23 January and on a number of occasions since, most recently this morning, that health service staff should consider this as an opportunity to strengthen the quality and safety of health services across New South Wales and should assist the inquiry accordingly. A meeting was held on 10 March to provide supporting advice to South Western Sydney Area Health Service staff that have been called to give evidence in this inquiry.

Apart from the administrator, Professor Deb Picone, none of those staff had ever been called to give evidence before an inquiry before and were understandably anxious. Three Department of Health staff attended that meeting, as did two members of the Secretariat for this inquiry, and that was much appreciated. My position has been, and continues to be, that witnesses giving evidence before this inquiry or any other parliamentary inquiry should tell the truth by being honest and frank. It is also my position that staff should provide to the inquiry any information or material that they have that is both factual and helpful to the inquiry. Further, it is also my position that the department has a duty to support its staff by reassuring them so they can be of help to the inquiry. I reiterate: I believe this inquiry represents an important opportunity to bring about improvements in health services for the community and have no doubt that staff throughout New South Wales Health share this view.

Can I also address: there has been some discussion in the media about a memo regarding appearances before parliamentary committees, which may have already been mentioned but I think it is worth covering. It should be clear—and I am sure a number of members around this table have seen that memo issued under successive governments—the purpose of that memo. The essence of the Premier's memorandum for appearance by public servants before committees is how to advise officers or employees. They should give evidence of a factual nature but should refrain from answering questions seeking opinions of a political nature. Political questions by their nature are matters for government and for parliamentarians.

I am very happy to table the successive memos that I have seen during my term of employment as a public servant issued to members. They are consistent; they are a bipartisan protocol in relation to public

servants giving evidence in an official capacity. I would like to refer members to a memo issued in 1984, which also makes it clear in provision No. 9 that officers who are required to give evidence to parliamentary committees should make themselves aware of the relevant law and practice of parliamentary privilege. It should be noted that the powers of select and standing committees derive from the resolutions establishing them, standing rules and orders and legislation, including the Parliamentary Evidence Act 1901. It was these matters, amongst others, that I discussed with your Committee Chair, and that is why I welcomed the participation of the inquiry staff in briefings of any members who wish to be acquainted with the rules of Parliament before they appeared before the Committee.

Chair, thank you for the opportunity to speak to the Committee and I am happy to table those memos if you do not already have them. They are memos provided by Premier Fahey, Premier Carr and Premier Greiner, which reiterate, in essence, the same provisions, which apply to bureaucrats appearing before parliamentary committees on, what I understand, an Australiawide basis. Chair, I table them should you wish.

DEPUTY CHAIR: I understand that one member of the Committee has sought that they be tabled.

The Hon. CHRISTINE ROBERTSON: I move that they be tabled.

Documents tabled.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Can they be made public documents?

The Hon. CHRISTINE ROBERTSON: Yes.

Ms KRUK: They are memos, Dr Chesterfield-Evans.

DEPUTY CHAIR: Ms Kruk, in relation to your opening statement, just for completeness, has any employee raised any concerns about feeling a sense of pressure in relation to the Committee?

Ms KRUK: I took a very proactive stance. I raised it with the CEOs. I made it quite clear that individual members of staff were free to make submissions before the inquiry. As I indicated in my comments, I am not necessarily aware of the submissions that the Committee has received. I am not necessarily aware of who appears before this Committee until you make your program of interviews actually a public one. I am not aware of any particular concerns having been raised by inquiry members. My CEOs fully understand the importance of individuals having the opportunity to present their views. It is clear that they present them in an individual capacity and they do not represent the views of the Government, so I separate the role of individual versus someone appearing, as I do, in an official capacity.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Is Circular No. 99/52 the latest in this series?

Ms KRUK: Can I have a look at 99/52, which I have just handed up?

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: There is not one later than 99/52?[1]

Ms KRUK: Bear with me a couple of moments. From my understanding that is the latest memo. For my own edification this morning I went back and actually had a look at them. They are literally a restatement of previous memos and just reaffirm a longstanding practice.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Far be it for me to accept that the Government for years has told public servants what to say and that makes it correct, but if I can quote from that:

> The primary rule is that officers may only give evidence of a factual nature and should refer questions seeking opinions or judgments of a political nature to the Minister when in attendance or take them on notice for a written response from the Minister. Where questions on notice are submitted to agencies prior to the Committee hearing, all answers must be approved by the Minister before being sent to the Committee. Answers that would affect the whole of government or other agencies are to be referred to the Premier for approval.

[1] Clarification received from Ms Robyn Kruk, Director General, NSW Health, 24 May 2004: "I was asked whether Premiers Circular 99/52 was the most recent circular on giving evidence before Parliamentary Committees. The most recent circular is in fact 2003/47.

That suggests that we may not have any public servant's opinion that is not approved by the Minister given here at all, does it not?

Ms KRUK: I would like to pick up a couple of the issues you raised. As I said, this is a rule that applies throughout the Westminster system and actually, from my understanding, derives its origins in those laws. It makes it quite clear that matters of policy or political matters are a matter for the Government to determine at the end of the day. It actually refers to the submission of formal documentation to inquiries, such as the document that we have provided, which is now on the web site, which actually pulls together existing government policy and has put some policy proposals to this Committee. It also provides just some basic background material for individuals appearing before parliamentary committees when they do so in their capacity as a public servant.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: The point is that while the Executive may be helpful in making some suggestions and, indeed, it would be nothing more than their duty, in my opinion, to provide all the information that they could to the Parliament, surely we may ask individual officers what their opinions are on the situation in the situation in which they are working?

Ms KRUK: I think it depends very much on the question that you are asking. Certainly, in the questions that you have given to me in my appearance before the inquiry, I have answered factually, I have related to existing government policy but I have not made my views available in relation to what I see to be the adequacy or otherwise of existing government policy. I have put forward proposals, I have answered factually, I have answered in accordance with the provisions of those memos and with longstanding practice.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: I am not asking you to give personal justification of your answers. I am asking for the general principle that officers who may have opinions closer to the coal-face—

The Hon. CHRISTINE ROBERTSON: Closer to yours, Arthur.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: That is just rude and deserves to be ignored—those who have opinions closer to the coal-face than you are, as the head, may have facts and opinions that are not necessarily entirely conducive to the needs and wants of the Minister, then surely it is the right of the people of New South Wales and the Parliament of this State to ask and get answers to those questions.

Ms KRUK: I think the contents of the circular clearly focus on the making of political comments. From my understanding, all of the witnesses that have appeared before your inquiry have answered freely, factually and openly and have in no way been constrained in their responses. Members have given opinions on the adequacy of systems in place, as has the Department of Health in relation to the systems it has commented on. I am also aware of the fact that a number of my CEOs who have appeared before the inquiry have also provided some commentary in relation to what they believe to be possible improvements to the system.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: There have been people talk to me in the tea breaks, however, who say that they are not really willing to give their own opinion because they believe it will adversely affect their career. You talked about judgments of a political nature. Opinions or judgments of a political nature is a very wide net to prevent people speaking on, is it not?

Ms KRUK: My understanding is that the inquiry has, in many instances, elected to take evidence in camera if there have been concerns raised by witnesses. I can only refer to the memo. The memo makes it quite clear, the emphasis on factual information being provided and that you, as a public servant, are appearing before a committee in an official capacity. From my understanding, each of the witnesses that you have received submissions from and who have agreed to appear before the inquiry are doing so in an individual capacity and have made some very broad-ranging comments in relation to improvements to the health system, and I think that should be encouraged.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: If you take the case of Malcolm Masso, who received this letter from Deb Picone referring him to the contents of this, you do not think he would find that in any way intimidatory?

Ms KRUK: That is no doubt a matter you will pursue with Mr Masso this afternoon. I make it clear, and I made that quite clear in my agreement to the Chair of your Committee, that we would encourage people to make submissions to the inquiry. We would in no way seek to constrain them. The policy that is in place—and my understanding was that was why I referred to the memos going back as early as 1984—is a longstanding policy in relation to appearances before parliamentary committees. You would be aware that I am of the understanding that Mr Masso is no longer an employee of New South Wales Health. They may be matters you should pursue directly with him.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: I would argue that it is even more intimidatory that it was being written to an ex-employee. Surely the question really is: Do you think that this memo is conducive to free and openness, because I would submit that it is not?

Ms KRUK: I think we are in the realm of conjecture. I can only restate the fact that individuals were free to make submissions. There was no vetting of submissions. The memo is a longstanding memo and unless the Parliament makes a decision or the Westminster system makes a decision about the standing of witnesses before parliamentary committees, I, as a public servant, act in accord with that memo. What was clear in relation to the nature of this inquiry is that a very clear message was sent out through the health system about the fact that individuals would not in any way be constrained from giving evidence before this inquiry. I can only restate that fact.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Be it inconsistent with 99/52 or not.

The Hon. AMANDA FAZIO: That is your opinion.

DEPUTY CHAIR: I will ask Robyn Parker to ask some questions.

The Hon. ROBYN PARKER: The meeting on 10 March, I understand the structural reform group prepared a briefing folder containing advice, responding to the Chair's concerns on this issue. Can you provide the Committee with the documents in this folder, please?

Mr McGREGOR: I understand that copies of that document were made available during that meeting to the staff of this inquiry who were present at the meeting, so I am sure you could obtain it from the inquiry staff if they have copies still. If not, we can provide them.

Ms KRUK: Sorry, I have just received advice that this has already been provided to Committee staff but if there is any confusion, we will check that out.

DEPUTY CHAIR: Can I ask some questions in a slightly different area? Can I ask about resource allocation, in particular, can you explain what is the resource distribution formula?

Ms KRUK: Chair, would you mind if I asked Mr McGregor to lead on that particular issue?

DEPUTY CHAIR: Mr McGregor?

Mr McGREGOR: In the broader sense the resource distribution formula is a population-based model, which guides the allocation of resources which are provided by government to area health services and the primary contributor to that formula is the population. There are adjustments which are made to that which recognise that in some area health services there are significant indigenous populations, so there is a weighting factor in favour of that. There are some other issues around mortality and morbidity where positive adjustments are made in respect of that. In the broader sense that is what it is about.

DEPUTY CHAIR: In your opinion does the resource distribution formula [RDF] ensure that resources get to the area where they are most needed?

Mr McGREGOR: As a population-based model of longstanding and general acceptance, in New South Wales we believe it directs resources towards the population needs. It makes an adjustment for flows of patients from area health services, particularly in relation to tertiary level service, such as those provided by the Royal Prince Alfred Hospital and other major burns units. They are adjustment factors because it is not policy or practice to have a major tertiary centre in every hospital.

Ms KRUK: To follow on from that, this matter was raised quite extensively before your sister committee looking at governance in various areas. It is an incredibly complicated formula that, in effect, seeks to introduce equity across the health system. There has been a longstanding policy commitment over the past 10 years of looking at the historical basis of funding, to look at population and a whole range of factors that seek to actually bring the funding base closer to the population demands and the various other factors that Mr McGregor has picked up in his statement. The intention has been, and remains, and we are now a lot closer to having a more equitable distribution, but with that goes the ongoing pressures of continuing to provide area health services to areas such as far western New South Wales that have a whole range of fixed pressures in relation to funding. The formula is complicated and we have covered it before. If Committee members want more details, do let us know.

DEPUTY CHAIR: Is it the subject of political interference?

Mr McGREGOR: No. The RDF was first devised in 1975 by an expert group. We have an advisory committee on the RDF and it provides advice to the department about what it should comprise. I cannot recall a situation in my experience where the department has taken issue about changes that might occur to the formula, recognising it is now well established as a guiding tool. But the major shifts that occur now are the population shifts that occur from time to time. That is how it is primarily adjusted.

The Hon. CHRISTINE ROBERTSON: Has there been a complaint, or incident, reported about the RDF in your time, Mr McGregor?

Mr McGREGOR: I cannot recall a complaint. Some area health service CEOs have different views about the share that they should receive, and have expressed that quite freely. The director general referred to the far west, where they believe that there should be a greater recognition within the formula of the remoteness issue and the social disadvantage issue in that area. They are recognised as factors, but clearly CEOs and boards of area health services would like to see their share greater than it perhaps should be.

Ms KRUK: Chair, I add that interestingly enough the members of the committee before which we appeared previously, were quite keen to see how they could influence the RDF. They wanted an understanding of how the priorities were determined. The RDF is literally a consistent formula where you try to introduce some equity over a longer period of time. That in no way precludes the identification of areas such as cancer, where a very deliberate decision is made by the government of the day to target resources at an area it believes to be of greater health need—this is well substantiated.

It is also clear that there are issues in relation to longstanding disparity. Before that inquiry Mr McGregor referred to some of the conditions in relation to some of the western area health services when he commenced his term of office with Health. A significant injection of capital that has gone into that, from my recall—and I am very happy to make sure that this is correct in the subsequent record—an area such as South Western Sydney Area Health Service has received an increase in injection of more than 120 per cent in the past 10 years. Mr McGregor may help me with that.

Mr McGREGOR: That is correct.

Ms KRUK: That is a very legitimate increase, given the population pressures in that area, and in some of the mooted developments in relation to Bringelly, which is a growth area.

Mr McGREGOR: From recollection, in 1995 the distance in the share of south western Sydney from its targeted share under the RDF was about 18 percentage points. In the last financial year, with the additional funds that were allocated by the Government, it is down to within 3 per cent of its targeted share. It has moved very much closer to what would be a fair share.

CHAIR: Ms Kruk, in relation to the memo that was the subject of some questioning a few moments ago and the meeting of 10 March, is it possible for the Committee to have the minutes of that meeting?

Ms KRUK: I am not aware whether the parliamentary inquiry would have kept minutes of that meeting. I am advised there are no minutes. It was a meeting of myself, some of my senior staff and inquiry members.

Mr McGREGOR: I think the question referred to the south west Sydney meeting.

Ms KRUK: Sorry, my confusion. I thought you were talking about the meeting with the chair of the Committee.

DEPUTY CHAIR: My question referred to the meeting at which various witnesses were invited to participate in an information meeting on 10 March. Dr Picone may have invited people to attend.

Ms KRUK: It is my understanding that there are no minutes of that meeting. It was literally an information session and an opportunity for members of staff to ask questions about parliamentary inquiries. I reiterate that in my discussions with your Committee I receive contacts from right across the health system about this inquiry, what people's individual rights would be in relation to appearing before the inquiry. People were concerned whether they would need legal representation and about what would happen if matters of a diverse nature were raised against them and what the opportunity would be to respond. These are very legitimate questions for individuals who are used to the circumstances.

The involvement of inquiry staff in the briefing was an important contribution to it and also made it quite clear that this was an exercise of an informational nature, so it could not, and some of the commentary is regrettable, be interpreted as being anything else. Had I not had sessions of this type, and a lot were informal, the Committee may in many instances have had to seek to subpoena members. That would have sent an adverse message. Although I am happy to hear otherwise, I think the Committee has received full co-operation and members have been very happy to appear before it as a result of some of that guidance.

DEPUTY CHAIR: Does the department collect data on the total number of staff-reported incidents by area health services?

Ms KRUK: I indicated in both the submission and my commentary during the most recent hearing that one of the initiatives that we have introduced in the improvement of complaint handling, and also as part of the broader quality reform agenda, was to seek to get greater consistency in the collection of so-called adverse incidents. We introduced that initiative, from memory and I am happy to correct the record, in the mid or early part of last year. Interestingly, that matter was discussed at the health Ministers meeting in Canberra last week. There was broad agreement that there should be consistency on a national basis in relation to both the type of incident-monitoring system that had been put in place and also the data that has been and is collected.

It would be commonsense to assume that events are collected on a similar and consistent basis and that we have the ability to look at both system-wide learnings and national learnings. I stress that New South Wales was the first jurisdiction to introduce those initiatives and we are making progress in that regard. As I said, the system is still in its infancy. We are seeking to refine it and to push a strong national agenda in that regard.

DEPUTY CHAIR: Does the data collection indicate whether reports are made by doctors or nurses?

Ms KRUK: As I indicated, there is a whole range of provisions that sit here and also seek to protect the privacy of individuals who may wish to make complaints, and to do so in an anonymous manner. They relate to legislative, vis-a-vis protected disclosure, provisions that you would be familiar with. In some instances an individual may seek to be identified, but certainly complaints would be considered on their merits. As you are aware, that was actually tendered in evidence at the last Committee hearing. There is regular reporting by the area health services in relation to the type and nature of complaints and there is a comprehensive policy framework in relation to how those complaints should be handled.

DEPUTY CHAIR: Do you think that recent events at Macarthur Health Service may have had an impact on the number of staff incident reports in area health services across New South Wales?

Ms KRUK: I think this was also highlighted in the submission. The experience in relation to veterans' administration [VA], the model upon which we have largely draw our current policy framework, is that when you seek to introduce a reporting system, and to do it with the coherence that we have, you would expect there to be an initial increase in relation to reporting. From memory, in VA's experience, that was as high as an eight-fold increase in reporting. That has also been my experience from when I worked in child protection, when we

introduced the concept of a child abuse registrar, in the vernacular. After those provisions were put in place, there was an initial increase in reporting.[2]

I would expect, and given the significance of this issue to the health system as a whole, all the area CEOs are cognisant of reporting. The cultural issues that have been raised in our submissions and by other member appearing before the Committee are about the need to encourage complaints to be raised and dealt with expeditiously. I have also been very transparent in relation to the fact that I know we have challenges ahead of us in that regard.

DEPUTY CHAIR: The HCCC found serious deficiencies in clinical governance at Macarthur Health Service and subsequently the general manager's employment was terminated. However, during the course of the HCCC investigation Macarthur Health Service was surveyed by the Australian Council on Health Care Standards and was accredited for another two years. Do you have any concerns about the reliability of the system used to accredit most health facilities in New South Wales?

Ms KRUK: From my understanding the accreditation system is an important part, but it is not the total of having in place an effective governance system. We have been in discussions with the Institute of Clinical Excellence and also some of the accreditation bodies over the past couple of months with a view to strengthening the clinical governance provisions and to make those part of future assessments for health services. Committee members would be aware that the Minister and the Premier recently announced the expansion of the functions and role of the Institute of Clinical Excellence to take a greater responsibility in a whole range of matters that pertain to clinical governance. What is important is that the accreditation system is a strong system. There is no doubt that we are well along the way of strengthening clinical governance arrangements.

The commentary of the HCCC was consistent with the commentary of Professor Barraclough and his report to me on the need to strengthen a whole range of those systems. In relation to accreditation, it has been an important process in providing a consistent external examination of the performance of hospitals. That is in accordance with my understanding of national standards, the ISO standards. It is important that we are now in a phase of also strengthening the clinical governance arrangements. I would hope, and this is the intention of the announcement on the Clinical Excellence Commission, that that body will be a major party in taking that forward.

DEPUTY CHAIR: Mr McGregor stated earlier in his evidence that when the South Western Sydney Area Health Service entered into negotiations with the nurse informants to secure a deed of release they were acting outside the department's requirements that they should not enter into deeds of release without approval. Has the department initiated an investigation into that matter?

Mr McGREGOR: I understand that issues around that are currently before the Independent Commission Against Corruption. I do not have detailed information about that, but that is my understanding.

The Hon. ROBYN PARKER: I would like to clarify something raised earlier, Ms Kruk, in relation to briefing papers from the structural reform group. You mentioned some that were tabled at the meeting on the 10th. Have other briefing papers been prepared by the structural reform group and, if so, may we have a copy of those?

Ms KRUK: Ms Parker, the structural reform unit has been a group of individuals that I have given the responsibility of pulling together the submission that was formally made available to the inquiry. So, I think the bulk of the work has been before your Committee.

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[2] Clarification received from Ms Robyn Kruk, Director General, NSW Health, 24 May 2004: "I also indicated that from memory, in the Veteran's Administration's experience there was an 8-fold increase in reporting. In an article published in the *Journal on Quality Improvement* in 2001*, the figures quoted are a 30-fold increase in adverse events and a 900-fold increase in the reporting of near misses.
* Bagian, JP et al "Developig and Deploying a Patient Safety Program in a Large Health Care Delivery System: You Can't Fix What You Don't Know About" *Jornal on Quality Improvement* Vol 27; 10; pp522-532.

The Hon. ROBYN PARKER: Is there other information that they prepared that we might get to have a look at?

Ms KRUK: That is the bulk of their responsibility in relation to pulling together parliamentary submissions. Given that there are a number of inquiries ongoing on this matter in various jurisdictions, including the Walker inquiry, this unit is responsible for providing any support to that unit and also assisting the department in pulling together any necessary submissions or background information to support that inquiry.

The Hon. ROBYN PARKER: When you say the bulk of information, can we have a copy of other things? Is there a yellow folder, perhaps, that might contain other information?

Ms KRUK: I am afraid I do not have a yellow folder, I am sorry. As I said, the responsibility of this group has been to pull together and to support the work of the inquiry. Those staff have been the primary contact point with your inquiry staff and, I hope, providing them with all of the necessary support and assistance. It has been their responsibility to pull together submissions for the various inquiries.

The Hon. CHRISTINE ROBERTSON: Is this document something that came from them that we were delivered last week?

Ms KRUK: Can I see what the document is, I am sorry?

The Hon. CHRISTINE ROBERTSON: "Providing the best healthcare NSW Health", April 2004. That is on the web site. Would they have prepared that?

Ms KRUK: Can I clarify that this is actually material provided by a quality unit who have been at the leading edge in relation to introducing initiatives such as the clinicians toolkit. This is the background information that supports the development of the clinical excellence commission and also put in place a series of recommendations about institutionalising complaint handling at the area health service level. What is important, and I think this is clear from the document, is that these are a series of proposals that we are putting before the clinical community and the academics in this area to get further feedback. My understanding is that these are documents also that have been provided to the Walker inquiry and, from memory, Mr Walker may have referred to this proposal in his interim report.

DEPUTY CHAIR: To avoid any confusion about the yellow folder, we are referring to the folder that is in the Committee room being held by one of your staff. I think that is the nature of the documents being sought by Ms Parker. The question is are you able to provide a copy of that material?

Ms KRUK: I would like to find out what the yellow folder is.

DEPUTY CHAIR: It is behind you, Ms Kruk. I can see it from here.

Ms KRUK: I am just taking some advice as to what is in the folder.

The Hon. AMANDA FAZIO: I raise a point of order on this matter in relation to the powers of the Committee to order the production of documents. The Clerk has provided advice on the power of Committees to order the production of documents, however the Crown Solicitor does not agree with it. I think when we have a grey area like that it is inappropriate for the Committee to ask for the production of documents like that. The Clerk has asserted that the House has delegated to this Committee the power to order witnesses to produce documents by resolving that the Committee has the power to send for and examine persons, papers, records and things, but the House can only delegate such powers that it has itself. I do not believe the House has those powers. Following the case of *Egan v Willis* we know this is taken to include the power to order executives to produce State papers to the House. I do not believe the Clerk's case, which is that the power that has been delegated to the Committee is appropriate. I therefore believe that this Committee does not have the right to demand the production of those documents. That is the basis of my point of order on this matter.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: To the point of order: I suggest that the order in *Egan v Willis* would override the Crown Solicitor's opinion and it should be subordinate to that. If it is good enough for *Egan v Willis* when we go to the High Court to get information, surely it is good enough for this Committee to get information now.

DEPUTY CHAIR: I am not going to seek to take this to a legal discussion at this stage. I will merely ask Ms Kruk, because we did not get an opportunity to ask Ms Kruk, would she table the documents? Before we pursue our powers, I ask a simple question would you table the documents?

The Hon. AMANDA FAZIO: How can you do that if you do not necessarily have the power to ask for them to be tabled? You are asking for the tabling of documents in the possession of a person who is not a witness before this Committee and who has not been sworn before this Committee. I think by attempting to do that you are stretching a bow so far as to be ridiculous. You may as well request that Ms Kruk provide us with documents that are held by someone in the Department of Health headquarters. It is totally inappropriate.

DEPUTY CHAIR: You are correct that the documents may well be held by someone who has not been sworn in. As I understand, they are providing the basis of some advice to Ms Kruk, and I am now asking Ms Kruk will she table the documents?

Ms KRUK: My understanding is that they are documents your Committee already has. I am afraid I am not sufficiently conversant with parliamentary law in this area. I am going to have to take some advice. The matter is beyond my level of comfort.

DEPUTY CHAIR: We will also take some advice about that and may way wish to pursue that separately.

Ms KRUK: Thank you for that latitude. I am just not familiar with the provisions that are being referred to.

DEPUTY CHAIR: There is also some suggestion that some of the documents may have been removed during the course of the questioning. We may wish to pursue the question of what was the full range of documents being sought.

The Hon. AMANDA FAZIO: I must object to that. That is the most ludicrous comment I have heard a Chair of any of these Committees ever make—the fact that somebody may have taken documents out of the folder while you are discussing it, when you know full well you do not have the power to request the documents to be tabled. That is a dreadful slur on whoever it is who has possession of the folder. It is disgraceful. You should be ashamed of yourself.

DEPUTY CHAIR: Thank you, Ms Fazio. I do have the right to request the documents. We will pursue all the legal issues about them later.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Referring to a comment by Mr McGregor about the resource distribution being a shortfall for the South Western Area Health Service, obviously a number of problems we have had would relate to resources of the South Western Area Health Service. I noted you said that one year the South Western Area Health Service was 18 per cent behind its resource distribution, causing a shortfall, and that had gone up to be only 3 per cent behind. Could you give us, either on notice or now, a table of the degree to which they were behind? Can you tell us what order of magnitude 1 per cent or less of their entitlement was, and did the 3 per cent shortfall even include the large amounts such as the obstetric contract for Camden or the large amount for the staff specialist locum that had come in in recent times to try to strengthen the medical team at Campbelltown and Camden hospitals?

Mr McGREGOR: I do not have that material available to me at the moment. I will take that on notice. I did say, though, that the variation or distance from target was, in 1994-95, of 18 per cent—17.9 I think it was exactly—and in 2002-03 it had improved to within 3 per cent. As it was 2002-03 that would not have included the significant amounts being expended on those initiatives.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Those two contracts?

Mr McGREGOR: Not that I am aware.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Those series of contracts?

Mr McGREGOR: Not that I am aware. But we will take that on notice and provide what information we have.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Can you tell me what a 1 per cent shortfall adds up to in dollar terms?

Mr McGREGOR: I do not have that information before me at the moment.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Can you give me an order of magnitude?

Mr McGREGOR: Honestly, I would be guessing. I would rather take that on notice.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: The medical error action group has given evidence to this Committee and it would seem to have acted as an amateur group almost parallel to the HCCC and other complaints mechanisms. What is the Health Department's attitude to that group?

Ms KRUK: I must admit I have not seen the submission of that group. I think it is consistent with what I was saying earlier, you need a structured process in relation to the information you collect about adverse events. You need an agreed understanding about a severity code, and that is what we have tried to do in the system we have introduced. As I also said, it would be sensible that there is an agreed basis for collecting information in relation to central events across Australia. At the moment I think there are different definitions in relation to what constitutes an adverse event. I think that group, without being aware of their specific issues, is important in that it typifies concerns in relation to community members about the need to have good reporting systems and a good understanding in relation to what adverse events occur, but equally, if not more important, also what action is taken to respond to those.

As I mentioned last time in my evidence, often the data can be incredibly misleading. It would be inappropriate, for instance, to focus on an issue such as mortality figures as being a measure of performance if you have a hospital that has a very strong palliative care function and would, for instance, have a very high number of mortality figures. That would not necessarily give any meaningful indication as to the performance of that hospital.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Given all those statistical points, have you yourself read any of the reports on hospitals or NSW Health produced by that group?

Ms KRUK: Yes, I have. I am certainly aware of their feedback. A number of other reports have been produced. I think also in documents like *Choice* magazine that seek to do it. The important issue is, and this has been the subject of some work within NSW Health for a number of years, to get an agreed and accepted reporting system. I have read their reports and am aware of some of the feedback they have come up with. In the past we have also raised some concerns about the accuracy and meaningfulness of some of the indicators.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Do you think that their work is valuable?

Ms KRUK: I think that the debate is an important one. I think what statistics you collect is quite critical. The use and interpretation of those statistics is equally if not more important, and the third point is what it does for system-wide learning. In relation to the collection of data, and I think they have played a role in relation to giving some prominence to the issue, I think that is important, but that does not replace the need to have a consistent and coherent information system.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: In the absence of a national or even a statewide information system, is it not reasonable to give some subsidy to a group like that, that is in effect pushing in the direction of better quality?

Ms KRUK: We now have in place already an agreed framework for a consistent system across New South Wales. What I indicated, and New South Wales has been a member of the national quality council, is the need for there to be some consistency across health jurisdictions so you can get some meaningful comparison data. One of the things that has struck me during the course even of the compilation of our submission to this inquiry is that it is very difficult to make meaningful comparisons between New South Wales and other States. It is difficult to make comparisons between our performance and that of, say, the Canadian or other OECD health

systems, which I think you could expect. We can try to get consistency in relation to the New South Wales system, which we are moving to do, but it is sensible given that we all come from the same funding body through the health care agreement that there be some agreed national measures. I am not commenting on the value of their work. I am saying it is not a replacement for a consistent and coherent set of variables that are used to judge performance and to guide improvement.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Given that the Tito report identified the problem is it not reasonable to get some push towards implementation of these lofty goals?

Ms KRUK: I think that it has been acknowledged that there has been quite a bit of progress made in this regard. I think having looked at the *Hansard* of a number of members that have appeared before the committee it has been commented on positively a whole range of the improvements that are underway. We have also been very honest in the fact that they are in their infancy but interestingly enough, while comparisons have been difficult, the changes and policy frameworks in the NSW Health system are recognised by bodies such as the NHS and our counterparts in other OECD countries to be leading edge.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Tito is 10 years ago, however, and we are still at this inquiry with the whistleblowers having put their necks on the line, would that suggest that progress is needed?

DEPUTY CHAIR: Do you wish to respond to that question?

Ms KRUK: I made it clear in my earlier evidence and also in the submission that work is well underway but we have also made it very clear that a lot more additional work needs to be done. At the heart of effective complaints management are both good systems but also cultural issues. There has been a consistent feedback that the cultural issues are the more difficult in the longer term to address and that has to be supported by good legislative framework, good systems, a whole range of issues that require changes at the hospital level. As I said, this inquiry is part of that process and, hopefully, a constructive part of that process.

The Hon. CHRISTINE ROBERTSON: The committee has received a lot of evidence in relation to the role delineation of Camden hospital. We have a copy of the review of the maternal and perinatal services in the entire area health service out there. Would you advise how comfortable are the people in the department with the process of role delineation and what is happening right across the State in this area?

Ms KRUK: As the committee members would expect, I have had a lot of contact with the clinicians out at South Western Sydney over the past couple of months, but obviously also previously. What has been impressive has been their work under some incredibly, I stress, personally and professionally difficult situations in pulling together what I believe to be a very coherent clinical services framework. That document is still in its final stages of development and the subject of discussions amongst clinicians, as it should be. The perinatal services and the whole discussion relating to the role of Camden hospital versus Campbelltown hospital and the other hospitals within that area health service are important. What is significant is that—I think it is an issue for both country hospitals and what we now call metropolitan or district hospitals—there is just not the work force to sustain services of a tertiary magnitude across each and every hospital site.

Over the past couple of years one of the most significant improvements that have been made in this area has been a strong support of clinicians for the concept of clinical networking. At the heart of that sits the very strong commitment to provide a good service but also safe services. That has to do with recognising the availability of manpower and clinical leadership at the various facilities but at the end of the day we have a health system that to operate effectively will need to strongly clinically network its resources. The smaller hospitals by definition are currently involved in a whole range of networking initiatives across the various disciplines and that should be encouraged and that is occurring on a statewide basis. Our major constraint—and I have said this in every other arena—at the moment is very clearly work force. We have shortages across a whole range of the professional discipline areas that cannot be solved by resourcing.

The Hon. ROBYN PARKER: Ms Jakubowski, what is your grade salary and position?

Ms JAKUBOWSKI: The grade is an SES 3 and the salary range is about $165,000 to $180,000.

The Hon. ROBYN PARKER: How many people work in the media unit?

Ms JAKUBOWSKI: In the media unit or in communications?

The Hon. ROBYN PARKER: Both.

Ms JAKUBOWSKI: In the media unit I have five people: four staff led by a Deputy Director, a senior officer.

The Hon. ROBYN PARKER: What is the role of the media unit when a contentious issue is raised?

Ms JAKUBOWSKI: Can you define contentious?

The Hon. ROBYN PARKER: Something that is likely to be publicly discussed. Perhaps it came out in media concern?

Ms JAKUBOWSKI: If I can give a couple of examples: the SARS alert. There was a lot of co-ordination by the media unit in relation to how the SARS issue was dealt with. As there is on any public health matter there is co-ordination across all of our public health professionals in all of the area health services. There is co-ordination on other areas such as immunisation. There is basically general co-ordination on many of those sorts of things. I can give a more recent example of a Legionella scare about one month ago. Again, we made sure that there was information that was available and provided a facts sheet on the effects and symptoms of Legionella—what people need to be aware of.

In fact, most recently last week we put up a message on swimming pool safety, issues about fencing on swimming pool safety. It is really a matter of whatever is current, whatever we perceive there to be an interest in. Either we get questions from the media or the general community about we try to respond to that and provide appropriate information.

The Hon. ROBYN PARKER: Does that co-ordination include liaising with the Minister's office?

Ms JAKUBOWSKI: Yes, definitely if the matter is relevant. We would certainly inform them about any of those sorts of issues.

The Hon. ROBYN PARKER: And seek advice?

Ms JAKUBOWSKI: In terms of advice of whether the public health message is appropriate? It depends on the message. If it were a public health matter, the public health experts and professionals in the department and in the health system would be advising on what sort of message that will be. So it really depends on the issue.

The Hon. ROBYN PARKER: Do you also liaise with public relations staff within the area health services?

Ms JAKUBOWSKI: Yes, definitely, whatever you want to call them—public affairs or community liaison officers, health promotions people and so on, yes.

The Hon. ROBYN PARKER: Do you do that regularly by weekly or fortnightly conferences?

The Hon. ROBYN PARKER: Yes, most regularly. We try to keep an open relationship with all the area health services. In fact, our media unit is quite diligent in terms of keeping them informed about any statewide issues. I think they have regular conferences weekly and fortnightly with the rural public affairs and community liaison officers. We also meet roughly bimonthly or quarterly as a group to discuss general professional development issues. So, yes, we would definitely try to maintain regular contact with them.

The Hon. ROBYN PARKER: With whom do you liaise in the Minister's office?

Ms JAKUBOWSKI: Me personally?

The Hon. ROBYN PARKER: Yes.

Ms JAKUBOWSKI: I would liaise with any number of people in the Minister's office, again depending on the issue. There are certain experts on public health matters and other policy matters. In terms of the media unit, it would primarily liaise with the relevant media officers in the Minister's office.

The Hon. ROBYN PARKER: If it were in relation to particular incidents or hospitals such as the ones, the subject of this inquiry, do you have a contact within the Minister's office with whom you would deal?

Ms JAKUBOWSKI: Personally I would not have. It depends on the issue. For example, the announcement about the clinical excellence commission, my media people would have liaised with the Minister's senior media officer about that announcement and made sure that the media release was available and distributed right across the health system and that we had the information on the web site. So it really depends on the issue. Is that helpful as an example?

Ms KRUK: Can I add to that, and it has come up in various contexts? One of the hardest things in a system as big as the Health one is actually communication to all of the parties whether that be in relation to inquiries made by members of the public, response made by media or response to inquiries from other government agencies or other jurisdictions. It is also important to get that information imparted consistently across the system. I think Liz is being somewhat modest in this regard, but we are obviously increasingly trying to use the Internet as a source of information. It is quite a critical issue for us. It is not just from a public health system but it was important in relation to her unit setting up very quickly the 1800 number in relation to complaints so members of the public had a standard contact form. What is also significant is to have information out in a form which is both accessible and understandable to the broader community.

So the functions of communication, as I demonstrated in some of my earlier answers, sits at the heart of so many concerns that can be raised in the health system. So it is getting the right factual information out in a timely manner, so it is not as simple as just fielding inquiries from the media. That can arguably be a smaller component of the job.

The Hon. ROBYN PARKER: We have talked about issues of concern. What is the role of the media unit in relation to a positive story? What was the role of the media unit in the February 2004 press conference concerning baby Paris Panetta?

Ms JAKUBOWSKI: In terms of positive stories or stories that promote initiatives in the system, obviously the media unit would have a strong co-ordinating role. We are very keenly aware of the need to communicate with the community and staff and wherever possible, in partnership with the media, to use the media to promote those sorts of objectives. Whether it is volunteer days, the latest information of findings out of the breast feeding report—a recent one that is up on the web, and I am just going through recent examples—telehealth grants which are IT electronic new ways to deal with better patient care using new technology, or numerous issues that we are constantly involved with in terms of promoting initiatives to the community.

Keeping in mind that health is top of the mind for the majority of the community out there. I think on average we would get probably—I do not know how many newspapers there are but every single community newspaper in New South Wales would have at least one or two health stories. The community is very interested in health and there is a very strong demand from the media from the general community about what is happening. We are constantly providing information on the latest treatments, the latest initiatives, new services, opening hours and those sorts of things.

In relation to baby Paris Panetta, if I have the name correctly, I understand the media unit was aware of the story. It received a call from the Northern Sydney public affairs officers, Pat McDermott, to explain that there was a request for the conference. One of the staff members offered, in fact, to come over and help Pat with the arrangements in terms of getting the baby to the press conference.

The Hon. ROBYN PARKER: From where did the request come?

Ms JAKUBOWSKI: From Pat McDermott, as I understand it, to our media office.

The Hon. AMANDA FAZIO: Miss Kruk, you mentioned the 1800 number that was set up last December to take complaints from members of the public. What is the usage rate of that number? Have many complaints come in on the 1800 number?

Ms KRUK: I am happy to take that on notice. I think the response from memory was very high in the initial periods. We have also tried to make sure that that is complemented basically by contacts at a hospital level and an area health service level. An 1800 number in many ways can be a somewhat impersonal means of raising concerns. So the announcement most recently by the Government of putting in place professional practice units at an area health service level would seek to strengthen the complaints handling function at a local level.

I am very happy to take the question on notice. My understanding is that there was initially a peak in relation to concerns, and that tends to peak depending on the issues that are raised in the media at any point in time. Understandably, what we try to do is to get the area health service to resolve the issues raised very expeditiously too.

I welcome the opportunity to raise this. From my understanding—and Ms Jakubowski may help me—I think our web site is the fourth most popular web site in relation to the number of hits, so it is an incredibly important communication tool. On the last occasion the Hon. Dr Arthur Chesterfield-Evans asked us how we promote quality improvements across the health system. It is the responsibility of the communications unit to pull together what we call our quality awards. During the course of this inquiry I think that has been loosely termed the Baxter awards. It is an important means of promoting quality initiatives and safety improvement initiatives across the health system.

The Hon. AMANDA FAZIO: Should incident reporting be mandatory, or do you believe that that would work against the whole idea of a culture of continuous learning within New South Wales Health?

Ms KRUK: I think that is an incredibly important question. What needs to be made clear is that a mandatory system will not necessarily encourage reporting. Under the current arrangements we have in place, a number of those are already mandatory. The system we have put in place in relation to what we call incident reporting is an obligation of the CEOs. There are also in place a number of other legislatively prescribed conditions and responsibilities through the various professional boards, and the responsibilities that flow on as a result of the health care complaints legislation.

What I think is important is that, even with the best and tightest laws and the tightest policy frameworks in place, you still have to have a climate wherein people feel free to raise issues, and that is something you cannot mandate or prescribe in law. I am very happy to provide some additional material to this Committee about some of the initiatives that are already in place and some of the issues that we may wish to pursue. I am very conscious that in our discussions with the clinical community in relation to the expansion of the role of the Clinical Excellence Commission there is concern from clinicians about reporting adverse incidents. What we are keen to do is to have the climate wherein people can report freely and that that information is used to improve the system of care that we offer. I will provide some additional material.

I am also conscious of the fact that the Walker inquiry is currently looking at the issue of individual versus systemic responsibility in that regard. Hopefully, it will give us some further input in relation to some of the policy or possibly legal directions that may be pursued. That is clearly part of Mr Walker's terms of reference in relation to system-wide improvement.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: With regard to the policy of code red, we have heard evidence that at times the administrators made the decision whether a unit should go on code red. Was there any pressure from the Health Department to stop hospitals or area health services going on code red?

Mr McGREGOR: No.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: If, however, a number of hospitals went on code red, presumably there would be a huge problem, would there not?

Mr McGREGOR: I understand Mr Rochford has already given some evidence about this matter. The code red system is an objective system that determines the status of each hospital. Where it impacts on more

than one hospital, there is normally a liaison between the Ambulance Service, the area health service and the individual hospitals about the best way to handle the matter.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Is code red really only about the distribution of ambulances?

Mr McGREGOR: No. Code red is about the status of hospitals according to some objective criteria, which were largely designed by a group of emergency department physicians to ensure that in elevating the status of each hospital according to the code it was done on an objective basis.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: But if all hospitals, for good reasons of their own and according to the most eminently worked out criteria, went on code red at the same time, presumably that would be a huge problem for the delivery of health in New South Wales. What co-ordination is there between hospitals so that they do not go on code red at the same time?

Mr McGREGOR: That is a matter we leave entirely to the Ambulance Service and the individual hospitals and area health services to manage.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: So it is a matter of liaison between the hospitals and the Ambulance Service in terms of where the ambulances go, and head office stays totally out of that, is that right?

Mr McGREGOR: The Department of Health is notified from time to time about the status of hospitals, but it is largely left to the area health services' managers and people employed in the hospitals and emergency departments to manage that.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: So we are assured that it is totally apolitical—the Minister and the department do not intervene in the code red distribution?

Mr McGREGOR: As the former Chief Executive Officer of the Ambulance Service and presently the Deputy Director-General of Health, I have never seen a situation where a Minister has intervened to suggest, or indicate or instruct, that the status of any hospital should be changed. The standard by which the code is determined has been designed by emergency department physicians, and it is left entirely to the managers in the health system, who manage it according to those criteria.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: But there is no pressure on hospital administrators to change that code?

Mr McGREGOR: Not that I am aware of.

The Hon. AMANDA FAZIO: Ms Kruk, I wish to follow up on an issue you raised earlier, and about which we heard evidence from Merrilyn Walton, the former head of the HCCC, in relation to encouraging and understanding the systemic origin of medical error and the need to ensure that individual health professionals are accountable. Do the recent changes proposed by New South Wales Health to improve quality and safety in health services include ways to improve professional accountability?

Ms KRUK: I think this is very relevant to some of the evidence we have tendered previously about the training and work that is currently under way in relation to introducing the root cause analysis process. I think there has been some misunderstanding about a number of those processes. What is important with regard to root cause analysis is the ability to reflect on adverse events and to learn from those events with a view to improving the system.

There is a misunderstanding about the concept of "no blame", which I think has probably been discussed in Ms Walton's evidence before the Committee. What sits underneath the ideology of that is the concept of having a just culture. I think "no blame" has become a confusing and potentially misleading concept. The concept of a just culture clearly accepts that an individual has an accountability in relation to his or her own responsibilities, but it acknowledges that a system as complex as health—which involves complex decision making and a whole chain of events involved in care—does have, in many instances, some system-wide issues that need to be looked at. I am sure Ms Walton most ably identified some of the issues beneath that.

I think what has been important in relation to the training that has been under way in the health system over the last couple of years in relation to root cause analysis is to get that learning out there. We have also made it quite clear that that is only the start; we really need to encourage that.

At the previous inquiry I think the Hon. Dr Arthur Chesterfield-Evans also raised issues in relation to root cause analysis and the process, which hopefully we have answered. It is a time-consuming process, but it is arguably one of the most critical in relation to ensuring that when something does go wrong, when mistakes are made, and when there are concerns about the level of care, the system corrects, and part of that is an individual accountability and the need to also look at the systemic issues.

The Hon. CHRISTINE ROBERTSON: I wish to place on public record that I have a strong recollection of this Committee being informed about the information day by the Secretariat and the Chair, and the Committee agreeing at the time that it was an empowering thing for the witnesses that were to come forward from the area health service.

The Hon. ROBYN PARKER: Ms Jakubowski, you spoke about your title and qualifications. I wonder whether part of your experience in coming to the role you now hold included working for a member of Parliament.

Ms JAKUBOWSKI: Working for a State member of Parliament, no. I have worked for Federal Ministers, in fact a number of them, in various States. Do you want me to outline them?

The Hon. ROBYN PARKER: Yes.

Ms JAKUBOWSKI: In the 1980s—I think from 1986 to 1991—I worked for the Minister for Arts and Territories, the Minister for Industrial Relations, the Minister for Local Government, the Minister for the Status of Women, and the Minister for Administrative Affairs.

DEPUTY CHAIR: I remind the media of the statement I made at the commencement of the hearing that whilst the media may take footage of the Committee and the witnesses, any photography involving the public gallery may only be incidental and should not be the subject of any particular photography.

(The witnesses withdrew)

(Luncheon adjournment)

DEPUTY CHAIR: The three witnesses appearing before the Committee this afternoon have previously been sworn. It is not necessary therefore for each of them to take the oath again, but I remind them that they are still under oath.

GREGORY JOHN DRIVER, Area Human Resources Manager, South Western Sydney Area Health Service;

RAAD RICHARDS, Chief Executive Officer, Carrington Centennial Trust; and

LISA MICHELLE KREMMER, Nursing Unit Manager, Emergency Department, Camden District Hospital, on former oath:

DEPUTY CHAIR: I again ask that anybody in the gallery, any witnesses or members of the Committee who have mobile phones should not switch them to silent mode but in fact turn them off. Does any witness appearing before the Committee wish to make an opening statement?

Mr DRIVER: No.

Mr RICHARDS: No, Madam Chair.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: I thought Professor Picone was appearing at the next session. Is she at both sessions, or is she at this session?

DEPUTY CHAIR: As I understand it, Professor Picone has sought permission, as she did previously, to sit with the witnesses and is not participating in this session by way of answering questions formally. But I assume she will perhaps provide some assistance to the Committee. She was previously given that permission by the Committee.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Right.

DEPUTY CHAIR: Ms Kremmer, you sat on the critical care committee. As a member of that committee, did Nola Fraser ever raise issues of clinical care at that committee while you were present?

Ms KREMMER: I honestly cannot recall Nola raising a specific issue at that committee, but members of the committee discussed issues that came up and Nola participated in that.

DEPUTY CHAIR: But you have no specific recollection of any issues being raised by Nola Fraser?

Ms KREMMER: Not specifically, no.

DEPUTY CHAIR: In your previous evidence you said you had never witnessed bullying or intimidation of staff in your time at the Macarthur Health Service. Do you stand by that claim?

Ms KREMMER: I do, actually. Yes I do. I have not witnessed that kind of behaviour.

DEPUTY CHAIR: Have you ever engaged in any bullying of staff?

Ms KREMMER: No, I certainly have not—not ever engaged in any form of bullying or harassment of staff, no.

DEPUTY CHAIR: What was your attitude to incident forms put in by Nola Fraser? Is it true that you accused her of overreacting when reporting a doctor for allegedly falsifying notes?

Ms KREMMER: No, I certainly did not. I took that incident as seriously as I take all the problems that are reported to me. I encourage staff to document concerns and I try to investigate them.

DEPUTY CHAIR: As background to some of what the Committee is doing today, there was a television program that touched on some of the issues that we are dealing with, in particular the *Sunday* program. Were you asked to provide any information to that program, and did you do so?

Ms KREMMER: I was not asked to provide any information and I certainly did not provide any information to that program, other than what was recorded.

DEPUTY CHAIR: What do you mean "other than what was recorded"?

Ms KREMMER: Well, we were interviewed, so we were asked questions and then we responded.

DEPUTY CHAIR: And you gave them no other material?

Ms KREMMER: No. None whatsoever, no.

DEPUTY CHAIR: Critical care minutes?

Ms KREMMER: No, absolutely not.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You said that Nola Fraser had not specifically reported any problems to the critical care committee, as far as you were aware.

Ms KREMMER: I cannot recall Nola raising a specific issue.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Were you the chair of that committee?

Ms KREMMER: No, I was not the chair.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Well, you were on that committee though.

Ms KREMMER: Yes, I was on that committee, but I was not the chair.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Nola, I gather, was removed from that committee?

Ms KREMMER: I am sorry, what was that?

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Nola Fraser was removed from that committee?

Ms KREMMER: I do not believe that Nola Fraser what was removed from the committee, no.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: We have had evidence that she—

Ms KREMMER: Well, there is from time to time a review of the terms of reference for a committee, and my understanding of those events was that that person's position had changed, but we still required a position on that committee. People were appointed or took up positions on the committee because of the position they filled, not because of the person—not because of who they were. We have the director of nursing on the committee, but it does not mean that the person—it was by position, not by person.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: So the position was changed and that is why she was taken off the committee?

Ms KREMMER: From my recollection, that person did not fill the position that she was filling, and therefore was not required to be on the committee. The committee position was an after hours hospital manager, and that is my understanding of what the committee did, according to the terms of reference.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: She was an after hours hospital manager, was she not?

Ms KREMMER: Yes, that is right.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: So if she was on a committee as an after hours hospital manager, she would have only been removed from that committee either if it was position related—she would only have been removed from that position if she was removed from the position of after hours hospital manager, would she not?

Ms KREMMER: You used the term "removed". I do not know that—it is a very strong word to use. My understanding of that was—

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Yesterday we had evidence that she was very upset after being removed from that committee. I do not think the word is mine—I would have to have a look at the transcript—but that is my understanding from the evidence yesterday.

Ms KREMMER: I have not seen the transcript so I do not know.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: But you were on that committee, and that committee did not discuss the removal of Nola Fraser at any time?

Ms KREMMER: No, no. I do not have a recollection of that.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: As a member of that committee, you were unaware of why she was removed from that committee?

Ms KREMMER: I was not really aware of it at that time.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: But you did not think that she made a lot of complaints on that committee which would have led to her removal?

Ms KREMMER: I do not know. No, I certainly could not agree with that statement at all.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Hang on. You said just a minute ago in evidence that she did not make a large number of complaints, on your understanding?

Ms KREMMER: I said I could not recall a specific incident or a specific complaint that Nola raised throughout the meeting.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Yes, so if she was not raising a lot of complaints, then she would not have been removed for making those complaints.

Associate Professor PICONE: Who said she was?

Ms KREMMER: I do not know that. I cannot—I am not sure what the question is and I do not know that I can respond.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: If she is not making complaints, then she could not have been removed for making complaints. Is that correct?

Ms KREMMER: Well, that would seen more than reasonable.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Yes. So you were not aware that she was removed from the committee?

Ms KREMMER: Well—

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You are aware that she ceased attending the committee.

Ms KREMMER: I have since become—

The Hon. AMANDA FAZIO: Why do you not let the witness finish her answer?

Ms KREMMER: Nola's position as an after hours hospital manager would not be—the committee required an after hours hospital manager on the committee. When Nola was seconded to be a nursing unit manager of another clinical area, we still required an after hours hospital manager on the committee, and that is my understanding of why a different person filled that position.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Okay. You were also the director of the intensive care unit, is that correct?

Ms KREMMER: I have never been the director of any intensive care unit. I am a nursing unit manager.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: There was not a medical director, so you were effectively the most senior person looking after that. Is that correct?

Ms KREMMER: Of the intensive care unit?

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Yes.

Ms KREMMER: No. That is completely incorrect.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: So you are the nursing unit manager [NUM] of the emergency department?

Ms KREMMER: Yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: At Camden?

Ms KREMMER: At Camden, yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You could not get surgical registrar coverage after hours. Is that correct?

Ms KREMMER: Surgical registrar coverage after hours is not provided at Camden, no.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Did you try to get surgical registrar coverage at Camden?

Ms KREMMER: We advocated for a number of what were perceived as gaps in the service.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: And you were not successful in those representations?

Ms KREMMER: For various reasons, no, obviously not. There is no after hours surgical registrar cover at Camden.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: And you took those to whom?

Ms KREMMER: It would depend on what the issue was. If you specifically are asking me where I raised the issue of the management of surgical patients, they were raised through problem report forms, through flagging incidents, they were raised with the director of the emergency department, David Hugelmeyer, they were raised with the director of nursing and acute services.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: So you lobbied for better coverage of your emergency department?

Ms KREMMER: It is part of my role.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: And you were unsuccessful in that?

Ms KREMMER: Not in all things, no. The department successfully obtained funding for an extra 12 hours medical cover, seven days a week. We received a significant amount of funding for capital purchases for new equipment and beds. We have a new transport service that operates 10 hours a day.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You were aware of the death of a patient that was investigated by the Health Care Complaints Commission [HCCC] who was transferred to Campbelltown after a somewhat late transfer. Is that right? It was a surgical patient who was assessed surgically to be seen by the surgical registrar.

Associate Professor PICONE: It is just very difficult, Chair, to answer questions on specific patients because I would imagine that there would have been hundreds of surgical-type patients. I am just wondering if Dr Chesterfield-Evans could give more detail.

DEPUTY CHAIR: I think it is a matter for the witnesses, if it is not possible for them to answer questions, to seek more information. I note your assistance to the witness but it is a matter for the witness.

Ms KREMMER: I would certainly have to ask for more information.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: There was a patient who is in the investigations of the HCCC who I believe was transferred, was within your casualty for quite a long time, came in late at night and was transferred late the next day and died relatively soon thereafter. Apparently they were waiting for a surgical registrar consultancy. You might have seen hundreds of cases but that would be a significant case, would it not?

Ms KREMMER: I would have to take that question on notice. I do not know specifically which case or which patient you are referring to.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: If there were a case like that would you put in an incident report and use it to lobby for more resources?

Ms KREMMER: From memory—and I am speaking generally, not about that specific case—most of the cases of the more serious nature were and had been reviewed by the critical care committee. I could take that on notice as well, if that is an insufficient answer for you.

The Hon. ROBYN PARKER: Ms Kremmer, are you familiar with an article or a letter published in the *Sun-Herald* under the name "Lisa White"?

Ms KREMMER: Yes I am.

The Hon. ROBYN PARKER: Are you Lisa White?

Ms KREMMER: I work under my maiden name, yes, and my married name is Lisa White.

The Hon. ROBYN PARKER: What was the nature of that letter?

Ms KREMMER: Do you have the letter with you?

The Hon. ROBYN PARKER: I do not. I am asking you what that letter was about.

Ms KREMMER: That letter was responding to articles that were within the *Sun-Herald*.

The Hon. ROBYN PARKER: Is your father Jim Kremmer, the former ALP Mayor of Campbelltown?

Ms KREMMER: He is the former mayor and former councillor of Campbelltown city, yes.

The Hon. ROBYN PARKER: Are you a member of the ALP or have you ever been?

Ms KREMMER: I certainly am not.

The Hon. ROBYN PARKER: Have you ever been?

Ms KREMMER: Many, many years ago.

The Hon. ROBYN PARKER: Do you know anyone on this Committee socially?

Ms KREMMER: No, I do not, but I have a very good working relationship with a number of people in Macarthur.

The Hon. CHRISTINE ROBERTSON: We heard some evidence yesterday about some very exciting work you are doing in Macarthur in relation to Camden's emergency services. I should not have pre-empted that because I think it is exciting but you might not. I just want to know how you feel about the implementation of the acute—I am sorry I have not got the words right, but the management of acute patients, introducing some beds in which acute patients can be looked after for a period of time.

Ms KREMMER: I welcome anything that helps the service provision and the way that we are able to meet the community needs.

The Hon. CHRISTINE ROBERTSON: Can you tell me from a nursing unit manager's perspective how that will work for your emergency department?

Ms KREMMER: To have a designated bed available for a Camden patient, is that what you mean?

The Hon. CHRISTINE ROBERTSON: It related—

Associate Professor PICONE: Yes, basically.

Ms KREMMER: It would expedite patient assessments and I think would be a very good thing.

The Hon. CHRISTINE ROBERTSON: I have one more question in relation to Hon. Dr Arthur Chesterfield-Evans' questioning. I am very interested to know if Camden is delineated to have after-hours surgery. Is there a role delineation that says Camden should have staffing for after-hours surgery?

Ms KREMMER: I do not have the role delineation information with me but it is freely available. My understanding is that Camden meets the level three role delineation. It does not specify surgical registrar cover within that, from memory.

The Hon. CHRISTINE ROBERTSON: So I will ask that question later when we have other witnesses here.

The Hon. AMANDA FAZIO: Ms Kremmer, when you appeared on the *Sunday* program and when you appeared before this Committee on 19 March you talked about the morale of staff working in the Camden and Campbelltown hospitals. This morning we heard some other evidence from people saying that they did not know how people could manage, after all the onslaughts in the media, to go to work there and feel like they are doing a good job. Can you give us an update? I know that it has only been six weeks since you appeared before us last time, but has there been any continuing improvement in staff morale?

Ms KREMMER: To be honest, the biggest improvement from staff morale was as a result of the *Sunday* program. It has waned somewhat since then. It is extremely difficult for staff to continue to go to work with these clouds over their heads. That affects morale on a day-to-day basis but it is especially worse when there is negative media publicity than it does at other times. We try to support each other. We have our international nurses day coming up at which we are focusing on horizontal healing. We have some great things planned for the nurses of Macarthur. So there are things we are trying to do to keep morale up because we still have a service to provide and that is what is upper most in everyone's minds.

The Hon. AMANDA FAZIO: Before lunch we heard some evidence about a briefing that was held in your area on 10 March, where some of the secretariat staff and senior management from New South Wales Health talked to people who might be potential witnesses to come before this inquiry to explain the way in which these committees operate and the rights of witnesses and stuff like that. Were you a participant at that information session on 10 March?

Ms KREMMER: Yes, I did attend an information session. I cannot recollect the exact date.

The Hon. AMANDA FAZIO: Did you find that of value?

Ms KREMMER: I absolutely valued it. I have never been called to appear before a committee such as those, and I valued the opportunity just to learn about how it worked and what I could expect. This is a daunting experience for a nursing unit manager.

DEPUTY CHAIR: Mr Richards, when the allegations surrounding Camden and Campbelltown hospitals became public did you spread information relating to any of the whistleblower nurses?

Mr RICHARDS: Can you clarify that question?

DEPUTY CHAIR: Did you ever suggest that any of the whistleblower nurses had what I will describe as a mental condition?

Mr RICHARDS: At no time I had any contact with the whistleblower nurses. I do not know any one of them and certainly we did not spread any information or misinformation about the whistleblowers.

DEPUTY CHAIR: It is not necessary for you to know them, of course, to perhaps be able to spread information. Did you ever describe any of them in terms like "mad", "insane" or "unstable"?

Mr RICHARDS: Certainly not.

CHAIR: I will be very specific. In relation to Nola Fraser, categorical denial.

Mr RICHARDS: Certainly not.

DEPUTY CHAIR: Did you refer to Nola Fraser as "mad", "insane" or "unstable" in a meeting with [name expunged on direction] and Mr Ian Southwell regarding a sexual assault matter?

Mr RICHARDS: [Name expunged] did not meet with Ian Soutwell So there is an error of fact there, and certainly I did not say those words.

DEPUTY CHAIR: In a separate meeting with either [name expunged] or Mr Southwell?

Mr RICHARDS: There was no meeting with Mr Southwell and [name expunged].

DEPUTY CHAIR: In any separate meeting with Mr Southwell or [name expunged]?

Mr RICHARDS: There was no other meeting with [name expunged] or Ian Southwell.

DEPUTY CHAIR: To discuss any matters?

Mr RICHARDS: To discuss any matters relating to this.

DEPUTY CHAIR: Why did you and officers at the hospital deny a staff member access to the sexual assault team and refuse to call the police on behalf of the staff member who was alleging that they had been sexually assaulted?

Mr RICHARDS: You are referring to [name expunged] complaint which goes back to early 2001. I believe Liverpool Hospital management at that particular time investigated the incident. I believe that the staff member was fully briefed about the investigation at that time in early 2000 and my contact with the staff

member, once the staff member came to see me in my capacity as the director of operations for the area health service, indicating that she would like to make sure that the staff member's records are secured, and I said, "Why would you say that?" Of course all records are secured at Liverpool or any other hospital in south-west Sydney. The staff member indicated that because the staff member had a call from Nola Fraser asking the staff member or pressuring the staff member to put a statement in relation to that matter or the incident in early 2000. We investigated the staff member's complaint in relation to the security of the record and the sexual assault notes and the notes were secured and I provided the staff member with that assurance subsequent to that investigation.

DEPUTY CHAIR: In the course of that discussion did you make any comments about Nola Fraser?

Mr RICHARDS: Certainly not.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Mr Driver, you were the head of human resources at Campbelltown hospital, is that correct?

Mr DRIVER: No, I am the manager of area human resources.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Were you in any way involved in the so-called deed of release between the unions as the negotiated settlement for nurses who had been whistleblowing?

Mr DRIVER: I was involved in the issue of the deed of release for the two operating theatre nurses, yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Is it standard practice that such a deed of release would be prepared with the unions?

Mr DRIVER: It does happen from time to time, yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: So you would say that that is not an uncommon practice to have that deed of release prepared?

Mr DRIVER: I have seen deed of releases prepared in the past, from my experience, yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Along the format that was suggested in the case of these nurses from the operating theatres?

Mr DRIVER: They would be in similar terms, I would expect.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: So that is more or less standard wording?

Mr DRIVER: Similar wording.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: So effectively saying that we will not criticise you if you do not criticise us is more or less the deed of release?

Mr DRIVER: There are provisions like that about criticising the other parties and also making sure that the issues contained in the deed of release are confidential between the parties, yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Is this effectively saying to people who leave because they are incompetent, "We do not want to employ you but you can go and work elsewhere"?

Mr DRIVER: I do not think so.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: If they left because of a justifiable reason that they were incompetent, you are effectively saying, "We will not criticise you" presumably when somebody rings up for a CV check or a reference?

Mr DRIVER: No, I am not saying that. I am not quite sure of the question.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: If you say you will not criticise a person when they have resigned, according to this deed of release, if someone then rings up for a reference they will not be criticised, will they?

Mr DRIVER: If there was a deed of release prepared like the one we are speaking about, and it does not happen all that often, there are often terms that the parties will give a statement of service or say where they have worked.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Is the deed of release not against the public interest in that if somebody is incompetent and dismissed for that, the people who re-employ them will never find out that they were incompetent?

Mr DRIVER: No, I do not think it is against the public interest. There have been some instances in the past when people have had their services terminated by the area health service and they have been referred to the medical board or the nurses registration board when there has been a concern about their performance.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: The other side of that deal is that the people who resign will not criticise the area health service. Is that not very convenient to the area health service if they have justified complaints, as the whistleblowers may well have had?

Mr DRIVER: The issues in relation to the deed of release were those matters relating to an employer-employee issue in August-September 2002. The issues which subsequently came out in November 2002 or thereabouts were not issues which were part of the deed of release.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You saying that the negotiations for the termination of employment of the nurses in the operating theatre did not relate to things that might have been embarrassing to the South Western Area Health Service?

Mr DRIVER: That is right.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: So you are saying that their negotiated dismissal had nothing to do with this inquiry?

Mr DRIVER: They were not dismissed by the area health service.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: The deed was not signed in the end but the thing was prepared and ready to be signed.

Mr DRIVER: But they were not dismissed by the area health service. They chose to resign their employment with the area health service. They were not dismissed.

The Hon. AMANDA FAZIO: Can I just ask you a follow-up question about the deed of release? Was it common practice in the area health service to prepare these deeds of release and how far up the chain of command was it authorised that this be prepared?

Mr DRIVER: It was not common practice. It has happened in the past but I cannot give you the details of when. It would depend on what was contained in the deed of release or the agreement reached between the parties. In this instance, the matter was discussed with Jennifer Collins, who was the general manager of the Macarthur health service. I do not recall discussing it with anyone else within the area health service.

The Hon. AMANDA FAZIO: Was this because I think we heard previous evidence that there was a policy that came out across the State that these sorts of deeds of release were not to be entered into, is that correct?

Mr DRIVER: At the time that this issue was raised, I was working on my experience and my knowledge of the Department of Health policies at that time. If it subsequently came to light that what I have done was not in accordance with that policy, I had no knowledge of that at that time.

The Hon. ROBYN PARKER: Mr Richards, I would like you to refer to a briefing note prepared by Professor Picone for this Committee surrounding Ms Audrey Daly-Hamilton. The note states that Liverpool Hospital discarded notes relating to an alleged euthanasia. Do you still stand by your earlier comments that all records at Liverpool Hospital are safe?

Mr RICHARDS: All the records at Liverpool Hospital during the time of my tenure as general manager were firmly secured in the clinical records department and no records would leave that department without higher authorisation, either from the medical superintendent or the director of nursing.

The Hon. ROBYN PARKER: Could you also tell me what is your relationship with the former health Minister, Craig Knowles? Is he a friend of yours?

Mr RICHARDS: No specific relationship to any health official with the Minister when they visit that particular health facility.

The Hon. ROBYN PARKER: So he is not a friend of yours?

Mr RICHARDS: He is not a friend of mine.

The Hon. ROBYN PARKER: What is your grade and salary?

Mr RICHARDS: SES level 4.

The Hon. ROBYN PARKER: Are you a member of the ALP?

Mr RICHARDS: I am a member of many community organisations and business organisations. What I do outside working hours is my own business.

The Hon. ROBYN PARKER: So that is yes then?

Mr RICHARDS: No, I did not say "yes". What I said is I am a member at various committees and management committees. I am a member of three boards, financial institutions. I am a member of the board of ACHSE, which is the College of Health Service administrators, so I am a member of these organisations. I did not indicate my affiliation to any political party.

DEPUTY CHAIR: Mr Driver, do you recall a meeting that you had with the whistleblower nurses in November 2002?

Mr DRIVER: I recall a meeting with Miss Fraser and her legal adviser on 5 November 2002, yes.

DEPUTY CHAIR: What was the nature of the meeting? What are your recollections?

Mr DRIVER: My recollection of the meeting was that Miss Fraser had sent an email to the Chief Executive Officer, Mr Ian Southwell, about some concerns that she had expressed in the email and requested a meeting take place to raise those matters with the area health service. A meeting was then arranged between the then acting director of operations, Miss Fraser and her legal adviser and I attended the meeting.

DEPUTY CHAIR: What was the mood of the meeting?

Mr DRIVER: From my recollection of it, it was an amicable meeting where Miss Fraser raised a number of concerns and elaborated on issues that she had raised in the email to the chief executive officer. During that meeting Miss Fraser said that she would provide further details to the health service and I think the meeting finished up on an amicable basis that Miss Fraser would provide those details to the health service.

DEPUTY CHAIR: There would be no suggestion of any feeling of intimidation by Miss Fraser arising from the meeting?

Mr DRIVER: I did not get the sense that Miss Fraser felt intimidated in any way by that meeting, no.

DEPUTY CHAIR: As a result of that meeting what action did you take?

Mr DRIVER: As a result of that meeting Miss Fraser did not provide any details of the issues that she had raised, but I subsequently found out that she and other nurses went to see the Minister later that day and, as a consequence of that meeting, the Minister referred the matter to the Health Care Complaints Commission and then asked for the matters to be looked at and provide a report to him.

DEPUTY CHAIR: In view of the nature of the issues that Miss Fraser would have raised at the meeting, did you make any independent inquiries in relation to the nature of the issues raised?

Mr DRIVER: No, I did not.

The Hon. ROBYN PARKER: Miss Kremmer, I just want to return to an issue we were discussing earlier, which was the letter you wrote to the *Sun-Herald*—and I now have a copy of it. The title of it was "Outlandish claims" on 15 February under the name Lisa White. You state in that letter that the "outlandish claims of a small number of nurses will be treated for what they are and no longer be seen as credible". Those informants claimed that practices were unsafe at Camden and Campbelltown hospitals as a result of management's inaction, even though they were fully informed. The Critical Care Review Committee, they claimed, was ineffective. They also claimed a culture of cover-up. Even though the HCCC report did not go as far as it needed to, these claims have been fully substantiated and validated not only by the HCCC but also with Professor Barraclough. Are you suggesting that the HCCC and Professor Barraclough, as well as the nurse informants, are not as credible people as you are?

Ms KREMMER: I think you would have to refer to the articles that were in that edition of the *Sun-Herald*—that it was purely and simply in response to those.

The Hon. ROBYN PARKER: But you did make those claims. Do you want to retract that at all?

Ms KREMMER: That was related to a specific article within the *Sun-Herald* the week before that letter was published.

The Hon. ROBYN PARKER: Your letter says that "when it comes to commenting on the health system in NSW", so you do not think they are credible?

Ms KREMMER: From memory, there was an article in a previous publication and, as a community member, I am also allowed to respond to newspaper articles, I should assume, and I was responding to a previous article in the *Sun-Herald*. I am not questioning the veracity of any of the inquiries at all.

The Hon. ROBYN PARKER: You also in the same letter state that your view was that at least one these nurses were being pursued for political point-scoring.

Ms KREMMER: Again, there are newspaper articles referring to that.

The Hon. ROBYN PARKER: Sorry?

Ms KREMMER: There was a newspaper article.

The Hon. ROBYN PARKER: A newspaper article of what? What was the newspaper article?

Ms KREMMER: It was a newspaper article and I cannot recall the exact words. It was a newspaper article about the whistleblowers—no names mentioned—and the whistleblowers being pursued for a career in politics.

The Hon. ROBYN PARKER: So you were just repeating what was in a newspaper article. That was not your personal view?

Ms KREMMER: I was responding to articles in newspapers.

The Hon. ROBYN PARKER: So that was your personal view as well, that their claims were not generated by a deep concern for the health system and those hospitals?

Ms KREMMER: I was responding to media articles as a community member.

The Hon. ROBYN PARKER: Why did you choose to use that letter to make a personal comment about Nala Fraser then?

Ms KREMMER: I was responding to media articles as a community member.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Do you stand by the phrase the "outlandish claims of a small number of nurses will be treated for what they are and no longer be seen as credible"? Do you think that is a reasonable assessment of where we are at now?

Ms KREMMER: I was responding to media articles, with one person's personal view of those articles.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You said, "a small number of nurses". Do you think that the claims that they have made are outlandish and will be treated and no longer seen as credible?

Ms KREMMER: That was in response to a media article.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: So you do not think that media article was a fair reflection of the overall situation. Either the article was wrong and different from every other article and, thus you are saying you deny that article but you accepted the truth of other things, or you say the whole thing has been outlandish claims. Which is the situation?

DEPUTY CHAIR: Just before the witness answers, I have a request that the letter be tabled and copies provided to the Committee.

Mr RICHARDS: Is that the article itself?

The Hon. CHRISTINE ROBERTSON: No, not the article, the letter.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: No, that is the letter.

The Hon. CHRISTINE ROBERTSON: We cannot get the articles at this hearing. Hopefully, we will get them later.

Newspaper excerpt tabled.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Are you saying that the article was outlandish but the overall process we are doing is not outlandish or are you saying that the whole processes are outlandish claims?

Ms KREMMER: I do not mean to be disrespectful, but can I ask about relevance.

The Hon. ROBYN PARKER: It is the nature of our inquiry.

Ms KREMMER: As a community member I responded with my personal views, as a community member based on published media reports.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: And you thought that the reports of what was happening were outlandish?

Ms KREMMER: As a community member, using my married name, my community name, my community address, responding as a community member to a published article.

Associate Professor PICONE: Chair, I was wondering if I could assist?

DEPUTY CHAIR: Could I just ask then: Is it your professional opinion?

Ms KREMMER: My professional opinion was not included and had nothing to do with that article.

DEPUTY CHAIR: No, I am now asking you is it your professional opinion?

Ms KREMMER: That there are outlandish claims?

Associate Professor PICONE: In the newspaper article that you were writing about.

Ms KREMMER: In the newspaper article? I would not want to give a professional opinion. I do not think that that is very reasonable. They were personal views expressed as a community member.

The Hon. ROBYN PARKER: Why did you choose to make a reference in that personal comment to the Liberal Party? Is that not a political statement rather than—

Ms KREMMER: Again, that was in response to previous published articles in the media.

The Hon. AMANDA FAZIO: In relation to the letter, the part that the Hon. Robyn Parker was referring to reads:

> Given media reports that at least one of the whistleblowers is being pursued for a career in politics, and that they have been receiving support from the Liberal Party, when does an allegation become an attempt to score political points, as opposed to a statement of fact?

Did you have any other information, apart from perhaps local talk, that led you to believe that one of the whistleblower nurses was receiving support from the Liberal Party?

Ms KREMMER: No, and I suppose the term "support" came from media, again, both written articles and media coverage with the Leader of the Opposition, John Brogden, and whistleblowers at times.

The Hon. AMANDA FAZIO: You were not alluding to the fact that at least one or two of the whistleblower nurses are frequent visitors to the Leader of the Opposition's office here in Parliament House?

Ms KREMMER: I was not aware of that, no.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Can I continue?

DEPUTY CHAIR: You can have the last couple of questions. We do need to finish on time.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Mr Richards, are you in any way responsible for this upper House inquiry, alleged euthanasia of Mrs Audrey Daly-Hamilton report?

Mr RICHARDS: No, I am not, Dr Arthur Chesterfield-Evans.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Mr Driver, going back to your point, the nurses, you said the whistleblower nurses were not dismissed. You said that they resigned.

Mr DRIVER: That is right.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Do you think that they resigned voluntarily, or were they under some pressure at the time that they resigned?

Mr DRIVER: I do not think that there was any pressure at all for them to resign. They made their own choice to resign.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You do not think that the system put them under any pressure to resign? Mid career they just up and resigned? Is that what we can conclude?

Mr DRIVER: I am not aware that any pressure was applied to them. As I said I am under the impression that they made their own choice to resign.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: So you are not aware of the antecedents that lead to their resignation?

Mr DRIVER: Sorry?

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You are not aware of what led up to it? So when you are brought in from the area to deal with these problems, you are not aware of what lead up to the problems? You are not briefed?

Mr DRIVER: I am aware of the action that led to the disciplinary action being taken, yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: So you are aware of the Jan Stowe report?

The Hon. AMANDA FAZIO: That is not—

DEPUTY CHAIR: I will allow the question to be answered.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Are you aware of the report from Jan Stowe, which went into the workings of the operating theatres?

Mr DRIVER: I am aware of the report, yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Were you aware of that at the time of resignations?

Mr DRIVER: Yes, I was.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: So you could not say that there was no pressure on them, surely?

Mr DRIVER: I am not aware that any pressure was applied; that they resigned.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You do not think that that report and its ramifications from management would have been a pressure to them?

Mr DRIVER: No.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You do not think so?

Mr DRIVER: No.

The Hon. AMANDA FAZIO: I ask for a frank answer to this question. Presumably, you deal with a lot of senior executives within the health sector. Do you believe that the treatment that the informant nurses, who were offered the deeds of release, received from senior management was really up to scratch? Do you think that perhaps the way in which senior management dealt with their concerns may have led them to feel that their was no real resolution to the problem, apart from leaving the employment of the area health service?

Mr DRIVER: At the time that matters were ongoing, I thought the action taken by the area health service and the executive of the health service was an appropriate course. There were other options given to both the operating theatre nurses to work outside the Macarthur Health Service. But as I understand it they chose not to take those. Both were still within the South Western Sydney Area Health Service.

DEPUTY CHAIR: In view of the fact that there are nine further witnesses this afternoon, I will hold to time at this point. I indicate that earlier in a question to Mr Richards, I identified a staff member by name who has not previously been subject of submissions in relation to this inquiry. It would be appropriate at this point

that I ask that that staff member not be identified. In doing so I therefore forbid any publication by any member of the public or media of that staff member's name.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: The end of this session is 3.00 p.m., not 2.45 p.m.

DEPUTY CHAIR: You are correct. I will finalise that matter. I make it clear that in relation to that particular staff member, there can be no publication. We do have another 10 minutes, and I will allow a few further questions, but we conclude promptly at 3 o'clock because of the need to deal with nine further witnesses.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Ms Kremmer, you were in charge of the medical emergency team at Camden, is that correct?

Ms KREMMER: By default, yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Were you aware that there were problems with resuscitation skills in that team?

Ms KREMMER: No.

The Hon. CHRISTINE ROBERTSON: Where did that come from?

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: My understanding is that the final HCCC report said that there were problems with the skill levels in that team. Is that correct?

Ms KREMMER: The team comprised a number of people. Not one person, not just two or three people comprised the team. It was a number of staff.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Did any incidents of that team lead to a discussion in the critical care committee?

Ms KREMMER: There were trends raised through the critical care committee. I am not aware of that specific incident.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: That did not reflect on the medical emergency team [MET] at Camden, in other words. Is that what you are saying? Is that your answer?

Ms KREMMER: I would have to take that on notice. I really cannot recall.

DEPUTY CHAIR: The question is taken on notice.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Were there procedural—

Ms KREMMER: I can check through the minutes, that is the best that I could do, if that would please the Committee.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: The HCCC mentioned in its final report the problem with resuscitation skills in that MET.

Ms KREMMER: Then I would have to accept that. I have not read the final report.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You were not aware of that in the HCCC report, is that correct?

Ms KREMMER: I have not read that in the final report, no.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Okay, and you are not aware or do not accept that there were problems with the resuscitation skill level in the MET?

Ms KREMMER: I have not read the Health Care Complaints Commission report front to back. I do not know what comments they have made regarding the MET or the resuscitation skills of staff.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Was there a training program for MET teams and ward staff resuscitation?

Ms KREMMER: There are a number of advanced life support courses available to all staff.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Is there any monitoring of who attends those? And any obligation on people in various teams to attend courses?

Ms KREMMER: Sorry, could you ask that question again.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Is there any obligation on staff to attend in-service training courses?

Ms KREMMER: If you are asking what staff participate in the MET, and what their skills are, the most senior staff attend the medical emergency calls including the senior medical officer that is on duty and the senior nursing staff that have resuscitation skills.

Mr RICHARDS: Could I just add to that, that is a well documented training program throughout the South Western Sydney Area Health Service, through the Simpson Centre, that had initiated the MET system right across the hospitals in south-western Sydney. The same training program that applies to Liverpool applies to Bankstown, Campbelltown, Camden and Fairfield hospitals. The staff receive similar training right across the area health service because it is run and documented by one unit.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: So everybody in those teams attend training regularly, is that correct?

Mr RICHARDS: As they are identified for that purpose, they do attend those training sessions.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Who monitors the attendance and makes sure that everyone on that team is up to date?

Mr RICHARDS: Of course it is up to the local management to ensure that the staff are receiving adequate training.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Are these matters checked at the critical care committee?

Ms KREMMER: I would have to check the agenda at this point in time.

Associate Professor PICONE: Chair, I may be able to help the Committee. The MET program that you are referring to is actually supervised by Professor Ken Hillman. You probably read quite a bit about this in the literature.

DEPUTY CHAIR: Professor Picone, it may be better if you give that as an opening statement. We did indicate that you would not participate in this session.

Associate Professor PICONE: I am just saying that it is not the responsibility of this nursing unit manager to do those things.

DEPUTY CHAIR: I am sure the witness is able to assist. You can give that information as an opening statement.

Ms KREMMER: I am responsible for working with the staff, to meet their training needs, their educational needs. We work together to do that. Resuscitation skills are certainly a component of that, as are a number of others.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Working with those teams could you guarantee at any time that the skills of the people on that MET had been recently updated?

Ms KREMMER: The team comprises a number of people from a large group of staff, including medical staff. Now, the staff work really hard to meet the needs of every individual patient, be it a patient that has a met call or not. They work together really well to do that. I have faith in their skills and in their education.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: But you were the de facto head of that, and you could not clearly state that everybody had regular update training as a matter of protocol? You cannot answer yes to that.

Ms KREMMER: No, I cannot.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You can say they are well intentioned and high up the scheme, but you cannot say—

Ms KREMMER: No, we do not have that level of system. We do not have that type of system.

The Hon. CHRISTINE ROBERTSON: May I ask a question, please, Madam Chair?

DEPUTY CHAIR: Shortly, I am not sure that we have quite finished on this point.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Can I then ask about—

Ms KREMMER: There is basic CPR accreditation, that is mandatory for all nursing staff within Macarthur. The advanced life support staff educates and we send people to courses when we can physically and reasonably do it. As often as we can. If that is annually, then that is great. I do not have an educator, there is no on-site educator for Camden emergency. We access any external course we can find, but for some staff it may be once every two years that they get to go to that advanced life support. But it is regular.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Is that also the case with nurses on the ward, that there is a shortage of update training in CPR?

The Hon. CHRISTINE ROBERTSON: You are not reading correctly from the HCCC report.

DEPUTY CHAIR: You will have an opportunity to ask a question.

The Hon. CHRISTINE ROBERTSON: All this is on the public record.

Ms KREMMER: What is your question?

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Is there regular CPR updates for nurses on the ward? Do they have to be accredited regularly?

Ms KREMMER: Yes, all nurses, in basic CPR.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Does that happen?

Ms KREMMER: At that point in time, more often than not the MET video is also shown as well so that nurses get the basic CPR and the MET at the same time.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Is that done rigorously, so that you can guarantee that every nurse is up to date with their St John qualifications, or equivalent?

Ms KREMMER: I certainly could not guarantee that, because I do not have that information.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: But it is held by someone in management, and we could guarantee it is the case, could we?

Ms KREMMER: Every individual staff member maintains a staff training record. There is also a database that maintains course registrations and other information pertaining to that kind of education.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: So it is up to the individual?

Ms KREMMER: No, that is not what I said. I was just informing you of where some of that information would be kept.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: But no-one supervises its implementation, that you know of?

Ms KREMMER: As a nursing unit manager, my performance management, we discuss the levels of training within departments at that forum, with my manager.

The Hon. CHRISTINE ROBERTSON: I have just gone through the HCCC report. The issue that that report well outlines was the issue about the confusion within the hospital about when a MET was supposed to be called and not supposed to be called. Could you outline the protocols that have been put in place by your department to resolve this very important issue? It was not about the skills of resuscitation.

Ms KREMMER: I have with me the medical emergency calling criteria; every staff has them. There are large, laminated copies of this available in every department. The MET system video is shown to every clinical staff member at orientation and it is also available and has been rotated throughout clinical areas for the staff in those areas to see. Do you want me to go through the criteria?

The Hon. CHRISTINE ROBERTSON: Yes, thank you.

Ms KREMMER: If there are any acute changes in an airway; if the airway is threatened, a MET is called. In terms of breathing, all respiratory arrests and wherever a respiratory rate is less than 5, or greater than 36. If there is an acute change in the circulation or cardiac arrest; pulse rate less than 40, pulse rate greater than 140, and a systolic blood pressure less than 90. Acute changes in neurology, a sudden fall in the level of consciousness of more than two points. Repeated or prolonged seizures. And there is another category, which is "any patient who you are seriously worried about that does not fit the above criteria". Mine is a little worn, because it goes with me everywhere.

The Hon. ROBYN PARKER: Ms Kremmer, just returning to your letter of 15 February entitled "Outlandish claims", I now have a copy of the article "Whistleblower nurse slams Premier" that you were referring to in your letter, which is under the name of Lisa White. I can find no reference in this letter to politics, to the Liberal Party or associating Nola Fraser with political influence. You say her allegations become an attempt to score political points. Is it not a fact that you were attempting to score political points by your letter?

Ms KREMMER: I have no vested interest in scoring political points.

The Hon. ROBYN PARKER: What was the point of your comments, then?

Ms KREMMER: I was responding to articles published in the media.

The Hon. ROBYN PARKER: You were responding to this article, which does not refer–

Ms KREMMER: That was one, but there were others.

The Hon. ROBYN PARKER: You did not refer to others in your letter.

Ms KREMMER: Perhaps not specifically, but the reference to the possible links, I suppose, or the part about being pursued by political parties was reported in another paper.

The Hon. ROBYN PARKER: You are sure about that?

Ms KREMMER: I am absolutely positive. It was in one of the local Campbelltown, Camden papers.

The Hon. ROBYN PARKER: This was a *Sun-Herald* article and letter.

Ms KREMMER: That is right.

The Hon. AMANDA FAZIO: Mr Driver, I am not sure if you have read the HCCC report but in part 1, page 5, it refers to disciplinary action against the nurses. In that section they are referring to the theatre nurses. Given what has transpired since the time they had the industrial problems with the Macarthur Health Service, do you now believe that the theatre nurses received procedural fairness?

Mr DRIVER: Everyone is wiser in hindsight. I think at the time that they did and from my understanding of procedural fairness they did receive what they were entitled to receive. If we were to relive that segment of time over again, knowing what we now know, I think there would have been some issues we would have dealt with in a different way.

The Hon. AMANDA FAZIO: Were you aware of the time that the HCCC found that the nurses were not fully informed of the allegations made against them, which helped precipitate the whole problem that they ended up having with the health service?

Mr DRIVER: Sorry, at the time of the Health Care Complaints Commission report? I do not understand the question.

The Hon. AMANDA FAZIO: In the Health Care Complaints Commission report they found that the theatre nurses who were having these difficulties, at the time that the difficulties were being dealt with, were not made aware of allegations that had been made against them. Do you think that is sound human resource management practice?

Mr DRIVER: My understanding of it is that they were made aware of the issues that had been raised against them, the details of which I do not know, but again we have to look at a place in time of what was dealt with at that time and it is difficult, I think, to try to go back and relive that, knowing what we now know.

(The witnesses withdrew)

DEBORAH PICONE, Administrator, South Western Area Health Service,

CATHERINE O'CONNOR, Nursing Manager, Intensive Care Unit, Campbelltown Hospital and

MALCOLM MASSO, private citizen, on former oath:

DEPUTY CHAIR: Do any of our witnesses wish to make an opening statement?

Associate Professor PICONE: Yes, I would appreciate the opportunity. Again I thank the Committee for providing us with a second opportunity to appear before you. Although I presented on a range of matters on 19 March, I did not have the opportunity to address concerns in some key areas and I thought it would be timely to canvass those briefly here today. I also made a commitment to present the interim report on the implementation of the Barraclough review, and I have that document for tabling today, together with an update for the period to 8 April. With your permission, I would appreciate the opportunity to table that.

Document tabled.

As I mentioned at my last appearance, it is my view that complaints handling and related quality improvements are not an end in themselves. They are only part of a good governance system. Good governance involves a system of accountability from the chief executive officer down, to ensure that the changes are implemented effectively. Ultimately, this is what will drive better risk management systems and quality improvements. We are doing that in south-western Sydney. We have just completed a far reaching new clinical services plan for the area which will form the template for the provision of area-wide services over the next three to five years. The development of the plan was steered by a clinical strategy group comprising 16 prominent clinicians and led by Professor Jeremy Wilson, the associate dean of the Southern Western Clinical School, University of New South Wales and the Chair of the South Western Clinical Council. Professor Wilson will be appearing before this Committee this afternoon.

A key feature of the plan is the formation of clinician-led, area-wide departments to create a one-service, multicampus health service delivery system in south-western Sydney. These will be led by area directors who may also be a senior clinical academic appointment. In June 2004 we shall also implement an entirely new clinical governance structure for the area health service. In complaints handling since October 2003, the area has now commenced collecting data from all facilities of complaints, whether they are lodged through ministerials, through the Health 1800 phone number or made to the area or directly to the facility. Data is now available on complaints handling in the area and shows that complaint numbers at Campbelltown and Camden hospitals have increased in the past few months. I see this as a positive step in ensuring that the best possible care and treatment is provided. It also demonstrates that a more positive environment is created to encourage patients and staff to raise more matters of concern. A team of three extra clinicians is now assisting Campbelltown hospital to address about 120 outstanding complaints.

At my last appearance members were briefed on the professional practice unit, which focuses on serious or unresolved complaints and grievances made by staff, patients and their families. I seek the permission of the committee to table for the first time appearing here, this brochure which details the role of that committee.

Document tabled.

The head of that unit, Mary Dowling, is also present here today. The professional practice unit has commenced providing training on complaints handling, letter writing and incident handling, initially to nursing staff at Liverpool hospital. Of course, this will go to all the facilities in the area. A review of the various complaints handling and quality improvement systems and processes across the area is close to completion. The objective of the review is to consider current structures and processes for patient quality and safety. The immediate challenges identified for the area through this review process are leadership and culture, the governance framework and reporting structures. These will be our focus in implementing an area-wide complaints handling and quality management system.

I go to matters that were raised by Dr Mary Prendergast at our last appearance at this committee. In evidence Dr Mary Prendergast gave to the committee inquiry on Friday 19 March 2004 she referred to concerns about some incidences affecting patient care and safety that she had raised with the management of

Campbelltown Hospital on four occasions in March, June and September 2003. Until hearing her evidence I had not been aware that Dr Prendergast had raised these concerns and I certainly thank her for having done that.

In order to ensure that Dr Prendergast's concerns were followed up promptly, I wrote to her shortly after the hearing and asked her to provide more details on these incidents. The four matters that Dr Prendergast raised are currently under investigation. I am advised that Dr David Saxton who is the medical director of obstetrics and gynaecology at Campbelltown Hospital has been in contact with Dr Prendergast and I understand that he is continuing to keep her informed of progress.

Advice to staff attending the inquiry—members may be aware of some media attention this morning concerning an information package prepared by NSW Health to advise staff appearing before the upper House inquiry into complaints handling in NSW Health. The information package comprised a number of documents covering the operation and process of such an inquiry. With your permission I would also like to table an example.

Folder of Documents tabled.

With your permission I will give you the contents: The Legislative Council information on taking evidence in committee hearings; the terms of reference of the standing committee inquiry into complaints handling; the New South Wales Parliament web site advice on the function of parliamentary committees; a copy of Premier's circular 99-52 on Guidelines for Appearing before Parliamentary Committees; the Premier's circular 2003 47 Guidelines for Appearing before Parliamentary Committees; the Premier's circular 96-4 Provision of Information to Members of Parliament; the Premier's memorandum 92-32 Provision of Information to Members of Parliament; a document advising on Actions for NSW Health Staff with Privacy or Confidentiality Concerns—of course, that goes to the matters of patient care and individual patient care; the New South Wales Parliament web site information on members of the parliamentary committee; and a document detailing lists of dates that the parliamentary committee would be sitting.

Staff to appear before the committee were invited to an information meeting conducted by officers of NSW Health and staff of the upper House committee to brief participants on the role and function of a parliamentary inquiry. At the briefing the information pack was provided to participants. Its contents were discussed and any questions from participants were addressed by NSW Health and parliamentary staff. A letter dated 11 March 2004 was sent to past and present employees scheduled to attend the inquiry who were not present at the briefing. The letter, accompanied by a copy of the information pack, was signed by the acting deputy chief executive officer on behalf of myself. The letter drew attention to the inquiry's terms of reference and the Premier's circular 99-52 on Guidelines for Appearing before Parliamentary Committees as a background information for staff who had no experience in appearing before parliamentary inquiries.

A number of staff have talked with me about the inquiry and have raised anxieties about appearing before the committee, as they have no experience of appearing before public inquiries of any kind. I have encouraged them to be open and honest and to tell it straight. I have also indicated that they should give their opinion about matters that they have been involved in, and to let the committee know of the good work that they do on a daily basis, particularly with their patients. At no stage have I vetted, or sought to vet, any individual's submission to the inquiry.

I thought I might just turn to one area that I am not certain whether the committee has considered, and that is actually the treatment of staff which I think is the other side of the coin in complaints handling. I have placed on the record my admiration for the professional and dedicated staff right across South Western Sydney Area Health Service. I have acknowledged the overall commitment and support of the wider committee in south western to its health service. Nevertheless, I remain concerned about the effect of media and public attention on the morale of staff, particularly nursing and medical staff at Campbelltown and Camden hospitals.

There is, regrettably, a dark side to the public attention drawn to the concerns about patient care and safety at those hospitals. Incidents of abuse, including violent abuse, of staff have increased markedly in frequency and severity since these issues became public. Data on assaults and offensive behaviour vary from month to month but I can inform members of the following. There were 30 reported assaults on staff in Macarthur Health Service which includes Campbelltown and Camden hospitals for the 12 months to October 2003. In the same time there were 400 reports of offensive behaviour which includes abuse, threats and harassment.

Members may be aware of the major research project conducted by NSW Health in 2001 to address issues of violence directed towards health staff and that, of course, resulted in the release of NSW Health's zero tolerance policy. The key finding of the research was that staff have the right to work in a violence-free work place. The purpose of the policy is to ensure that in all violent incidents appropriate action is taken to protect health service staff, patients and visitors from the effects of this violence. Of very real concern to me is the report from some staff, and particularly the emergency department—I met with them two or three weeks ago—of abusive behaviour in the emergency department of Campbelltown hospital to the point that a group of nurses said to me they really have to pick out the patients who are not abusive to them. I think this is a major concern for all of us.

I think honourable members will agree that this is a deeply disturbing development which I find totally unacceptable in our public health service. Health workers should not have to tolerate such behaviour from anyone whether patients, family members or other employees. I put that to you because a great deal of material has been worked on in this area. Initially we looked at emergency departments and mental health units. It is interesting, I visited the United States in the mid-1980s to look at a very exciting thing: peritonitis rates in people on peritoneal dialysis. I remember going to a hospital in the Bronx.

The Hon. AMANDA FAZIO: It sounds riveting.

Associate Professor PICONE: It was very exciting, being a dialysis nurse, I can assure you. I went into a hospital. To get into the hospital I had to go through a metal detector. Then when I went up to the unit that I had to visit—it was actually HIV people on dialysis and we were trying to understand it—there were armed guards walking up and down the wards. I remember thinking back then "I hope this never happens back at home." I just think that is a salient point for all of us.

In closing I wish to table the second interim report of the Implementation of the Barraclough Review Team's recommendations which includes an update on area health services' achievements in 2004 and what we propose to do after the next three months.

Document tabled.

DEPUTY CHAIR: I have given approval for Ms. Nell Buttenshaw to sit at the table. She is providing support assistance to the witnesses. She has not been sworn and will not be giving any evidence. Associate Professor Picone, you referred to evidence given to this committee by Dr Prendergast who highlighted on four occasions incidents of which you were not aware had been followed through. Arising out of that evidence have you sought to contact other doctors in the system to inquire whether they have any outstanding incidents that have not been appropriately followed through?

Associate Professor PICONE: No.

DEPUTY CHAIR: Do you treat the evidence of Dr Prendergast as isolated and a one-off?

Associate Professor PICONE: No, not really. What I wanted to do was to encourage people when they have concerns, if they feel that they are not being addressed at a local level, to know that we will address them, and then put in place a system to make certain that does not happen in the future. I hope by the end of our involvement—I mean in that the area health service—in the concerns that Dr Prendergast raised that we will both improve the responsiveness next time but also that she will feel that her concerns have been genuinely investigated. I found the delay in dealing with her concerns unacceptable.

DEPUTY CHAIR: Are you treating her concerns as a one-off?

Associate Professor PICONE: No, we have many complaints, some do come directly to me, others go locally, many now go to the Professional Practice Unit. There are people who are concerned that their complaints are not dealt with adequately or in a timely fashion and that is one of the reasons we have created the professional practice unit to allow people, if they are not happy at the local level, to take it up the next notch.

The Hon. ROBYN PARKER: When you appeared before the committee last time you took some questions on notice. I know you have talked today about instructions to staff in terms of circulars and how they

should go about presenting questions on notice. Did the answers on notice that you have provided so far go to the Minister's office before they were sent to the committee?

Associate Professor PICONE: I would have to look at each one of them. No, they did not.

The Hon. ROBYN PARKER: Did they go to the office of Ms Kruk?

Associate Professor PICONE: No, not that we are aware.

The Hon. ROBYN PARKER: Did you contravene the instructions that you gave to Malcolm Masso, that is, circular 99-52, questions on notice submitted to agencies prior to the committee, all answers must be approved by the Minister? You did not do that yourself?

Associate Professor PICONE: That circular is a very old circular which I understand has been around for 20 years. It was in a package of circulars and advice provided to people.

The Hon. ROBYN PARKER: Clearly you think it is relevant. On 8 March you wrote to Mr Malcolm Masso enclosing the circular and drew his attention to it.

Associate Professor PICONE: That is correct, I did write to him.

The Hon. ROBYN PARKER: Is there anyone else to whom it does not apply?

Associate Professor PICONE: No.

Mr MASSO: Would it be permissible to make a short opening statement? I was not given an opportunity before. I will be very short.

DEPUTY CHAIR: Yes.

Mr MASSO: I was not intending to make an opening statement because I actually had that opportunity last time, but given the publicity this morning in the *Daily Telegraph* I thought I would say a few words. I was referred to in the paper this morning as having received this information from the area health service. I have to say at no time did I believe that I was being warned in any way. I saw it as an honest attempt to provide me with information. You do not front up to these sorts of gatherings terribly often in one's career, and I certainly knew nothing about how to present to this committee. I saw it no way as a warning or anything like that.

I was also fairly sure that the particular Premier's circular that was referred to in the article in the *Daily Telegraph* did not apply to me as I would be appearing as a private citizen which was a fact that I checked with the Secretariat of this committee. So at no time did I feel I was being warned or gagged, or any of the other emotive words that may have been used in that article this morning. I just wanted to place that on record, thank you.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Do you feel bound by the limitations of circulate 99-52?

Mr MASSO: Based on the advice given to me by the Secretariat of this committee, no.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You would if you worked for the Health Department?

Mr MASSO: That is right. That was the advice given to me and unless somebody has got any advice to the contrary, that was the advice given to me by the Secretariat of this committee.

DEPUTY CHAIR: I will allow the Hon. Robyn Parker to complete her questions first.

Associate Professor PICONE: With your permission could I add one extra comment by way of mitigation of my compliance or not with said circular? We were advised by the director general at a number of meetings that she wanted a very open and frank process in this and that she wanted to encourage people to

provide submissions. They did not want any vetting. Maybe that was sitting in the back of my mind when I had failed to comply with the circular.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: In your enthusiasm you overlooked the circular?

Associate Professor PICONE: And also from listening to the director-general, she was very keen that we all participate in this process because we all believe that at the end of today we will end up with a better complaints handling system in New South Wales Health.

The Hon. ROBYN PARKER: Have you ever discussed this inquiry with any of the witnesses in relation to the evidence they would give?

Associate Professor PICONE: Yes, I have.

The Hon. ROBYN PARKER: In terms of coaching them about how they might present to this inquiry?

Associate Professor PICONE: No, I have not. The major discussions I have had with people—and there have not been that many—is that people have been concerned about appearing. I have encouraged them to tell the truth, to give their opinions, but also to tell people about the positive things that they are doing on a daily basis. I certainly have done that.

The Hon. ROBYN PARKER: In your mind, that is not coaching them?

Associate Professor PICONE: No, I do not think so.

The Hon. ROBYN PARKER: Whom have you met with and discussed the inquiry?

Associate Professor PICONE: After the briefing meeting, I think David Hugelmeyer stayed and asked me some questions. I had a talk to Lisa Kremmer—in passing; I have not made appointments. I think I have talked to Cathy O'Connor. I was at a meeting with the medical staff council at Campbelltown and I discussed the evidence I would be putting in; that was on Wednesday afternoon.

The Hon. ROBYN PARKER: Which Wednesday afternoon was that?

Associate Professor PICONE: This Wednesday, I think. I did talk to Dr Parker, but not in terms of any evidence that may or may not be given. He was not able to attend the meeting, and I simply went through with him some of the procedural matters of the Committee. It was pretty basic advice, such as, "If you don't know the answer, say you don't know", explaining to people it is not an examination, it is not a test; "If you can't remember something, say to the Committee you can't remember." I explained to people the term "I will take it on notice", because people did not understand what that was. It was those general sorts of things.

The Hon. ROBYN PARKER: We do not have a list of the people who attended that meeting and who might have been sent briefing information. Are you able to provide that to us?

Associate Professor PICONE: Yes, I would be happy to provide that to you.

The Hon. ROBYN PARKER: On the last occasion you appeared before the Committee you took on notice questions about your involvement with the Sarita Yakub case. Why did you take those questions on notice?

Associate Professor PICONE: Because I could not recall the details and I wanted to provide the Committee with proper advice. It was over 18 months ago, and I think I said at that time there had been many more patients and issues since then, so I felt that it was better to provide you with the facts that you were seeking rather than try to pull it out of my memory bank.

The Hon. ROBYN PARKER: You still have not provided those answers to us, have you?

Associate Professor PICONE: My understanding is that a brief has been provided by the Department of Health.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Mr Masso, you were the 2IC to Jennifer Collins, is that correct?

Mr MASSO: Not in a formal sense. Since I have left Macarthur Health Service they have created a position of deputy general manager. However, as part of my job description, when Macarthur Health Service was formed in 1998 the service was keen to have a situation where, if for some reason the general manager was not available—for example, they might be simply out of the area or they might be having a day off or whatever—automatically somebody had the delegated authority to make decisions in their absence, and that was in my job description. If Jennifer was not available for any reason and decisions needed to be made with the authority of the general manager, I would do that. Certainly during the five years that I was part of Macarthur Health Service I would routinely relieve Jennifer when she went on leave, but it was not formally seen as a 2IC role.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You must have been aware of the problems with staffing and resources then in your job?

Mr MASSO: Yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: I gather that the health service was getting considerably less than its share of the resource distribution formula, is that correct?

Mr MASSO: It is my understanding that that was the case, although the exact detail I do not know and I am sure that somebody could provide you with that information. But you also have to remember that from about 1997 there was a whole planning process put in place for the redevelopment of Camden and Campbelltown hospitals and an integral part of that planning process was a calculation of around about $29 million as enhancements in funding to Macarthur Health Service that would occur with the redevelopment of the two hospitals.

I suppose every health service likes to think they are underfunded or they could always do with more money. But we were in the environment where there was this expectation that there would be this stream of enhancements coming over a period of time as the services at Campbelltown and Camden hospitals, and particularly Campbelltown, were redeveloped.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: But the redevelopment of Newcastle hospital led to the dismissal of the chief executive officer there, Dr Owen James, who was arguing that he should have the same amount of money to treat patients while the new hospital was being built. He was criticised for being over budget, and eventually he lost his position there. Was your ongoing cost of running the system less because of the cost of the building program?

Mr MASSO: Our costs were not less.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: I am sorry. Was your disposable income less?

Mr MASSO: We were certainly in a situation where I think it is fair to say there was a growing demand in the local area that it was difficult to contain meeting that demand within our available resources, and certainly for the whole five years that I worked for Macarthur Health Service we were over budget every year. As I recollect, it tended to creep up every year. I think that is an indication that whilst the budget may not have increased, the demand was certainly there.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: I think you kindly wrote me a letter clarifying the doctor-staffing numbers at Camden Hospital.

Mr MASSO: Yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: So you were aware that there was a shortage of doctors there, particularly at nights and on weekends?

Mr MASSO: As I think I said in my opening statement last time, when we first formed Macarthur Health Service in 1998, if I had then been asked what was the major single issue in terms of the redevelopment of services that was being planned, it was ensuring that there were enhancements in the medical infrastructure, whether that was residents, registrars or specialists.

Despite the budgets that you mentioned, sometimes you have to take the opportunity to increase staffing although the money is not always there. For example, the lead time to get additional resident medical staff is about 12 months, because you have to apply to the Postgraduate Medical Council. Certainly a couple of years ago we applied a year in advance for an extra surgical resident, an extra medical resident and an extra resident in palliative care, hoping that we would have the money in 12 months time to pay for them. In fact, it turned out that we got all three positions, which was a bit to our surprise because they are quite difficult to get. There was no enhancements in the budget to meet that, but nobody said, "Look, you can't do that."

So there was an element where, if you like, the enhancements in funding got out of sync with some of the enhancements. Certainly there were opportunities to get additional surgical registrars, as I recall, and we did not knock those back because the colleges are not familiar with our funding time frame and we have to take the opportunities when they arise, and we did that.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You were aware of the fact that you had problems with staffing, in terms of fewer doctors per head of population in the area, and presumably fewer doctors on the ground per patient than the comparable-size hospitals in more favoured locations?

Mr MASSO: Yes. And it was not just a question of numbers. For example, if you look at staffing of the emergency department and the intensive care unit, we were highly reliant on locum doctors. So it was not just a question of numbers; it was also a question of trying to stabilise the staffing, and the way we saw of doing that was through getting more staff specialists and building up particularly the registrar infrastructure.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: The intensive care unit roster often had no doctor written on it, is that the case?

Mr MASSO: As I said, as long as the after-hours cover was provided by locum doctors—and there were certainly situations when it became very close to not being able to fill the shifts. We would certainly have situations, particularly on the weekend, when we might get to a Friday afternoon and have one or two shifts still vacant on the weekend. Our way out of that was to offer higher and higher rates, until we were able to fill them. I do not honestly recall a situation when we had no doctor in the intensive care unit, but I stand to be corrected on that. We had to play the locum market and try to get the locum, like many hospitals in the State.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Did you take this issue to Jennifer Collins?

Mr MASSO: Absolutely. One of the things we tried to resolve that, for example, was to go to tender, to try to get a particular locum agency to take on responsibility for filling our rosters. That was managed through the contractual staff, because unless you have that sort of situation the locum agencies take absolutely no responsibility for filling the shifts; it is purely a free market.

What are we wanted to do was to go to tender, which is a situation in some hospitals whereby, by gaining the tender, the locum agency then takes on responsibility to fill the shifts. We were unable to get an agency to meet the tender. I was not actually involved in the tender evaluation because I was on leave at the time. My feeling is that we were probably too big for any one agency to want to take us on, because we had so many shifts to fill.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: We have heard evidence that Jennifer Collins pressured staff. Did she ever pressure you? Did you ever feel pressured by her?

Mr MASSO: Previously there was Camden Health Service and Campbelltown Health Service. When we restructured those two services to form Macarthur Health Service, my job, along with all the other senior executives in both Camden and Campbelltown, was abolished because we created a new structure. It was my intention to leave at that time. The reason I did not leave was that I took on, in an acting capacity, the job that I subsequently filled for five years. Because of the support I received from Jennifer in that role, that was the main

reason for my deciding to stay and apply for the job when it was advertised on a permanent basis. I have to say that Jennifer Collins has been the most supportive person to me personally. She has provided me with enormous support, in very difficult circumstances at times, and I thoroughly enjoyed working with her and would work with her anywhere at any time.

The Hon. AMANDA FAZIO: Associate Professor Picone, what improvements have you made to emergency services at Campbelltown and Camden hospitals in the past six months? Is access block still an issue at Campbelltown?

Associate Professor PICONE: We have appointed six new locum emergency physicians; they worked in Campbelltown and emergency department from December to January to cover the roster for 16 hours a day, seven days a week. There has been a clinical nurse consultant appointed to the emergency department. We now have access to after-hours CT scanning. We have upgraded the operating theatres in various areas, which of course assists with surgical patients. Only this week we commenced a specialist cardiology roster, which we are absolutely thrilled about because, as you know, about 40 per cent of patients who come through emergency departments have a cardiac condition.

We have expanded the ultrasound services. In terms of the access block issue at Campbelltown Hospital, Campbelltown Hospital has one of the lowest rates of access block of any hospital in the metropolitan area. It is a very busy emergency department. Out of the 30 metropolitan hospitals in the month of February, Campbelltown emergency department had the fifth best performance.

The Hon. AMANDA FAZIO: The other question I have for you is in relation to the review done by Professor Henderson-Smart into the maternity and perinatal services in the South Western Sydney Area Health Service. I have had a look at his report, but would you say what you think of the most important conclusion you drew out of it? What do you think about what he had to say in relation to the Camden hospital?

Associate Professor PICONE: First of all, Professor David Henderson-Smart, as you know, is one of the most eminent neonatologists in this country. After the, as I would call it, divergent political opinion—and some not clinical, may I say—in relation to the operation of the Camden maternity unit, I invited Professor David Henderson-Smart, who is the deputy chair of the New South Wales Maternal and Perinatal Committee and also the head of the New South Wales Pregnancy and Newborn Services Network, Professor David Ellwood, who is the obstetrician and fetomaternal specialist member, Ms Suellen Allen, who is a clinical adviser on maternity services for the New South Wales Department of Health, Ms Joe Kent-Biggs, who is the manager of the New South Wales Pregnancy and Newborn Services Network to conduct a review of maternity services, not just at Camden hospital but in fact across the South Western Sydney Area Health Service. What they found is what I suspected, I have to say—that we were operating six maternity units as separate entities across the area health service that had different admission criteria, different operating policies, different clinical protocols and that what we need to do to create a critical mass across the area health service was to establish an areawide approach to the provision of maternity services to women in the area health service.

They made a series of recommendations in relation to the operation of all of the maternity units, but most importantly they recommended that we appoint a medical head who could either be a fetomaternal expert or obstetrician to head up an areawide maternity service. They also recommended that we appoint an area director of midwifery services, also a medical academic specialising in obstetric anaesthesia—because, as you know, that had been somewhat of an issue at Camden—and as a priority engage the existing areawide muiltidisciplinary maternity service network to develop and implement strategies to improve the integration of consistency and quality of maternity and perinatal services. Professor Henderson-Smart does these reviews regularly across New South Wales. There was broad-ranging discussion over the conditions and also the community. On the basis of that I recommended that we accept his recommendations to the point that we have actually appointed an acting head of maternity services and an acting head midwife. Because there was some interest in relation to Camden and the safety of the Camden maternity unit, Professor David Henderson-Smart's report said that Camden hospital has a safe maternity unit.

He said that there is a very experienced team of obstetricians on site 24 hours a day, seven days a week, providing a level of obstetric service equal to the best in the State. He concluded from an analysis of the data that the perinatal death rate at Camden is lower than the State average. On the basis of that he recommended that the Camden hospital would continue to provide a safe service for normal-risk births, with high-risk births being referred to Liverpool Hospital, as a part of the new network, and with the hub of the South Western Sydney

Area Health Service maternal and perinatal services network also located at the Liverpool Hospital. The pleasing thing about Professor Henderson-Smart's report is I genuinely do believe it will lead to considerable improvements in the provision of maternity services because women will now know that if they are going to the unit at Camden, what services they can expect at what level, and if they go to Campbelltown and if they go to Liverpool or if they go to Fairfield or they go to Bankstown. The really good thing about this is, over time, that group of clinicians and community people will shape the maternity services in south-western Sydney, so it could be that, in 12 months time there could be different views on what should be where, but I think that the shaping, the development and the enhancement of those services will be well led in the area health service for people in south-western Sydney.

The Hon. ROBYN PARKER: Professor Picone, I just want to return to the questions we were asking before about the Sarita Yakub case. We have ascertained since we were discussing that that we have not received information from you on that case from questions on notice that you took last time you were with us on 19 March. I wonder whether you have had an opportunity to check and if you are now in a position to explain to the inquiry the role you played in dealing with that Mr Yakub's complaint?

Associate Professor PICONE: I am happy to take questions and then advise the Committee when I cannot recall. I have looked over a briefing of the chronology of events and I am happy to take questions, but I would again ask the Committee to be aware that these events did occur 18 months ago and where I cannot recall them I may have to take them on notice and ask the department who holds this information to provide you with the detail.

DEPUTY CHAIR: It may be appropriate for Hon. Robyn Parker to go through the series of questions and you can indicate those that you will take on notice and those that you are able to answer.

Associate Professor PICONE: Yes.

The Hon. ROBYN PARKER: How many meetings and telephone conversations did you have with Mr Yakub?

Associate Professor PICONE: I spoke to Mr Yakub by telephone—this is from the chronology—on four occasions and I met with him on at least two.

The Hon. ROBYN PARKER: Did you provide the clinical review report into Mrs Yakub's visit to Nepean Hospital to Mr Yakub?

Associate Professor PICONE: That was provided to Mr Yakub by the Health Care Complaints Commission.

The Hon. ROBYN PARKER: Could you clarify who it was you were briefing in the department regarding the Yakub case?

Associate Professor PICONE: I briefed—there were three meningococcal patient-related matters occurring at the time and as a part of those I did brief the director-general. I cannot recall how often, but I did.

The Hon. ROBYN PARKER: What about the briefings to the Minister's office? What briefings did the department provide to the Minister's office on the Yakub case?

Associate Professor PICONE: I do recall that we briefed the Minister's office at general meetings between the department and the Minister's office on the Yakub matters as a part of the three meningococcal issues that we had concerns about at the time.

The Hon. ROBYN PARKER: So you could give us the dates of those meetings then?

Associate Professor PICONE: I cannot answer that. If those records are kept at the department, then that would be possible.

DEPUTY CHAIR: But you can take that on notice.

Associate Professor PICONE: I will take that on notice.

The Hon. ROBYN PARKER: If that is the information, you could come back and give us that on notice so far. In what context was that case discussed? For example was it discussed in terms of keeping the story out of the media?

Associate Professor PICONE: I never ever recall discussing that. Is this at the meeting when we briefed the Minister's office?

The Hon. ROBYN PARKER: Yes.

Associate Professor PICONE: No, absolutely not.

The Hon. ROBYN PARKER: How often do you discuss those sorts of issues at an executive level with the Minister?

Associate Professor PICONE: It depends on—when we have very serious adverse incidences that may have a systemswide implication, we would then discuss those with the Minister's office. If I recall correctly, one of the issues in relation to Mrs Yakub was that we did not have signage in the emergency department at the time to let people know that if they were going to leave, they should go to the desk. I felt very strongly about this because in a ward, in an inpatient sense, if a patient decides to leave, they are required to sign a release form, so that would then involve some discussion going on and someone saying, "Look, you know, why do you want to leave? Is that such a good idea?" I felt that we did not at the time—that has now since changed—we did not provide that sort of sound advice at the emergency department. So that then became the subject of a circular after it was discussed with various groups, such as the emergency department implementation group if I recall, and also we sent a memo out I think or a circular. But we felt we should change that statewide policy, and in fact we have. So now if you go to an emergency department, there is a sign that says if you are going to leave, will you please go back and inform the desk that you are going to go.

The Hon. ROBYN PARKER: In terms of your presentation today, you have talked about improvements within the emergency department and within the hospitals. I wonder then how you explain the death earlier this month of Sharon Brophy who died in a toilet, not having been attended to in the emergency department?

Associate Professor PICONE: This was a very sudden and tragic death. We immediately obviously referred Mrs Brophy's death to the Coroner, as was appropriate. I will give you some detail on the public record, but the other matters are still the subject of a coronial inquiry. I will give you as much detail as I am able to at this time. Mrs Brophy was a 34-year-old female who presented to the emergency department at Campbelltown Hospital on Friday 26 March with a four-day history of chest pain. She had recently seen a dentist on 22 March 2004. Upon presentation at the emergency department, Mrs Brophy was quickly triaged by the clinical initiatives nurse at 13.05 as a category three and her vital signs were performed within three minutes of presentation. A category three triage requires medical review within 30 minutes of the presentation. Mrs Brophy was triaged to the emergency department waiting room as there was no allocated space within the emergency department. The period of time between triage assessment and Mrs Brophy being found collapsed in the emergency department toilets by an eyewitness was about to one hour and 40 minutes.

On the basis of this, we obviously forward the matter to the New South Wales Coroner who has a provisional interim report determining the cause of death to be a myocardial infarction due to coronary artery disease. The South Western Sydney Area Health Service professional practice unit has contacted the nominated next of kin, who was the patient's father, and offered support, counselling and access and any information that they may need. In addition the professional practice unit has also contacted the general practitioner.

The Hon. AMANDA FAZIO: I know.

Associate Professor PICONE: Do you want me to stop?

The Hon. ROBYN PARKER: Not at all.

The Hon. AMANDA FAZIO: No. I beg your pardon.

Associate Professor PICONE: Right. The professional practice unit has not at this stage been able to obtain a copy of the ECG. Professor Bruce Barraclough is overseeing a review of this matter, which is currently being conducted by the professional practice unit, following the completion of a root cause analysis. To assist the professional practice unit with its investigation, the matter is now being examined also by an external review. The report will be provided to the Coroner and to the family upon completion of the investigation. I am unable to comment any further on this matter until that investigation is completed.

The Hon. ROBYN PARKER: Given your comments that you are macro-managing referrals to the Coroner, why then is Helen Parsons, the medical director, still in her position, given that it is her role to ensure that these actions are undertaken?

Associate Professor PICONE: Well, Dr Parsons in her position has many other duties other than that. I did set up, when I commenced within the area health service, a committee that would provide advice to me on whether matters should be referred to the Coroner. The reason I did that is that I had concerns arising from the HCCC report that there were patients who in my view should have been referred to the Coroner at the time of their death. I wanted to ensure that there was a system in place that, should that need to happen, I received the best expert medical advice for that to occur. The reason I wanted to do that is that I did not want to be routinely referring deaths that we just had concerns about to the Coroner and overburdening the Coroner's office. And so there is no question at all. I have put in a very senior medical committee to advise me on that, and I will continue that for a period of time until that committee advises me that in its view it is no longer necessary.

The Hon. CHRISTINE ROBERTSON: What actions have you implemented to stop people like me wandering in and out of your hospitals at any time they please?

Associate Professor PICONE: Since I have got the farm I have learnt about cattle electric fences. No, I am only joking. I think I did something because there were some questions raised at the last Committee about an honourable member visiting our facilities. I will just see what I did about that. I wrote to the general managers of Bankstown, Fairfield, Liverpool, Macarthur, Wingacaribee, Braeside karitane. I also wrote to the directors of mental and population health—I was very busy this day—and I asked them had they ever been aware of any member of General Purpose Standing Committee No. 2—and you could have had a cup of tea—having visited South Western Sydney Area Health Service. There is no record of Dr Chesterfield-Evans or any other committee members visiting South Western Sydney Area Health Service facilities in an official capacity in relation to this inquiry.

As you would be aware from our earlier evidence, South Western Sydney Area Health Service follows New South Wales Premier's Department guidelines, such as circular C2003-09, in relation to the hosting of visits by members of Parliament to public facilities, and notes accepted practice and custom for members of Parliament to inform relevant ministerial offices or government agencies if a visit in an official parliamentary capacity is proposed. I hope that answers your question.

The Hon. CHRISTINE ROBERTSON: My next question relates to the briefing notes on Ms Daly-Hamilton which was mentioned earlier in this particular section of the inquiry. Were the discarded notes that are referred to actual patient records or were they a record of a meeting between two staff members?

Associate Professor PICONE: They were not clinical notes. My understanding on advise is that they were file notes that were in an office of a senior doctor who had resigned and gone to work in another State. Another doctor was cleaning out the office of that person and they threw out a whole lot of things. The doctor who threw that out then in light of the serious allegations that were raised later on raised that with me and I felt that I should at least advise ICAC in relation to that, but they were not clinical notes.

The Hon. CHRISTINE ROBERTSON: My next question relates to the clinical council process. I would like to hear from you, although you have had given us a written report on its implementation, if it is making any difference in getting the health professionals in that particular area health service and the management to get a handle on what the role delineations actually mean, what can happen in their hospitals and when they should transfer people.

Associate Professor PICONE: That is an absolutely excellent question. Yes, it is. I do not know whether it would be Professor Wilson's intention but he may brief the Committee on a proposal that we have to

set up what we are calling the golden phone system. The non-tertiary centres, the non-Liverpool hospitals, now will be able to ring Liverpool Hospital with a critically ill patient. Liverpool Hospital will take ownership of the care of that patient to ensure that the patient will be transferred up to that level of care more quickly. Whether that is a critically ill adult or child, or even a mental health patient, we will put into this network, but I think Professor Wilson would be better placed to provide you with advise on that.

DEPUTY CHAIR: A few weeks ago in evidence it was suggested to us that in relation to Camden Hospital obstetrics care that a private consortium was being paid more than $750,000 a year to provide that service. Is that an indication of the amount that is being provided?

Associate Professor PICONE: I cannot answer that question commercial in confidence. I am happy to take legal advise on it.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: It is a matter of fact.

Associate Professor PICONE: It is a commercial in-confidence contract so for me in a public place to give you those details would be in breach of our contractual arrangement. Would I be able to take advise on how best to inform the Committee on that?

DEPUTY CHAIR: Thank you. Ms O'Connor, are you the chair of the critical care committee?

Ms O'CONNOR: Yes I am.

DEPUTY CHAIR: How long have you been in that position?

Ms O'CONNOR: Seven years.

DEPUTY CHAIR: Can you confirm that matters raised by Nola Fraser regarding patient care were in fact discussed at this committee?

Ms O'CONNOR: Issues raised by all members of that committee were discussed thoroughly. If she were one of them to have raised those issues, they would have been discussed.

DEPUTY CHAIR: Is it a standard practice that matters raised at these meetings that reflect poorly on the area health service are not documented?

Ms O'CONNOR: No, that is not true.

DEPUTY CHAIR: Is it your responsibility to ensure that matters raised at meetings are acted upon?

Ms O'CONNOR: It is the responsibility of the committee to make sure that the issues that are raised at that committee are acted on.

DEPUTY CHAIR: And is a process in place to ensure that that occurs?

Ms O'CONNOR: As would be with all committees.

DEPUTY CHAIR: In your role as intensive care unit manager, is it true that you left the unit to be staffed without a doctor?

Ms O'CONNOR: No, we did not.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: What follow-up was there of the matters discussed at the critical care committee?

Ms O'CONNOR: If a patient issue was raised at the critical care committee we would then allocate that issue to two members of that committee to take away and investigate. They could ask questions of anyone else they needed to to get the information they needed. They would then report back to the committee what they

had been able to find out through the course of their investigation. Whether or not the committee members were satisfied with that, then the issue would be investigated further.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: So in each case there was a report back for each issue and item discussed?

Ms O'CONNOR: Yes, there was, if it was in fact in relation to a patient care issue.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Was Nola Fraser on that team?

Ms O'CONNOR: She was on that committee, yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Did she bring up a number of issues?

Ms O'CONNOR: I do not recall that she brought up any more than anybody else on that committee, no.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: She was taken off that committee?

Ms O'CONNOR: She was not removed from that committee. Under the terms of reference of that committee, there was a provision for the person to be on that committee as an after-hours manager. When she was no longer fulfilling the role as an after-hours manager she was no longer required to be on that committee, and that position was then taken up by someone who was in the position of an after-hours manager.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: So it related to her position, not to her personality or anything she did on that committee?

Ms O'CONNOR: That is correct, as per the terms of reference.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You were also head of a MET, is that correct?

Ms O'CONNOR: By de facto, I look after the MET because it is the responsibility of intensive care staff at Campbelltown Hospital for whom I am responsible.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Is there a training program for the MET?

Ms O'CONNOR: Yes, there is.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Do you supervise that?

Ms O'CONNOR: I do not personally supervise it but it is supervised, yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Does everybody on that MET have regular training?

Ms O'CONNOR: Yes they do.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: And that is audited?

Ms O'CONNOR: Yes.

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

Ms O'CONNOR: Yes, annually.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: There were times when there was no doctor rostered on to intensive care units, is that correct?

Ms O'CONNOR: That is not correct.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Every time there has been a doctor rostered to intensive care?

Ms O'CONNOR: When the issue was first raised by the HCCC investigation some 18 or 19 months ago we took it on notice to go back over a period of five years to look at the rosters. Certainly, over a period of five years the intensive care unit at Campbelltown Hospital was covered by medical staff 24 hours a day, seven days a week, as indicated earlier. Sometimes it was at the last hour but there was always cover for the intensive care unit at Campbelltown Hospital.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: That is separate from the ward cover—

Ms O'CONNOR: That is separate.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: —so you are not saying the same doctor covering both?

Ms O'CONNOR: No.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: In no cases?

Ms O'CONNOR: In no cases.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Did you have relatively inexperienced doctors coming in to do that coverage?

Ms O'CONNOR: The medical staff that we employed predominately from locum agencies were required to fill out a form. On that form it went into some length for them to explain to us what experience and procedural experience clinically and theoretically they had. They were required to fulfil a certain level of experience. If they fulfilled that experience then we would employ them through a locum agency to work in the intensive care unit.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Have you had people like psychiatric registrars working in there who did not have training in the area?

Ms O'CONNOR: We had a number of people who had come from various backgrounds. Perhaps one of them was from a psychiatric registrar background.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Did you have a death of an asthmatic woman of 26 there?

Ms O'CONNOR: Yes we did.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Was that a Coroner's case?

Ms O'CONNOR: Yes it was.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: It was made a Coroner's case.

Ms O'CONNOR: As I understand, it has been since, yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: But it was not made a Coroner's case at the time, is that correct?

Ms O'CONNOR: I do not recall.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Was the patient being treated for asthma prior to their death?

Ms O'CONNOR: Yes they were.

The Hon. ROBYN PARKER: Professor Picone, to clarify something relating to the notes that were thrown out, are you telling us that notes were thrown out that related to a potential criminal offence?

Associate Professor PICONE: At the time when the good doctor cleared that office it was not a matter that was the subject of a homicide investigation. But because she then afterwards—and I do not know the months—she then said to me, "I did clear out this office. There were some notes." She raised that directly with me. I thanked her for that and I referred that on to the appropriate bodies, the police and ICAC, with her agreement.

The Hon. ROBYN PARKER: Returning to the Yakub case, you do understand that this matter goes to the heart of whether a Cabinet Minister was involved in a cover-up prior to the State election. You are aware that the Minister was briefed by you and you controlled those briefings. Are you covering up for Minister Knowles?

Associate Professor PICONE: Covering up what?

The Hon. ROBYN PARKER: His involvement in the Yakub case just prior to the State election.

Associate Professor PICONE: I honestly do not know what that means.

The Hon. AMANDA FAZIO: To follow up on the medical emergency issues raised by the Hon. Dr Arthur Chesterfield-Evans, we heard evidence in our first hearing that people were being physically obstructed from pressing the buzzer to get the MET to come and deal with a patient. We then had further evidence that it may well have been a matter of a definition of some people wanting people resuscitated that went beyond the guidelines that are in place. Do you have any comments to make on that?

Ms O'CONNOR: At no time during the seven years that I have been employed and involved in Macarthur health and involved in the medical emergency team have I ever heard of anybody being prevented from calling a medical emergency team to a patient who fulfilled the criteria or for whom they were concerned in any way.

The Hon. AMANDA FAZIO: So you think the evidence we heard earlier—

Ms O'CONNOR: I am not aware of that happening.

The Hon. ROBYN PARKER: In terms of the Yakub case, Professor Picone, was the purpose of your briefing and in fact your continued ministerial briefing over that case an opportunity on your behalf to manage it, to keep it out of the media?

Associate Professor PICONE: No it was not. That matter as best I can recall was investigated at a clinical level. It was then referred by us to the Coroner for a determination and then from there to the HCCC. I would think that that constitutes a very thorough investigation of those matters.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Dr Picone, you have written us a letter about the alleged euthanasia case of Ms DH. Are you happy with the report that was sent with that case to us as an appendix to your letter?

Associate Professor PICONE: Could I just check, please?

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Perhaps I could read the first part of it to you. Ms [DH] "presented to Liverpool Hospital on 15 January 1999 with an ischaemic left foot and an aorto-femoral bypass. Ms [DH] developed a four-limb weakness and breathing difficulties in her first post-operative day. She was initially ventilated, however respiratory support was withdrawn after discussion with the family."

Associate Professor PICONE: Yes, if it is the same document I have here, I am happy with it.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Do you think that the paragraph I have just read is a satisfactory summary of the situation? It does not mention the patient's age, it does not mention what the pathology was, it does not mention what operation she had and it does not mention that there was an allegation of euthanasia. So apart from that, that is pretty comprehensive, and you are sending that to us as an example of how you fixed up a problem.

Associate Professor PICONE: Can I say in this case you are more learned than me, having a medical qualification; I am but a mere bureaucrat. If you require further clinical details, then we can always provide those to you. I would have thought that the heading, which says, "Alleged euthanasia of Ms Audrey Daly-Hamilton" was an indication that there was an alleged euthanasia of Ms Audrey Daly-Hamilton.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: It does suggest that, but the point is that there is no case summary; there is no other evidence. Then it goes on, there is a four-year gap, it seems, between when she went to hospital on 15 January. It does not say when she died or what operation she had, and then we hear on 16 January 2004, just over five years later, the Coroner is asking for material, which the Coroner gets a few days later, and then there is some fuss because one of her relatives is notified and then 10 days later the relative who was unhappy with the treatment is not notified.

Associate Professor PICONE: Can I say that this is an excellent summary of the situation: that this matter occurred five years ago and was raised—I would have to check but I think initially from a nurse complainant at Liverpool; I am not certain whether it was initially through the media—no, it was raised with me actually by the Coroner, who said that there was an allegation of euthanasia of a patient called—we thought it was a male anyway—Daly-Hamilton, so we went searching through our records for a Daly-Hamilton, who had been at Camden Hospital. In fact, there was no Daly-Hamilton at Camden Hospital. There was a Mrs Audrey Daly-Hamilton at Liverpool Hospital.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: I was trying to keep the name confidential.

The Hon. AMANDA FAZIO: It was discussed at our previous hearing.

DEPUTY CHAIR: It has been the subject of previous hearings.

Associate Professor PICONE: You are quite correct. It was five years ago, so you can imagine that five years later there has been some difficulty in going back now and looking over this issue, but the five years nevertheless should not, and certainly has not for our part, stopped the investigation and we are obviously co-operating very closely in this matter with the homicide squad, with the Coroner and with the ICAC.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Certainly, but it would appear, though, that the notes have been discarded.

The Hon. CHRISTINE ROBERTSON: No, not the notes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: I am very disappointed with the nature of the explanation in the brief because if that is the health department doing a great job, I would defer.

Associate Professor PICONE: I take your comments on board and if you require additional clinical detail, I am happy to provide that.

The Hon. CHRISTINE ROBERTSON: Have clinical notes on this patient been discarded?

Associate Professor PICONE: No, they have not.

The Hon. ROBYN PARKER: The information that has been discarded, however—will you sack Helen Parsons for destroying that information?

Associate Professor PICONE: Helen Parsons, honourable member, did not destroy this information.

The Hon. AMANDA FAZIO: You should withdraw that comment. It is very insulting.

Associate Professor PICONE: I think I have not been helpful enough to the Committee.

The Hon. AMANDA FAZIO: He told us yesterday.

Associate Professor PICONE: This is not the same patient I think people may have been talking about yesterday. This is another patient at Liverpool Hospital. Dr Parsons does not work at Liverpool Hospital.

The Hon. ROBYN PARKER: So it is common practice for notes to be destroyed then?

Associate Professor PICONE: No, I do not believe it is. I might just help the Committee again. There was a record of an interview that took place between a senior doctor and a nurse concerning the care of a patient at Liverpool Hospital five years ago in the intensive care unit and the doctor kept a file note. That doctor left, went to another State. Another doctor moved into that doctor's office and somebody else cleared it out and through out all of their old papers. They were not clinical notes. There were no clinical notes destroyed.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: So those file notes mentioned in your report were not the clinical file notes?

Associate Professor PICONE: No, they were not.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Because that is not specified, actually.

The Hon. CHRISTINE ROBERTSON: I asked that question.

The Hon. AMANDA FAZIO: He does not listen to anybody. He is a lunatic.

Associate Professor PICONE: No, I actually think Dr Chesterfield-Evans is correct. I have not, in my brief, made that clear enough and I will do that.

The Hon. ROBYN PARKER: I want to follow up on Dr David Hugelmeyer's information yesterday that there are two cases. Will you take action?

Associate Professor PICONE: I have referred those allegations of Dr Hugelmeyer's today to ICAC. Can I say one more thing? I do have the report of Professor David Henderson-Smart and with your permission I would like to table that entire report into maternity services.

Report tabled.

DEPUTY CHAIR: I thank the witnesses for their participation and their co-operation in answering our questions.

(The witnesses withdrew)

BRADLEY SCOTT FRANKUM, Medical Practitioner and Director of Medicine, Macarthur health service;

STEPHEN ANTHONY DELLA-FIORENTINA, Medical Practitioner, Chair of the Macarthur Medical Staff Council and Director of the Macarthur Cancer Therapy Centre,

AMANDA HOPE WALKER, Medical Practitioner, Vice Chair of the Macarthur Medical Staff Council of Macarthur health service, and

JEREMY SOMMERS WILSON, Medical Practitioner and representative, sworn and examined:

DEPUTY CHAIR: Do you wish to make a brief opening statement prior to questioning?

Associate Professor FRANKUM: I do.

Dr DELLA-FIORENTINA: Yes, I do.

Dr WALKER: Yes.

Professor WILSON: No.

DEPUTY CHAIR: If any of you should consider at any stage during your evidence that certain evidence or documents that you may wish to present should be heard or seen in private by the Committee, the Committee will consider your request, however, the Committee or the Legislative Council itself may subsequently published the evidence if they decide it is in the public interest to do so. I am now going to ask each of you to make your opening statement. To facilitate general questioning I will start with Professor Frankum.

Associate Professor FRANKUM: Thank you and I apologise for my voice. I have got laryngitis. Some would say that is a good thing. I was on call last night at Macarthur Health Service because one of my valued colleagues had to have urgent surgery last week and he had been rostered on yesterday. His wife believes the stress of the last 18 months caused his illness. I am not sure that I disagree. I should be at the hospital right now seeing the patients who were admitted under my care last night but instead I sit here. Another of my valued colleagues is seeing my patients.

Over the last 16 months, since taking up my position as Director of Medicine at Macarthur health service, I have spent vast amounts of my time dealing with the fallout from the actions of the whistleblower nurses. In many ways I feel my time could have been better spent. There is much work to do at Macarthur health service to develop services that the people of the area require. If you people can understand that we need money, and lots of it; and staff, and many of them, so that the people of south-western Sydney get a fair deal finally, then perhaps my time today is not wasted; for the real issue is not about complaints handling or the way a small group of nurses feel they were mistreated; the real issue is about resources. It is about successive governments failing to direct the dollars for health out to where the population is. It is about a lack of Federal planning and foresight, resulting in a medical work-force crisis. It is about expecting a group of doctors and nurses to work harder and see more patients than their colleagues throughout New South Wales Health, and then not understanding that that will inevitably lead to mistakes being made—not because clinicians are incompetent or evil or substandard, but because they are human.

I am a member of the group of the vast majority of staff at Macarthur health service who are the ones who know that there is no evil conspiracy at Macarthur health service. We know that our fellow doctors and nurses most certainly do not turn their backs on dying patients or treat them like animals. We are deeply offended at the suggestion that numerous patients are dying unnecessarily in our hospitals. We are angry that we look after more emergency and inpatients at Macarthur health service than St Vincents Hospital, yet we have less than half the specialist staff and one-third the junior medical staff. We care very greatly about our patients and we are saddened that we are prevented from doing that as well as we could if we were given an equitable share of resources.

Since being at Macarthur health service I have seen no evidence of cover-ups. The silent majority of staff are happy with the way they are treated and perform their jobs extremely well. When things go wrong and

mistakes are made, we are our own harshest critics and we would never seek to minimise the distress of patients or their families when an adverse outcome occurs. But creating a climate of fear and blame will never solve problems, and pretending that adverse events do not occur throughout hospitals throughout the world is not a reasonable standpoint. I have worked in other hospitals in New South Wales, including teaching hospitals. I know what I am talking about. In closing, can I implore this Committee to start taking into account the views of the hundreds of doctors and nurses in Macarthur health service, who quietly go about their business and despite very serious accusations having been levelled against them, have never been given the opportunity to present their views to any of the inquiries. I believe it is time for evidence rather than emotion or personal agendas. Thank you.

Dr DELLA-FIORENTINA: Thank you for the opportunity to speak at the inquiry. As the elected chair of the medical staff council of Macarthur Health Service, I would like to inform Committee members of the current activities already in place as they pertain to the culture of learning and open and active involvement in review of errors, and ongoing improvements in clinical care in Macarthur. The NSW Health clinicians tool kit, published in late 2001, is a framework for the notification and investigation of adverse events. This has already been adopted and implemented at Macarthur. In 2003 the quinquennial recredentialling of every senior medical staff within Macarthur Health Service required evidence of participation in peer review, incident reporting and quality improvement activities. Identification of serious adverse events and sentinel events are investigated using the tool of root cause analysis, with many members of senior medical and nursing staff participating and producing recommendations to the hospital executive for improvements to a system of health care.

Departments undertake case reviews and review adverse incidents in regular peer review meetings within a multidisciplinary team environment. Regular educational meetings involve medical students, junior doctors training registrars, senior clinicians, nurses, allied health and pharmacy. Video links between Campbelltown, Camden and Liverpool hospitals broaden the opportunities for staff to attend and participate in those meetings. Macarthur is a leader in many aspects of health care delivery in this State. The partnership with our community with committee representation and active involvement of the community in root cause analysis teams are evidence of open and active involvement in improving patient care and listening to the concerns of our community.

The Macarthur Cancer Therapy Centre, part of the South West Sydney Cancer Service, is well advanced in meeting benchmarks in the New South Wales cancer plan. The colon-rectal unit has one of the lowest incidents of complications in the State. The Macarthur ambulatory care service is a model for the State in providing acute care to patients outside a hospital setting and forging strong links with general practitioners. This list is not exhaustive but is indicative of patient focus care and the good work we are doing today, our commitment to investigating adverse outcomes and offering solutions for improvements and prevention. In conclusion, Macarthur Health Service is a vastly different health service today. Intensive care services, cardiology, senior nursing and registrar positions have been enhanced. Further improvements will occur with the implementation of the area clinical strategy to further integrate services within the area. We have come a long way, we have further to go. We are committed to providing a high-quality health service to our community, we are open to suggestions for improvement, embracing continuing education and we are focused on safety.

DEPUTY CHAIR: Dr Walker, would you like to make an opening statement?

Dr WALKER: Yes, Chair. Since the end of September 2001 I have been an employee of the South Western Sydney Area Palliative Care Service, which has in place a service level agreement with Macarthur Health Service. Currently I am the clinician in that role. In December 2003 was elected as vice-chair of the medical staff council at Macarthur. Today I would like to speak not just for the members of the medical staff council but take the liberty of speaking for the silent majority of staff in Macarthur Health Service, including nursing staff, allied health, junior doctors, administrative staff and corporate service providers. By its nature an inquiry into complaints handling is likely to hear the issues of those who feel their complaints have not been handled to their satisfaction. I have no wish to malign, discredit or detract from any of those who have come become before you or dispute their claims.

However, I would like to suggest, like Brad, that they form the tip of an iceberg. The submerged part, that remains unseen and invisible, is a far greater proportion than the visible tip. The submerged part consists of hundreds of employees working within Macarthur Health who either have no complaints or grievances, or whose grievances have been settled to their satisfaction. Even if this inquiry draws to a close I am not aware that

you have met with many or possibly any of them. For the record I wish to state that I personally have never been bullied, I have never been harassed, I have never been intimidated, in the course of delivering care to patients of Macarthur. I have had grievances, but they have been met with response; indeed, what I believe are appropriate responses. Those responses have been followed up by action by the relevant clinicians or by the administration. I will refer to both the current temporary administration and the previous administration.

I put to you that there are not merely dozens but hundreds of other workers in Macarthur Health Service who could stand before you under oath, one by one, and say that they too have not been bullied and that their complaints have been satisfactorily dealt with. Indeed the internal processes of complaints and grievance handling must be functioning, for our system could not have withstood the external pressures that it has been subjected to over past 18 months. That is not to say that I have not been frustrated in the delivery of clinical care to my patients. I have, I am distressed by the level of unmet health care needs in Macarthur. In that line as a clinician I look forward to the implementation of the clinical strategy, because it brings the hope of being able to deliver the services that the people of south-western Sydney deserve.

In the course of my training I have worked for varying duration at six area health services. At the end of it I sought employment with South Western Sydney Area Health Service for two reasons. First, I believe very strongly that health care should be delivered where the people are, rather than sending people to health care. Second, the South Western Sydney Area Health Service has been an extremely progressive area health service, it continues to move forward, it has not stagnated. I am sad to say that I feel that this whole debacle has occurred just as Macarthur was really starting to gain forward momentum both in staffing and resources as well as safety and quality processes. My frustration now is that Macarthur is still being judged on past performance. As someone working within the system, it feels a bit like not doing so well in the year 10 maths exam, but lifting your game, studying four-unit maths and going on to do university level applied mathematics. But no-one is interested in your current results, they keep going back to that bad year 10 result.

I first visited Macarthur Health Service as a registrar rotating at Braeside hospital, coming out to consult on a patient. I was rotating from central Sydney in 1999. The service I visited then bears absolutely no resemblance to the one I left to come here today, not only in terms of the physical rebuilding of both campuses, but also in terms of the staffing profile, the services that are now delivered and the safety and quality processes that have been outlined. Macarthur is moving forward. We who provide care to the communities of Wollondilly, Camden at Campbelltown ask to be allowed to get on with delivering that care.

DEPUTY CHAIR: Dr Wilson, you do not wish to make a statement?

Professor WILSON: Correct.

DEPUTY CHAIR: Dr Frankum, earlier this year you and several colleagues wrote a response to an earlier editorial in the Australian medical journal about events at Macarthur Health Service. At the end of the article you state, "Be very afraid. The precedent is set. Blame is back on the agenda." What did you mean by those comments?

Associate Professor FRANKUM: The New South Wales health department in its guidelines as to quality improvement urges us to take a no-blame approach to the review of clinical cases, to look beyond individuals and look at systems about why something might have gone wrong. My belief is that the inquiries that have occurred into Macarthur Health Service thus far have very much tried to blame individual clinicians for things that have gone wrong, and thereby absolving blame from government and bureaucracy, who have not provided adequate resources to south-western Sydney over many years.

DEPUTY CHAIR: Do you regret the actions of the whistleblower nurses?

Associate Professor FRANKUM: I started at Macarthur Health Service after they had all left. So I do not know those people individually. I certainly regret the damage that this has all caused to our community's confidence in our ability to provide them with health care. I resent and regret the damage to the reputations of my colleagues that has occurred.

DEPUTY CHAIR: As a consequence of actions taken by NSW Health to address some of the issues that have been raised, there have been suggestions of various improved systems at all levels through the service.

The Committee has just heard from Professor Picone about some of those as well. Do you believe that the system has improved in recent months as a consequence of those changes in procedures?

Associate Professor FRANKUM: Yes, I do. I can speak for my department, the Department of Medicine, over the past 16 months. We have made huge improvements to the functioning of that department. I add, that a lot of those improvements had well and truly begun before the draft HCCC report was leaked, in August last year. I also see improvements in other departments.

DEPUTY CHAIR: Should incident reporting be mandatory?

Associate Professor FRANKUM: Yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Do you think that this improvement and massive influx of funds and energy could have happened without the whistleblower nurses publicity?

Associate Professor FRANKUM: Can I say that in my department prior to the publicity we had opened a stroke unit and an acute medical unit. We had employed an extra cardiology position. We had very ambitious plans for expansion of my department. Has all of this hastened that occurring? I believe so. Would it have happened anyway? I hope so. It was certainly my job to ensure that it did.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: People had been trying to get more resources for quite a long time. If you talk to Dr Gattenby for example, he had been trying to get more resources for a long time. You have unprecedented changes in your level of resources since this furore. Is that not so?

Associate Professor FRANKUM: It will be so if our clinical strategy is supported, as we hope it is. But many of the positions currently in place are temporary positions. Yes, they cost money, but in terms of permanent positions that is what we absolutely need. Whilst some of that has occurred, we need more of that.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Do you believe that when the temporary positions come to the end of their time that the replacements to them will have been a large increment in staff and resources?

Associate Professor FRANKUM: I believe so. I certainly hope so.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Would you say that the whistleblower nurses were part of that? A catalyst, if you like, for a hastier change?

Associate Professor FRANKUM: If you are saying that one needs a catastrophic catalyst to achieve change in NSW Health that would make me very disappointed.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Possibly. The problems identified by Fiona Tito in 1995, were in terms of preventable deaths in the Australian hospital system. I think she said 18,000, and she gave evidence earlier. Currently she is working academia, having not had a job since she drew attention to those deaths in 1995. Certainly there have been changes in procedures in dealing with unnecessary deaths. Does it not need some fairly powerful spur to get that more widespread within the health system?

Associate Professor FRANKUM: I am not familiar with Miss Tito's situation or her work. But there needs to be a very robust system of reporting adverse outcomes and effecting change that does not involve people having to go outside the framework and go public.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: That would be desirable, of course.

Associate Professor FRANKUM: That is essential, in my opinion. I believe we have that system in place in Macarthur now.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Would you have, without the nurses?

Associate Professor FRANKUM: I was not there then, I worked somewhere else. But may I say that in the other hospitals where I have worked there are adverse outcomes and unnecessary adverse outcomes at

other hospitals. What I resent is Macarthur being singled out as somehow being extraordinarily bad when there is absolutely no data to support that assumption.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: If a whistle needs to be blown in the hospital system, obviously it has to be blown in a hospital. It is more likely to be blown in one that has a third the junior staff of another major hospital of comparable size.

Associate Professor FRANKUM: You are assuming that a whistle needed to be blown. I do not support that.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: It is suggested by the data on unnecessary deaths, although as pointed out by Fiona Tito that study has not been done again. She was the first of the shop whistleblowers, if you like to put it that way.

Associate Professor FRANKUM: I am the director of a large department at Macarthur Health Service. It is my responsibility to have quality systems in place to detect adverse events and act upon them. I do not need whistleblowers to help me achieve that.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: That is good.

The Hon. CHRISTINE ROBERTSON: My question was deferred to Professor Wilson from Associate Professor Picone. It is in relation to the work you are doing with new clinical council. How broad is the information and the work of the clinical council within the health service, especially in relation to the work that your people have done in specific specialty areas so far about role delineation and what individual hospitals should do and when they should be permitted to transfer, and those sorts of things. Those are general quality questions. How far in recent times has this gone into the workforce itself? I realise that the documentation we have is brilliant about what is going to happen. How far has it gone?

Professor WILSON: Can I just clarify something. I am the chair of the clinical council for the area, which is the peak body for clinical governance in the area. That clinical council has been in existence since November 2002, a little under 18 months. How the system runs throughout the area, each hospital has its own what is called a clinical advisory council which meets directly with the general manager of that hospital and advises the general manager about quality and safety issues, issues of resourcing, issues of investment and disinvestment, and so on. The clinical council for the area has a responsibility looking into area-wide issues that are germane to the entire area and not just hospital specific. So, I think that describes what the clinical council has done.

In its first 12 months I think the clinical council met only eight times. We accelerated our meeting schedule because we realised we had a lot of work to do and we were not coping with the schedule that was originally constructed. Most of our efforts have been on advising about service plans and service developments rather than safety issues within individual hospitals. Since what I call the tragedy at Camden and Campbelltown took place—and it was an explosion, a nuclear explosion—I was commissioned in addition to my role as chair of the clinical council to form a clinical strategy group with the intent of developing a clinical plan for the area, which then could attract enhancement funding from the Department of Health. I was helped by a number of fantastic colleagues in this regard.

We have been meeting since December for between five and 15 hours a week—that is just meeting time—to get this clinical plan together. We were operating on a number of principles. The first and foremost principle was one of equity. Any patient who plugged into any facility in the South Western Sydney Area Health Service would receive exactly the same quality of care as at any other facility, and we did not believe that existed when we took over our brief. There were other principles regarding quality and safety, and obviously big issues came out of Camden and Campbelltown which we had to pay attention to. We were also focused on upgrading the medical workforce for the area, because I had the opportunity of reviewing with the previous chief executive officer for the area about 30 of the medical cases that were subject of the HCCC inquiry after the preliminary report of the HCCC inquiry came down.

It became apparent to me that we had a crisis across the area, not just in Camden and Campbelltown, with respect to the quality and quantity of our medical house staff, from PGY 3, that is postgraduate year 3, up to registrar level. Interns and PGY 2 individual medical graduates are distributed by ballot across the State, so

there are some wrinkles in that system but nonetheless it is fairly fair in the distribution of house staff allocation. But we rely on, I think, to provide services to a population of 800,000 people, an inadequate number of medical house staff who on the average do not have that same clinical quality—I am talking about medical house staff as distinct from surgical house staff—as one would find, for example, at Prince Alfred hospital or Royal North Shore, because there are attractions in working at those institutions that make them the preferred places to work. So, that has been some of the background with which we have embarked upon developing this clinical strategy plan, and the plan is nearing completion for submission to the Minister in the next couple of weeks.

In terms of the key elements of the plan, it became apparent to us that the sector structure for the area health service was an impediment to the delivery of uniform quality of care. The sectors have been described as semiautonomous fiefdoms, and rather than the area providing a uniform quality of care it was heterogeneous across the area, and there was competition between sector institutions in this regard. So, one of the key elements of our clinical strategy plan is to provide or call for the creation of area-wide departments with area-wide directors who will be responsible for care right across the area. For example, if somebody becomes the area director for intensive care, that person will not only be responsible for Liverpool hospital, which is the flagship of the area health service intensive care unit, he will be responsible and accountable for the quality of intensive care facilities at Camden, Campbelltown and Fairfield hospitals, and so on. That is one of the elements of the plan.

The second element of the plan that I think is important is what Professor Picone has referred to as the golden phone concept. I think it is commonplace in NSW Health and possibly in Australian Health that people in small hospitals often get caught with sick patients that they cannot transfer because beds are full. They waste a lot of time phoning around tempting people to take their sick patients. Sometimes they are successful; sometimes they are not. This system accounts for some of the unwanted deaths in hospitals that are smaller than the larger hospitals such as Liverpool. By the golden phone concept we mean that if a patient is acutely ill, either mentally or physically, there will be somebody at the other end of the phone, somewhat like an air traffic controller, who will take responsibility for that patient and if they cannot find a bed in the area for that patient to be looked after with an adequate level of care, the patient will be transferred out of the area. It will be the responsibility of a senior person—a professor, a senior nurse—to direct operations with respect to the transfer of that patient. I think that is a vital part of the plan.

Obviously the other element of the plan that I have alluded to earlier is the quality and quantity of our medical house staff. Now, we have some excellent registrars in the south-west—and I am only talking averages and I do not mean to cause offence to any of our existing house staff—but clearly something has to change and it has to change quickly. We can wait 20 or 30 years and develop training programs to attract people and wait for the services to develop, but we need change faster than that. To this end, Professor Bruce Dowton, who is the Dean of the Faculty of Medicine, my faculty, at the University of New South Wales, and also the chair of the medical training and education committee of the Department of Health, is devising a metropolitan-wide training program for those medical registrars, PGY 3, up to senior registrar level to have them effective in 2005. So, there will be more equitable distribution of medical house staff sort of personnel across the area.

We clearly need more money to employ more junior medical staff as well as senior medical staff. To that end our plan has listed our service requirements and they will be presented to the Department of Health. The South Western Sydney Area Health Service has a half to a third of the number of staff specialists in corresponding area health services on the eastern seaboard, and to my mind that is nothing short of scandalous. By having an increase in funding come in to the area we will be able to recruit more specialists to the area to provide supervision for the increased quality and quantity of the registrars that we are going to get. Funding is very important. I think it has been alluded to by Professor Frankum earlier. If you look at funding per head of population, the South Western Sydney Area Health Service receives only 60 per cent—I am talking in approximate terms—of the level of funding of the Central Sydney Area Health Service.

The Hon. CHRISTINE ROBERTSON: Do you also have, like the country areas do, difficulty with the colleges, getting the right to have the registrars? You know how the colleges have a say if they can have one or not?

Professor WILSON: We do not. It is because the colleges differ in the way that they approach training programs. The College of Surgeons were very well-organised in statewide rotations. So, the south-west is a preferred place for surgical training because surgical registrars get plenty of chopping experience. They get close to the patients. With respect to obstetrics and gynaecology, the situation is a little different. We have a

very large obstetrics and gynaecology service with, I think, 18 trainees at any one time. That service is about to be contracted unless we get more funding because the professor of obstetrics and gynaecology cannot guarantee the quality of the supervision in peripheral hospitals. With respect to the College of Physicians, anybody can apply to sit for their examination, and we have training programs to accommodate them.

The Hon. AMANDA FAZIO: I have a question I would like to direct to both Dr Della-Fiorentina and Dr Walker. Since all the publicity about the problems in the area health service, have you found more difficulties in the relationships you have with both patients and their families, with their being less confident in the quality of care that they might be receiving or their being more questioning of the role of doctors and other staff and also more questioning about the appropriateness of the care that they are being given?

Dr WALKER: I would have to say absolutely and most definitely. A doctor-patient relationship is always dependent on trust and a relationship with the patient with any of the health care providers is dependent on trust. We start so far behind the eight-ball it is unimaginable. For me particularly, because I look after patients who are dying or who have incurable diseases, the first step is for them to accept at some point that their disease cannot be cured. That is a problem anywhere in New South Wales or for any palliative care practitioner throughout the world. In Macarthur we have to prove in the first place that it is not because the doctors were incompetent and it is not because they got the wrong treatment, it is just really horrible, it sucks, but that is the fate they have been dealt. So we have to start from that point of establishing that that is the way it is, that this person is deteriorating.

People assume incompetence and, in fact, sometimes they assume malevolence. That is very hard when you come in to work to have people assume that you are there and that somehow you have a hidden agenda or you are part of some evil process. I consider myself privileged to work with some of the finest nurses in the State. I would nurse my mother in the Camden palliative care unit, and bring her all the way down from the North Shore to do that. Those staff are pilloried, abused. I personally have been spat at as I have walked in to work, I presume for wearing a stethoscope and a name badge. Staff have been blackmailed. I have been told "If you don't do this I'll go straight to the media". It is has been really hard.

Yet we do manage to get past it. I can say that in our unit we get more chocolates and cake than is good for us but it takes so much extra work. And when you are already overstretched in time and numbers, putting that extra effort is really hard.

Dr DELLA-FIORENTINA: As Amanda said, building trust with the patient to get them to be part of a decision process to accept treatment or be involved in decisions is really one of the critical aspects of a therapeutic relationship and trying to make people better and well. I am not too sure if Professor Dunn mentioned this morning, but we know that much of what we tell people does not sink in and that we are forever having to reiterate and go over things. If they come in already with some preconceived ideas we do need to break down those and individuals do that. We know that we have to regain our good name in the community. Individuals work hard at doing that but it is very hard to regain people's lost confidence.

People, once they are in the system and they are part of the treatment process, and the team that is around us, are involved yes they come to that. We hear all the time great stories of "Thank you" and get thank you letters, and "I've got no problem with your hospital" and things like that and that is important that we feed that back to our staff and we do that as best we can. But it is an unnecessary or unwanted additional burden that the patients already have to face, when they are already ill and facing potentially their own mortality.

The Hon. AMANDA FAZIO: Associate Professor Frankum, when you appeared on 29 February when you appeared on the *Sunday* program you gave an example of the impact on some of your colleagues of all the controversy. You said that if it got to the case where in your heart you thought a person ought to be discharged one day, but the family said "Can't they stay another day?" that you would err on the side of caution and leave them in another day. Do you think that the changes and all the different inquiries that have been going on are gradually letting people get back to the stage where they follow their true instinct in terms of the clinical care that they give people? Are people still erring on the side of caution just in case?

Associate Professor FRANKUM: I think we still have a long way to go and part of our problem at the moment is that people are just tired and overworked and so as new people come in they are also a little nervous about working in this place. So I think everybody is practicing more defensively than we would like to, and I think it will take a long time for that to go away.

The Hon. ROBYN PARKER: All of you have mentioned a lack of resources. Professor Wilson, in your expert opinion do you think that the Camden maternity unit was provided with appropriate clinical staff when it opened?

Professor WILSON: I cannot comment on that at all. I am not even sure when the Camden maternity unit did open. All I know is that I have read the report of Professor Henderson-Smart and my group and I are prepared to accept what he says about the safety of that unit at present.

The Hon. ROBYN PARKER: Associate Professor Frankum, you have talked about an equitable share of resources and that the real issue is resources. Are there other health service areas of which you are aware that are lacking in resources and equitable resources?

Associate Professor FRANKUM: I do not consider myself an expert on the health system in the whole State but I think allocation of resources is discrepant for a wide variety of reasons. But I think—probably Professor Wilson talked about it—the greatest and most dangerous inequity is lack of access to registrar staff that the outer metropolitan hospitals have. That is the thing that needs to be fixed first. The second most dangerous thing is the lack of specialist medical staff available to the peripheral outer metropolitan hospitals, and that is an even harder issue and really until those things are fixed problems will remain.

The Hon. ROBYN PARKER: Dr. Frankum, did you ever meet with Minister Iemma and other doctors from Macarthur Health Service? In that meeting was it said that if negative findings were made against doctors resulting in their dismissal doctors from Camden and Campbelltown would go on strike?

Associate Professor FRANKUM: I most certainly never said anything like that and I cannot recall that being said. I have a fear that a number of doctors who have been under constant pressure through all of this may choose to leave the system but there has been no talk of a strike that I am aware of.

Dr DELLA-FIORENTINA: If I can just add to that as well because I have been part of meetings with Minister Iemma with Professor Frankum. At no stage did I ever mention anything like that. At no stage has the medical staff council ever passed a motion that they would strike.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: At the end of the interim period do you believe that the staff level will have been sustainably increased so that the standard can go up? Presumably the number of specialist staff reflects the number of registrars you can carry which then reflects the quality you can deliver, does it not? At the end of this process with all this influx of resources and when the contracts of the locums expire will the system have been improved? If so, how much?

Professor WILSON: I do not think we know. I think it is funny that the tail will come before the head of the dog in this instance. The registrars will come first. They will come in 2005. We have guarantees from Memtec and from the Minister about that. The recruitment of the staff specialists is more unknown in terms of whether we can without restructuring the health service redistribute positions across NSW Health.

Dr DELLA-FIORENTINA: The human resources issue, we hope, will come as Professor Wilson said. But we are building on the structure of having the clinicians tool kit, the root cause analysis and the incident reporting already there. So we are building the system and we are hoping then to populate it with the human resources to improve the level of care.

(The witnesses withdrew)

MARY ROSE PRENDERGAST, Visiting Medical Officer, Obstetrics and Gynaecology, Macarthur Health Service on former oath:

DEPUTY CHAIR: Do you wish to make an opening statement?

Dr PRENDERGAST: I did not, but I feel compelled particularly after my colleagues have just spoken because I do represent probably, not the director of the departments, but the small cogwheel of the doctors and I would like to think some of the nurses that work in the system and have worked in the system for a long time. I first started working in the South Western Sydney Area Health Service as a medical student in 1975. I was an intern at Liverpool hospital in 1977 and I have been at Campbelltown, Camden and Liverpool hospitals since 1990. So a lot of what I have seen and the conditions in which I have worked predates a lot of the newer directors and appointments that have been made.

I would like to think that I represent a lot of the nursing staff, the domestic staff, the cleaning staff and the gardener that work in our hospitals and have thrown up to them all the problems that have arisen. The information that we have not worked for this—I mean, I have personally attended just about all the medical staff council meetings. I try hard to work for my patients to get better care to try to improve things in the hospital and we have battled with the administrations over the years. We have attended those. We make resolutions in our medical staff council that we see things are wrong and we want them to improve and the practice that has been happening in recent years—let us say for the past five or six years—is that things have not changed. Things do not change. You make your complaint and nothing gets done.

My personal purpose for being here is that I do feel strongly about complaint making. I have written formal complaints to the medical superintendent and got acknowledgement that they have been received. They affected my individual patient care, and my patient that I knew on a personal level, and affected some of them badly how they were managed and to date I have still not had any answer to those. They date back now, just the ones I have got, to March last year.

So the process of complaint handling is not being handled at the moment. Sure, it might change and I greet that with great wonder that it is going to but I can see how the problems and how some of the nursing staff that became the whistleblowers' situation got into that complete frustration of getting to the point that they felt that was the only way to go. I think if I can represent that as the other half of the majority—sure there is a lot that have not got complaints—there are still a lot who put in instant reports and do complaints and feel that they are getting nowhere with them. If I can represent that then I feel that I am doing something to help improve the quality of care of the patients that attend at Campbelltown and Camden.

DEPUTY CHAIR: What has happened to the four complaints that you identified to the committee when you last appeared?

Dr PRENDERGAST: First of all, I heard in the press the next day that Professor Picone said that the new administration had heard nothing about these complaints, which was wrong because when the new administration came to Campbelltown Hospital my department, particularly the visiting medical officers in my department, requested a meeting with her to try to bring up some of these complaints to see why we could not get them answered. So that was done in December last year so they were presented to the administration.

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

DEPUTY CHAIR: In your last appearance before the committee you were asked about the maternity unit at Camden. In your professional opinion was there adequate staff to manage births at the facility when it opened in February 2003?

Dr PRENDERGAST: I am not part of the staff of Camden hospital. The obstetrics staff is a completely different contract and it is staffed by completely different obstetricians so I am not actually on site there at Camden hospital. The only input I have is that if we have transfers from there or patients that are seen in the anti-natal clinic for assessment whether they are suitable to deliver there.

The Hon. ROBYN PARKER: When you appeared before us on the last occasion you said that you felt that that unit was opened due to political motivations. Do you believe that opening the Camden maternity unit was political, and that the safety of patients, both mothers and babies, was put at risk?

Dr PRENDERGAST: First of all, as an obstetrician-gynaecologist—and my colleagues and I are in absolute agreement on this—we felt that that was not the appropriate best use of resources for the Camden and Campbelltown area. All of us unanimously wanted the unit to stay at Campbelltown, to redevelop Campbelltown as a bigger unit with a completely midwifery-run section and everything on site.

I particularly felt that, because I had worked at Camden previously, where we had no registrars on site, where we had no facilities, and there were major problems and great difficulties in managing patients there. I, and the rest of the VMOs in the department, did not support that. We were virtually told by the administration—the administration at that time being Jennifer Collins and Mr Southwell—that this was a fait accompli; that it was not going to be up to us, that we could have input but it would not go any further, and that they were going to open it by whatever means they could. If that is a political input, I would have had to say yes.

Given the timing of the opening, three weeks before the election, one would also wonder whether there was some political input into it. As far as safety is concerned, it was opened as a low-risk unit, which means there would be low-risk patients and there would not be services there such as epidurals. There would not be a paediatrician there; the paediatrician would be on call. This is how Camden was run years before, and there were problems. Whether that was advertised sufficiently to the patients that that was the state of events, I am not sure. I think it probably was not.

Patients did not have that understanding. They were keen. They lived in the Camden area. Here was a nice, new hospital where everything was spanking new—as compared with Campbelltown, which has not been redeveloped for ages. We have a maternity ward where we have four patients per room. We do not even have a private examination room where we can examine a gynaecological or obstetrics patient in privacy. We now have gynaecological beds, where you have patients with a miscarriage in a room next door to people having babies. That is the state of affairs at the moment. Working at that detriment, it prompts patients to go to hospitals where it looks nicer, new and better.

The Hon. ROBYN PARKER: Do you think that if the risks were explained to mothers, they would have used Campbelltown hospital?

Dr PRENDERGAST: Some have certainly changed their minds and transferred back, particularly after advertising of the distressing case in which a baby had to be resuscitated and subsequently had a neonatal death. That was due to the fact that the paediatrician is only on call and obviously there is a time delay. I have certainly seen and counselled patients who have changed their site of confinement on the basis of that, because they have more of an understanding by that being made public.

The Hon. ROBYN PARKER: Do you believe that doctors were pressured to open the hospital for political reasons? Did you ever have discussions with any of your colleagues about that?

Dr PRENDERGAST: I think that generally the obstetrics and gynaecology VMOs at Campbelltown hospital felt that that was the case, the evidence for that being that when we said we could not provide that service and were very unhappy about providing the service, particularly without having more staff, more registrar staff, better facilities for blood bank and so on if we had someone bleeding postpartum, we were told that we could not provide that service. The administration said they would find other means to do that, which they did.

Then the anaesthetic department said that they did not have enough anaesthetists to cover the service, and the answer to that was that they would go overseas and get staff, and subsequently that is what happened. Jennifer Collins went overseas on a recruitment drive and brought back five anaesthetists. If that was not political, why have we had an intensive care unit going for so many years without any staff? Why could they not

go over to South Africa, or wherever they are going to go, and find intensive care doctors to come back and run a functional intensive care unit?

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: I understand that the staffing at Camden in obstetrics comprises two obstetricians, is that correct?

Dr PRENDERGAST: It is completely separate. They are not VMO appointments as such, like I have. As far as I understand, a private company contracts to the hospital to provide a service in that they will have an obstetrician available on site or nearby on site constantly. There are various people who work in that position, including our medical director, who works as a staff specialist at our hospital. He works there part-time on some weekends to cover the roster there, completely independent of the work he does at Campbelltown.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: The obstetricians on contract are on a relatively low-risk unit, is that correct?

Dr PRENDERGAST: Basically, yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: The back-up units of paediatricians and anaesthetists are also there?

Dr PRENDERGAST: No. They are on call.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: So they can get the full gamut of anaesthetists, theatres—

Dr PRENDERGAST: They are on call. They are to arrive at the hospital within 20 minutes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Have you been asked to alter notes at any stage?

Dr PRENDERGAST: I have not been asked to alter notes. With the HCCC, I was involved in one of the cases, in that an obstetrics patient presented to casualty that was managed by the casualty department, and it was only later when they realised there was a problem that the obstetrics people were asked to be involved. I was the VMO on that, and I became involved quickly and treated that patient and transferred her out.

The medical director of services at Campbelltown asked us, either as a department or as individuals, to write a report about particular cases. I did that, and I gave it to the medical director at Campbelltown. I was subsequently phoned by that medical director and told that the lawyers had reviewed my report and they were not happy with it, particularly because it said that there was a delay of four hours, and that she wanted me to change that. I said that I really could not change that because it was the basis of my report, that I was on call for a four-hour period. The medical director told me that that reflected badly on my colleagues and people in casualty, and that she felt I should change it. I said that I felt quite strongly that that was my report, that that was the basis of the cases, and I did not change it.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: They were not clinical notes?

Dr PRENDERGAST: They were not clinical notes; that was my report to the HCCC.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: After the event?

Dr PRENDERGAST: After the event, I summarised my role and virtually answered the HCCC. I was asked to give a response.

The Hon. CHRISTINE ROBERTSON: Are you playing a part in the area obstetrics program that is currently being put together?

Dr PRENDERGAST: Not at all.

The Hon. CHRISTINE ROBERTSON: Why not?

Dr PRENDERGAST: I do not know. You would have to ask the administration. Unfortunately the people like us who do the work do not always get involved in making the decisions.

The Hon. CHRISTINE ROBERTSON: What obstetricians are involved in the current program?

Dr PRENDERGAST: I do not know. I do not know who is on that committee.

The Hon. CHRISTINE ROBERTSON: It is a committee of obstetricians?

Dr PRENDERGAST: I do not know. As a working obstetrician, I have no idea who is on that committee and who is involved in it. I have not been notified as such.

The Hon. CHRISTINE ROBERTSON: Have you made any effort to find out, because obviously there are changes going on?

Dr PRENDERGAST: As a department we have asked. We discussed that report in our department meeting, and we were asking who is doing this, but we have not got any answers as far as I know.

The Hon. CHRISTINE ROBERTSON: You are in the department—?

Dr PRENDERGAST: I am in the department of obstetrics and gynaecology at Macarthur Health Service.

The Hon. CHRISTINE ROBERTSON: No-one in your department has been involved in this whatsoever?

Dr PRENDERGAST: Our medical director probably has, but he has not passed that information on to the general VMOs.

The Hon. CHRISTINE ROBERTSON: Regarding the complaints that you outlined for us, I understand Associate Professor Picone is now dealing with them, is that correct?

Dr PRENDERGAST: As far as I know. I have not received any reply from her.

The Hon. CHRISTINE ROBERTSON: She is currently investigating them, after she made approaches to you to get some proper information after your evidence?

Dr PRENDERGAST: Yes. But the information has already been sent to the medical director at Campbelltown Hospital. I have sent detailed letters of my—

The Hon. CHRISTINE ROBERTSON: You have put in a complaint, so they have to go back and investigate the notes and so on.

Dr PRENDERGAST: She said at this hearing today that that is happening, but I have not personally received any correspondence or any input into that yet.

The Hon. CHRISTINE ROBERTSON: But she has contacted you and asked you for the information?

Dr PRENDERGAST: I have given that, yes.

The Hon. CHRISTINE ROBERTSON: Are any of those complaints about any public patients?

Dr PRENDERGAST: They are all public patients. I am sorry; two of them are private patients.

The Hon. CHRISTINE ROBERTSON: I would like to ask you about the information that both you and Dr Parker gave us in relation to Camden hospital and the quality of care there. Are you saying that you

disagree with Professor David Henderson-Smart's report on the safety and appropriateness of services and the advice about the changes to those services?

Dr PRENDERGAST: No, I do not disagree with it, but I can see the practicalities of working that system because I have done it for so many years. I can see it is 2 o'clock in the morning and you are trying to transfer a lady out from Camden to either Campbelltown or Liverpool, or somewhere else, or you are trying to transfer out someone who has come in accidentally with very premature labour and you have delivered a very premature baby.

I can see how putting so much money into that service is taking away from the larger service at Campbelltown, where we have very poor basic facilities to work with. I can see it taking the midwifery staff away from the higher-risk cases at Campbelltown. Not uncommonly, some of the midwives at Campbelltown, where it is a busy unit, will say that they have just been on rotation for a week to Camden and have had no deliveries or done very little work. I can see that happening.

The Hon. CHRISTINE ROBERTSON: The new world of clinical service provision relates to evidence-based, expert information before decisions are made about where things happen and how. How do you think this should happen, if you are saying that the information is not accurate or proper?

Dr PRENDERGAST: I do not know that the information is accurate or proper; I am not really saying that. I cannot quite see your point.

The Hon. CHRISTINE ROBERTSON: We have a report from Professor David Henderson-Smart relating to the obstetrics services in that area. We were told today that we have a group of, I gather, very well-meaning clinicians who are working through a long-term program to ensure the future of obstetrics services in your area health service. But from you we are hearing that Camden hospital is an inadequate place and cannot do the job properly.

Dr PRENDERGAST: I am not saying it is an inadequate place. I have never said that at all. I do not recall saying that. I said that when it was planned to be opened, we as VMOs said that without proper back-up of having registrars and proper doctors and facilities on site, we felt it would be unsafe to run it. But it has a specialist obstetrician there, so in many ways it has the services they. That is how they decided they would run it. So it is not inadequate.

And it has good figures. You can get good figures out of it because you are doing low-risk patients, and anyone who is high risk you transfer out. You are going to get good figures out of the unit like that, and you want good figures out of the unit like that. But still they have caesarean sections that need to be done, and that is not without risk. One of the problems the anaesthetists have is that they are there by themselves with no want to help them to do a potentially dangerous operation.

The Hon. CHRISTINE ROBERTSON: Of course, that is the issue for all district hospitals, which is what it is?

Dr PRENDERGAST: Yes.

The Hon. CHRISTINE ROBERTSON: Your private patients going off to Camden hospital?

Dr PRENDERGAST: I do not have private patients in obstetrics. Since the changes in insurance, in the area in which I work, where people do not have a big income, I cannot afford to work in private obstetrics. After doing a mix of public and private obstetrics for a long period of time, for the last two years I have not been able to do that because financially I cannot afford to do it.

The Hon. CHRISTINE ROBERTSON: So you did not opt to take up the NSW Health of far in relation to insurance?

Dr PRENDERGAST: No, because even in my area, people have difficulty paying a gap payment. Of the patients I see in my private practice, more than 50 per cent bulk bill.

The Hon. CHRISTINE ROBERTSON: It was about you dropping the gap payment?

Dr PRENDERGAST: Yes. And I could not practise without dropping the gap payment, so I do public practice.

The Hon. AMANDA FAZIO: Have you ever had any disciplinary proceedings taken against you?

Dr PRENDERGAST: I have been under disciplinary things primarily for speaking out about patient care and patient issues, and that has been in Campbelltown hospital.

The Hon. AMANDA FAZIO: Have you ever been referred to the New South Wales Medical Board?

Dr PRENDERGAST: On one occasion, yes.

The Hon. AMANDA FAZIO: Could you give us the details of that?

Dr PRENDERGAST: That was in the initial days of the Health Care Complaints Commission. I had three complaints from patients. We were advised then by the medico-legal section that we did not have to answer them, that we just had to wait until they wrote to us. So I did not put in an answer to them, and because of that I was asked to go to the Medical Board to present them.

I presented those cases to the relevant people and was told that they felt that I was doing the best I can in the situation that we work at, and they felt that those complaints were not justified, and there were no findings whatsoever against us. That was the common thing when the health complaints first came out. We were advised as medical practitioners not to give information because that would be giving information that may subsequently be used for a medicolegal case, et cetera, et cetera. I was only doing what I was advised in that situation.

The Hon. AMANDA FAZIO: If you had not been given that advice by the medicolegal section, what would—

Dr PRENDERGAST: I would have answered them because they were minor. They were cases of one patient who, in my rooms, was upset because she was delayed with her appointment. It is very difficult running a very busy obstetric practice to avoid delays in appointment. Another one was unhappy that she had a stillbirth. She had a delivery and the baby was stillborn for various reasons, you know, and she was unhappy with that, which I can completely understand. So we were advised at those times not reply to them. I am talking back now about 1990-91-92.

The Hon. AMANDA FAZIO: We have heard evidence from quite a few people before the inquiry that, legal constraints aside, they would have preferred to have actually discussed in detail what happened with patients who had adverse outcomes.

Dr PRENDERGAST: Absolutely.

The Hon. AMANDA FAZIO: So you support that?

Dr PRENDERGAST: I do, very much so.

The Hon. ROBYN PARKER: Dr Prendergast, do you believe that the result of the early opening of Camden was that there were deaths because of inadequate staffing?

Dr PRENDERGAST: I do not think it was inadequately staffed. It was staffed as a low-risk unit. It was staffed with obstetricians and midwives with paediatricians and anaesthetists on call, so that is how it was meant to be staffed. When they opened, it was fully staffed how it was meant to be. One of the cases that I am aware of, the paediatrician was on call so it took time for the paediatrician to come to the hospital to attend t hat patient.

The Hon. ROBYN PARKER: Given the benefit of hindsight and knowing what you know through your expertise, if there was a recommendation for another hospital to open with a low-risk birthing centre staffed only by midwives with no obstetricians on site, would you recommend that that is an appropriate service to operate from a hospital?

Dr PRENDERGAST: I personally would not, but we have areas of Australia—I have done some work in New Guinea as medical student—where midwives run a lot of the complete service, but we are talking about a unit that is geographically within a short range of another unit. In that context I think it is not the place to build it. As I said, it would be better to have a completely midwifery-run unit next door to your standard unit and if you have got any problems you just transfer the patients through the door. I mean, that is how birth centres are run in places such as the Royal Hospital for Women at Randwick and that is how it is run at the Royal Prince Alfred Hospital and how it is run in Melbourne, and has been run for a long time.

The Hon. ROBYN PARKER: But a unit that is not near another unit—what would you suggest?

Dr PRENDERGAST: Well, if that is the only service that you have got for resources, then it is better than nothing but there are inherent dangers in doing that if you have a problem. You have to explain that to the patients, that potentially you have a problem there. It is up to the individual patient to take the relative risks and decide where they are going to confine.

The Hon. CHRISTINE ROBERTSON: This is a question that I did ask in some way after this discussion when you were last here. It relates to people actually having the right to access the same care wherever they are. That does not necessarily mean in the current structures that everybody has got a tertiary service with obstetricians, does it?

Dr PRENDERGAST: No, not at all.

The Hon. CHRISTINE ROBERTSON: So you are saying it is acceptable for district hospitals to operate with their GP obstetricians and their midwives, or are you saying that that is no longer acceptable?

Dr PRENDERGAST: No, no. I am saying as an ideal. I can only talk from the area I really know, which is Campbelltown and Camden. If you have got those two sites so close together I see duplicating those services causes problems and you would be better to have one service there. If you have got an area in the country where you have no obstetricians and you have GP obstetrics and that is the only service you have got for that area, then I do not see anything wrong with that as long as you work within the confines of that area. If you have got a high-risk patient, you transfer them out. You are aware of your limitations and what you can do, or you have a flying service backup or you use your perinatal emergency transfer team to do that. You have got to be realistic with what you are doing, you know.

The Hon. CHRISTINE ROBERTSON: Thank you. That has answered the question well.

The Hon. AMANDA FAZIO: Dr Prendergast, I am not quite sure of travelling times in the area that you are in, but my understanding is that the obstetric services are available for people who live as far down as Wollondilly. What would be the relative travelling times from Wollondilly to Camden and from Camden to Campbelltown?

Dr PRENDERGAST: These days most of it is up the M5 so if you are coming down from those areas you join the M5 and you come down that, and it is actually quicker that way going to Campbelltown now than going the back route by the razorback mountain range in the old Hume Highway to go to Camden. We also have patients coming down from as far afield as Macquarie Fields and places like that which have less—they cannot go to Liverpool. They live close to Liverpool but geographically they are told that they have to be confined in the Campbelltown area, so they have to come distances down as well—far more than having to come from Camden to Campbelltown or from Bargo to Campbelltown.

DEPUTY CHAIR: By way of a final question Dr Prendergast, how would you contrast the culture within the Macarthur Health Service today with, say, the time when the whistleblower nurses felt it necessary to go public with their concerns?

Dr PRENDERGAST: The culture today has changed in that the morale, as Professor Frankum tried to indicate, in the general population of doctors, nurses and everybody is bad and it is affecting people. I see patients at an individual level and I see some of the nursing staff as gynaecology patients and I see some of the doctors' wives as gynaecology patients and those in the general community and that, and I can see that it is causing extreme distress. I see people getting demoralised and people like myself thinking that, after doing this for 15 years and planning initially to work another 10 years or so, is there any point in doing it.

DEPUTY CHAIR: Thank you, Dr Prendergast, for giving us your valuable time.

The Hon. CHRISTINE ROBERTSON: Thank you. That was good.

(The witness withdrew)

(The Committee adjourned at 5.37 p.m.)