REPORT OF PROCEEDINGS BEFORE

GENERAL PURPOSE STANDING COMMITTEE NO. 2

INQUIRY INTO COMPLAINTS HANDLING WITHIN NSW HEALTH

At Sydney on Monday 29 March 2004

The Committee met at 9.30 a.m.

PRESENT

Reverend the Hon. Gordon Moyes (Chair)

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

CHAIR: I welcome you to the fifth public hearing of General Purpose Standing Committee No 2's inquiry into complaint-handling procedures within NSW Health. Before we commence, I would like to make some comments about aspects of the Committee's inquiry. The inquiry will raise difficult issues for many participants: 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 terms of reference require the Committee to examine the system for handling complaints in New South Wales and whether the health system in New South Wales encourages people to reflect upon errors. People's individual experiences of this system will help the Committee understand how the complaint-handling system works, or does not work. I ask everyone who is interacting with the Committee to reflect 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 also be remembered that the privilege that applies to parliamentary proceedings, including committee hearings, is absolute. It exists so Parliament can properly investigate matters such as this. It is not intended to provide a forum for people to make adverse reflections about others. The terms of reference refer to failings of systems, not individuals. I therefore ask witnesses to minimise their mention of individual health care workers unless it is absolutely essential to address the terms of reference. Individuals who are subject to adverse comments in this forum may be invited to respond to the criticisms raised, either in writing or as a witness before the Committee. This is not an automatic right but rather a decision of the Committee that will depend entirely on the circumstances of the evidence given.

I ask you now to note particularly these words: that while parliamentary privilege applies to these proceedings, the privilege only extends to what you say while you are a witness during this hearing. The privilege does not extend to any further comments you may make once you complete your evidence and leave the witness table, even if these comments repeat what you have already said as a witness. The Committee cannot protect witnesses from action taken against them in relation to comments made outside the hearing or away from the witness table.

I also ask that witnesses be mindful of the ethical and legal implications of disclosing personal information about patients. Health practitioners and managers should only discuss personal information about a client or a patient if they are specific to the terms of reference and that person has authorised them to do so. I also ask my fellow committee members to consider the ethical duties owed by practitioners to patients when putting 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 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 also considered by a court of law. The weight of opinion supports the view that a parliamentary committee may discuss a matter that is being considered by another inquiry. This would include investigations undertaken by the ICAC. Nevertheless, I remind people today that this inquiry is about systemic issues and not the culpability or otherwise of particular individuals. If you have concerns about any of these issues please raise them at any time with the Committee and we will consider your concerns.

The Committee has previously resolved to authorise the media to broadcast sound and video excerpts of its public proceedings. Copies of guidelines governing broadcast of the proceedings are available from the table by the door. In accordance with the Legislative Council guidelines for the broadcast of proceedings, a member of the Committee and witnesses may be filmed or recorded. People in the public gallery should not be the primary focus of performing or photographs. In reporting the proceedings of the Committee, the media must take responsibility for what they publish or what interpretation is placed on anything that is said before the Committee. I remind everyone to please turn off their mobile phones.

JENNIFER ELIZABETH COLLINS, Former General Manager, Macarthur Health Service, sworn and examined:

CHAIR: What is your full name and occupation and in what capacity are you appearing today?

Ms COLLINS: My name is Jennifer Elizabeth Collins. I am unemployed. I am here as a private citizen.

CHAIR: Because of some media speculation this morning I will ask you this. Have you come to this inquiry as a result of my invitation?

Ms COLLINS: I have.

CHAIR: Would you like to make a statement?

Ms COLLINS: Yes, thank you. I would like to open by making a statement on the death of the 19 patients who have been so frequently cited in the media. No organisation is perfect, and Macarthur Health Service is no exception. We have always acknowledged that adverse events occurred and have done our best to investigate why these occurred and how they could be avoided in the future. Indeed, I have always been open about the fact there have been a number of cases in which errors have occurred that resulted in serious adverse events. These cases were deeply distressing for the families involved, the clinicians who delivered the care and management.

All the most serious cases were known to the organisation at the time. Media reporting has given the impression that there was no system in place at Macarthur for reviewing or analysing adverse events, and the whistleblowers have alleged that adverse events were and are being covered up. The reverse is true. All but one of the cases were reviewed prior to these allegations being received. Of the 47 cases that were the subject of the Health Care Complaints Commission [HCCC] investigation, 16 were very serious, with severity assessment called 1 or 2, 19 were moderate and 12 cases were rated with low severity assessment scores of 4.

In a review of the 47 cases the Macarthur Health Service invited a professor of medicine from another hospital to lead a senior review of each case. Additionally, each of the medical department heads plus the clinicians directly involved in the patients' care undertook a detailed review of the cases. After reviewing each separate case they concluded that quality and safety problems may have contributed to the deaths of seven patients. They dispute the findings in the other cases. The review of each case was provided to the HCCC but it is clear that the information was ignored. It is important that this information is finally placed on the public record. The media continue to report that adverse events at Macarthur led to the deaths of 19 patients, and both staff and local residents continue to suffer the consequences of not having the truth told. There was no cover-up of any clinical cases. I refer you to the HCCC final report, part 5, page 83, where it is noted:

> We found no evidence that failure to notify was deliberate and designed to cover up deaths arising out of inadequate care.

In November 2002 Macarthur was advised by South Western Sydney that the HCCC would be undertaking a systems review of Macarthur Health Service. This commenced in December 2002 and officers from the HCCC undertaking the investigation spoke to about 30 people from three specific areas: operating theatres at Campbelltown, the medical ward at Camden and the department of emergency medicine. We objected to the narrow focus of just these three departments, where disaffected staff worked, while ignoring the many departments where a positive work environment existed, staff had a team approach to their work and colleagues and worked well with management. At the end of January, as I know this Committee is advised, the HCCC commissioner stated:

> I wish to confirm that the investigation has not resulted in any findings to support any loss of confidence …

You have all read that statement. A different approach was taken by the HCCC in February 2003. South Western Sydney and Macarthur were not advised of the reason for this change although it did occur during a period of extensive media coverage. Originally, Macarthur Health Service had wanted each of the cases that were raised in the media to be reviewed but the HCCC had refused, indicating it would be too resource intensive. In several meetings held by the HCCC officers with staff at Macarthur questions raised by staff appeared to be treated in a defensive and aggressive way by officers from the HCCC. By way of example, when staff at general information sessions with the HCCC on 29 November 2002 and 10 January 2003 raised

questions such as the methodology to be used for the systems review and what evidence would be required, the HCCC officers became defensive and indicated that staff should not be questioning the process to be used by the HCCC. Additionally, officers stated that the process would be robust enough to counter any bias that may occur by restricting the focus to three departments only.

There was wide dissatisfaction with the process used by the HCCC. They were unstructured. Some interviewees did not realise they were being interviewed until after the meeting was concluded. To date I have not received all of my transcripts and, in addition, I had several interviews with officers from the HCCC at which no notes of the interviews were taken. I find it extraordinary that at no time in a complex 13-month investigation did officers from the HCCC seek any clarification or have any questions regarding the huge amount of information we provided to that investigation. I wonder if they even read it.

I received one of three copies of the draft report, section 43, in August 2003. This report contained numerous inaccurate statements on the clinical cases. However, the report also referred to the outstanding work undertaken by Macarthur to improve its quality systems and processes and its efforts to reduce the number of adverse events. Interesting enough, many of the positive comments in the draft report were removed from the final report, while most of the inaccuracies and errors of fact were not.

As I indicated the final HCCC contained numerous inaccuracies. I will not go through the extent of those but there were many one-liners in the final report. For example, it is stated that one of the nurse informants suggested that the clinical governance consultation process was flawed in that attendance was by invitation only, with selection being made by senior managers. That is in part 7, page 9. This is written as fact, despite evidence provided to the HCCC that an extensive consultation process involving over 200 staff and members of the community occurred. It is important to note that this was the first time the HCCC had undertaken a multiple case investigation and systems review. My view is that the HCCC lacked the resources and the HCCC staff lacked the skills and experience to attempt a review of this nature. I, like many doctors and nurses at Macarthur, am now a victim of failure of the HCCC to investigate the matters fairly and accurately.

Many comments have been made about the clinical quality systems and processes in place at Macarthur Health Service. As to that I make the following comment. In June 2003 Macarthur Health Service underwent an Australian Council Health Care Standards [ACHCS] accreditation survey. The five surveyors were very experienced and continue to work within the Victorian and Queensland public health system. Two were senior medical officers and the other three were very experienced nursing and general managers. The surveyors reviewed over 60 departments and spoke to a very wide range of staff and community members. The ACHCS review provided 22 commendations to the health service and made 26 recommendations. Not one high-priority recommendation was made. This result, as a first review under these health care standards, is evidence that a positive culture of improvement, standard settings and quality excellence were in place throughout the health service.

While I do not intend to discuss in detail the elements of a good clinical quality information system, my view is that such a system has the following aspects: incident monitoring; central event management; use of clinical indicators; peer review; mortality and morbidity reviews; audit reviews; and chart reviews. All of these systems were in place at Macarthur. Yes, there may have been different levels of maturity in each department. However, it is my view that we were no different to other facilities in this regard. In fact, the ACHCS external review of Macarthur's quality systems highlighted that the aim of the quality system was evidently being achieved. The ACHCS surveyors commented that:

> Reporting of adverse events, complaints and incidents is system wide and extensive with good documented processes and analysis of data, action and outcomes. Considerable effort has been made in developing a culture of recording and reporting with effective outcomes in increasing reporting. Incident flags against reporting were also observed to include some nine established criteria for acute services which are applied across the continuum, as is the root cause analysis systems for adverse events. There are funded resources at a number of levels to support quality and/or to monitor, analyse and address incidents and adverse events. A system is in place for problem reporting. The service has provided education and root cause analysis to staff and consumers and is currently engaged in analysis of both its complaint reporting system and the effectiveness of the outcome from complaints through an analysis of these areas has been directly undertaken by consumers. Comprehensive of this approach, the development of a culture that encourages reporting and innovative involvement of consumers in evaluating organisational effectiveness is commended.

The problem reporting system is well developed and a crucial part to quality work at Macarthur Health Service. I know that somebody-else presented here and indicated how many had been reported. The problem reports are submitted by a large number of staff. In total 520 staff submitted a total of l,458 reports during the

period January 2002 to September. This suggests that the problem into the reporting system is well utilised by all teams and at all levels. It is also suggested that Macarthur has an open culture in which problem reports are able to be lodged without fear of reprisal. Of note is the following comment that appeared in a section 43 report of the HCCC, which was removed in the final report:

> The system with problem reports and the process that operated would appear to be sufficiently robust to deal with clinical issues including error and near misses and are noted to be consistent with or surpassing both what has been found or what would be expected by the commission and by the panel to be in place without the health care organisations around Australia.

The HCCC final report identified only one area where there were concerns about the staff's willingness to use the system. This area was the operating theatres at Campbelltown. I quote from the report:

> There is pressure from team members not to submit problem reports and clear messages from local management, (i.e. the nursing unit management,) not to submit problem reports. For example, "We can deal with this without involving the hierarchy."

I agree with the HCCC on this issue as I too had significant concerns about the culture operating in the operating theatres at Campbelltown. As to the clinical infrastructure, one of the root causes of many of our problems was the lack of clinical staff, especially senior staff. This remains the case today. However, it is important to recognise that we have been actively involved to improve medical infrastructure and leadership over the last five years. We have given priority to increasing the senior medical staff, to raising standards of clinical governance, to decreasing rates of medical error, to increasing capability to provide supervision for other medical officers and to providing manageable workloads for medical staff. Since 1998 Macarthur has made major achievements in medical infrastructure against a national and international medical shortage. I will not give you a lot of details, but some examples are the appointment of 29.5 staff specialists across the health service, bringing the total to 33.5. When I started at Macarthur there were three staff specialists in place. Further, the recruitment of staff specialist directors in the emergency department, obstetrics and gynaecology, paediatrics and medical ambulatory care; the appointment of department heads in anaesthetics and surgery; and the appointment of nine additional medical officers. In the 2003 ACHCS report for Macarthur it was stated:

> Given the considerable growth of the organisation and significant physical redevelopment facilities and changes to the committee structure, the surveyors noted a positive culture throughout the organisation, good leadership and support for the staff from the executive and good commitment to clinicians.

In reference to the comments made about the culture of the organisation, I quote from the ACHCS accreditation final report, which states:

> Senior management at Macarthur Health Service has been proactive in recruitment and workplace relationships in promoting an open, transparent, honest and non-confronting environment. This has contributed significantly towards effective communication, consultation between management and staff and in underpinning a positive culture in the workplace. During the process of the survey, staff commented that Macarthur Health is a good place to work and that staff are valued for their input.

Since the leaking of the HCCC draft report I have received well over 500 letters, cards, flowers and individual approaches from all levels of staff within Macarthur. Today I continue to receive that support. On 2 October 2003 at a meeting with staff at Macarthur Health Service in the presence of Professor Barraclough, the Deputy Director of Health Debbie Piccone, the Chief Nursing Officer Mary Ciarella and the Northern Sydney Area Health Service Director of Nursing Kathy Baker, I received a standing ovation from well over 100 staff who were present. At a meeting on October 2003 between the chief executive officer of the South Western Sydney Area Health Service and Professor Barraclough, the latter indicated his belief that I had the support of 70 per cent of my staff, 20 per cent did not have a view and 10 per cent were non-supportive. He believed this was unusual and impressive.

Five months after leaving Macarthur Health Service I continue to receive enormous support from my staff. Only in the last two weeks the two nursing association branches at Campbelltown and Camden hospitals issued a vote of confidence in me and demanded that the Minister for Health reinstate me back into the New South Wales public health system. Such actions do not support the assertion that a blame culture existed under my management or that I endorsed actions such as bullying and harassment of staff or that I covered up adverse events. Much has been said by many about the alleged culture of bullying and harassment of staff at Macarthur Health Service. What is unclear in the media reporting is that several of the nurse whistleblowers had themselves been the subject of investigation for bullying and harassment of other staff, and these allegations were substantiated. I can confirm that there was a culture of bullying and harassment within Campbelltown operating theatres. Nurses 17, 18 and 19, who are identified in the HCCC final report, were the subject of

bullying and harassment along with several medical officers. In regards to the ongoing comments in the media about staff being disciplined by me for raising clinical concerns, I say quite clearly that no staff has ever been disciplined for raising concerns about patient care with me. I quote also from the HCCC final report where it states:

> We have not identified any direct or causal relationships between incident reporting by the four nurses and subsequent discipline, intimidation or bullying by Macarthur Health Service.

Many of the incorrect conclusions have been drawn based on a false chain of events. This false chain of events has as its starting point that the so-called nurse whistleblowers raised patient safety issues and that Macarthur Health responded by disciplining them and accusing them of bullying and harassment. This is not factually correct and a review of the dates of key events can confirm this. The correct chain of events has as its starting point the fact that other staff raised their concerns about being bullied and harassed by three of the so-called nurse whistleblowers. In addition, concerns were raised about one—who is, for the record, an enrolled nurse—for undertaking procedures for which she was not qualified and in doing so endangered patients. Macarthur Health responded to these allegations by undertaking investigations and taking disciplinary action. This disciplinary action was undertaken before they began making allegations about patient care and before they went to the Minister and the media and was unrelated to patient care. Despite their claims, none of the nurses was dismissed from Macarthur.

I wish to make a response to statements made by other witnesses to this inquiry. In relation to the statements made by the so-called nurse whistleblowers I make the following statement. Macarthur Health employed 1,954 staff in 2003. I knew most staff, not all by name. I have never met or spoken with either Cherie Martin or Vanessa Bragg in their roles as employees of Macarthur Health Service. I know the other two nurses Yvonne Quinn and Val Owen as a result of their fact-finding interview and some educational programs they run. My last conversation with Nola Fraser was on 14 July 2001. At no time did any of the so-called nurse whistleblowers ever come to me prior to taking their complaints to the Minister and the media. In relation to the statement by Dr David Hugelmeyer I make the following statement. In July 2003 I received a memo from Dr Hugelmeyer on behalf of the emergency department committee. I attempted to contact him to discuss the memo and was advised that he was overseas again.

I was also informed that another member of that committee had written several e-mails to Dr Hugelmeyer expressing very serious concerns about the tone and the slanderous comments he had made and stating that the rest of the committee did not agree with him forwarding the memo. In fact, the committee minutes state that I should be invited to the next meeting to discuss certain matters. I spoke with members of that committee and all agreed that the tone and comments within the memo were offensive to other staff. On Dr Hugelmeyer's return to work I and one other person met with him to discuss the leaking of the memo to the media and its tone. I reminded him of the media policy and how to construct a less offensive memo. Did I take the matter seriously that he raised? Yes. I negotiated with South Western Sydney who in turn successfully negotiated with New South Wales Health for an additional $1 million recurrent funding. We also submitted to the Greater Metropolitan Transitional Task Force for an additional nine career medical officers at the cost of $900,000 at Camden Hospital.

It is important at this stage that I clarify my delegated authority. The overall management structure was, for example, nurses on the ward reported to a nursing unit manager who in turn reported to the nursing director who in turn reported to me. I reported to the deputy chief executive officer of the area health service who reported to the chief executive officer who in turn reported to the director-general and the board. I was one of the many layers of management in a large and complex organisation. I had delegated authority to spend up to $50,000 from within the allocated budget. I did not have authority to hire or fire or commit any funds that were not already within my budget. I did take a strong role in advocating for more resources, but the decisions about whether Macarthur Health Service received additional resources was never mine.

In conclusion, as previously stated, each of the medical department heads plus the clinicians directly involved in patient care undertook a detailed review of the cases. They agree that quality and safety problems may have contributed to the death of seven patients. They dispute the findings of the HCCC in relation to the other cases. Macarthur Health Service faced greater demands on its health services which added to the pressure to manage the impact of major growth to new services, a massive building program and an undersupply of health professionals. This occurred despite innovative recruitment strategies and necessitated the development of innovative models of service delivery.

Added to this environment, funding for new services and the increased demand have not been allocated in line with agreements between the South Western Sydney Area Health Service and New South Wales Health. A funding shortfall of at least $27 million for the South Western Sydney Area Health Service resulted in the area health service being forced to accept significant overexpenditure in the operating budgets of Macarthur and other sectors. This situation created increased patient safety inequality. While I fought as hard as I could for additional resources, and I managed the risk as best I could, it is unreasonable to expect that there would not be some impact on service delivery.

I turn to the standard of reporting by the media. In September 2003 the so-called nurse whistleblowers went on a certain Sydney radio station and commenced making public comment on a range of issues. The media reported the information provided by the nurse informers as factually correct, and continued to use only one source, without any collaborative evidence from any other source.

We, the South Western Sydney Area Health Service, and Macarthur Health Service were given explicit instructions by New South Wales Health that the staff could not comment on or even correct the facts as reported; in fact, we were gagged. The leaking of the HCCC report placed us in an untenable position. In the eyes of the media and the community, our failure to respond to a wide range of allegations was interpreted as us having something to hide and therefore being guilty of all allegations. The Committee may wish to question why no action was taken by the Minister for Health or by the New South Wales Health Department to investigate or refer to the ICAC the leaking of the draft 43 report, despite this being an illegal act and the draft report naming individual patients who were not even aware that cases were under investigation.

Finally, I wish to place on record my appreciation to all the staff at Macarthur Health Service, who, over the last 16 months, have been subjected to the most intense media scrutiny that no health professional should ever be subjected to. When I started in Macarthur in late 1998 I found some of the best and dedicated staff and managers I have ever had the fortune to work alongside. Their work values and ethics, and commitment to their community, work colleagues and health service are the things that make up the real culture of Macarthur. It is my belief that at all times they worked to provide the best possible health care to the people of Macarthur, given the limited resources they had to operate with. I hope that, despite all the many inquiries and allegations, they continue to work as a team and do not lose sight of the great things they have done and will do in the future.

I have nothing but empathy for those who have been affected by adverse events that occurred at Macarthur. At all times I worked to the best of my ability to ensure the best possible treatment was available from the resources we had. It is my sincere hope that these inquiries are seen as an opportunity to look at the issues and to put in place improvements across the entire health care system, to generally improve the standard of health care in New South Wales.

CHAIR: May I clarify some statements you have made. This inquiry has not seen the draft report from the HCCC that you referred to several times.

Ms COLLINS: It is called the section 43 report.

CHAIR: The Committee will hold a deliberative meeting later this afternoon—and I think we have called for that report—when we will look at some of the issues you have raised. However, for the sake of questioning today, on the basis that we have not seen the report, may I clarify some statements you have made. About half way through your comments about that report you said that there were something like 1,500 reports requiring review in the Macarthur Health Service over a certain period of time. Can you inform the Committee the number of reports and the period of time?

Ms COLLINS: It was 1,458 reports during the period January 2002 to September 2003.

CHAIR: That was a period of about 21 months?

Ms COLLINS: Yes. Those reports would not relate to just clinical matters; they relate to a whole range of issues.

CHAIR: You said there was clear evidence that in the operating theatres at Campbelltown the nurse unit manager said there was no need to report issues for review.

Ms COLLINS: No. What I said was that the HCCC final report identified only one area in which there were concerns about the willingness of staff to use the system. The area was the operating theatres at Campbelltown. I will quote from the final report at part 7 on page 56. It says, "There is pressure from team members not to submit problem reports and clear messages from local management …"—and I have interpreted that to mean the nursing unit manager—

CHAIR: I simply wanted to clarify whether that was the nursing unit manager.

Ms COLLINS: It says "local management", so I assumed that it was the nursing unit manager—that we can deal with these without involving the hierarchy. That is in the final report.

CHAIR: Towards the end of your statement you spoke about the shortfall in the Macarthur budget.

Ms COLLINS: No. It was the shortfall in the South Western Sydney Area Health Service budget.

CHAIR: You spoke about a shortfall of $27 million for the South Western Sydney Area Health Service?

Ms COLLINS: That is correct, based on the latest resource distribution formula figures.

CHAIR: At what stage of the budget process would that shortfall be? Was that the final budget, or was it an ambit claim, in the way departments cut back budgets?

Ms COLLINS: No. That is based on the resource distribution formula. You would be better to ask the department about that. I do not have that extent of knowledge for the South Western Sydney Area Health Service budget, but it certainly would have been a bid put-in by the South Western Sydney Area Health Service as part of its ongoing operating budget.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: What is that as a percentage of the budget? What is the total budget approximately?

Ms COLLINS: I am not sure. You would have to check with the South Western Sydney Area Health Service. I am with Macarthur Health Service.

CHAIR: Towards the end of your statement you spoke about how the media took up the issue. You said that New South Wales Health gagged the staff of Macarthur Health Service.

Ms COLLINS: Yes. When the issue first started being raised in the media in November, obviously the chief executive officer at that time was having extensive conversations with the Department of Health. A whole lot of cases were brought to the media's attention, that the clinicians were saying to us, "These are factually incorrect." We were seeking advice from the department on how we may respond to the media with regard to that, and we were effectively told that they would manage it, that we could not proceed to have any dialogue with the media.

CHAIR: When examples of misinformation were spread to the media, did you indicate that New South Wales Health did not take proactive action by sending off documents to a body such as the ICAC?

Ms COLLINS: I am sorry, I am not sure of the question.

CHAIR: When misinformation was spread, did you say that New South Wales Health should have sent off the documents for further investigation to some other body, such as the ICAC?

Ms COLLINS: No. I was saying that when the cases were being reported in the media, I would get to work with case notes and I would get the clinicians involved. I would say, "Give me your interpretation of this particular case." We would put a brief or some information together, send it up to the area health service, and it would go to the department. We got no feedback about that, and it certainly never appeared in the media.

What I said about the ICAC was that the section 43 report—which is on my understanding a qualified document, therefore the fact that it was leaked to the media appears to me to be an illegal act, and I would

assume that the Minister for Health would have a responsibility to refer that to the appropriate body for whoever leaked it. That was my interpretation of the qualified document.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You said that there were resource problems in Macarthur Health Service. Were you taking representations from your staff that you were short of resources?

Ms COLLINS: Absolutely. There was a regular meeting. I have not worked in Macarthur Health Service for five months, so I do not have access to the information. But there was certainly a committee that we formed at the local level with the area health service, which was called the Macarthur Recurrent Funding Strategy Committee, where we sat down and discussed our recurrent funding needs. As part of the Macarthur strategy there was a funding strategy put together, and that was sent to New South Wales Health as part of the bid for the capital program. That equated to about $30 million. So each year, as part of the enhancement process, we as a committee would make recommendations. Certainly much later on, when we formed our clinical advisory committee, all the requests for enhancements went to that meeting of clinicians, who then prioritised their requests, and that would go to an area clinical meeting.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Did you believe that you had sufficient resources to run an emergency department in Camden hospital, receiving ambulances 24 hours a day?

Ms COLLINS: As I said in my statement, once the emergency committee put a recommendation to us we certainly went in and very heavily batted for additional resources.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: And did you believe that there were sufficient resources?

Ms COLLINS: I do not think any health facility in Australia would say that they have sufficient resources to run any health care facilities.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Did you tell the people above you that you did not believe you could safely run Camden hospital with the resources you had?

Ms COLLINS: Certainly as part of our regular ongoing discussions, and certainly with the recommissioning of Camden hospital, the issue around resources was raised.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: I understand that they have had one doctor on at the hospital—

The Hon. AMANDA FAZIO: Point of order: I know that the Hon. Dr Arthur Chesterfield-Evans has a great interest in the provision of emergency services, but his questioning appears to have nothing to do with the Committee's terms of reference. I would have thought that, given the opportunity to ask Ms Collins more detailed questions about the allegations of complaints handling, the Committee's time would be better served by members asking questions of that nature.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: To the point of order: The question of resources is critical. If a person does not have the resources to do a job, surely complaints about the inadequacy of the performance of that hospital are relevant. The witness would be put in an unenviable position if she said that there were not sufficient resources to deliver this service. I am simply seeking to ascertain whether there was any possibility of her delivering a service—

The Hon. PATRICIA FORSYTHE: To the point of order: There is absolutely no doubt that the question also arose from the statement made by the witness.

CHAIR: Yes. In fact, it is a clarifying question on the basis of the statement already given by the witness.

The Hon. PETER PRIMROSE: But it is not our terms of reference.

CHAIR: That may be so, but the question was based upon the statement already given by the witness, and I will therefore allow the question to stand.

The Hon. PETER PRIMROSE: This is open slather.

CHAIR: That is not correct, and I resent that remark. The question arose out of the statements made by the witness.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Did you put it to management that there were not sufficient resources for Camden hospital? Did you believe that Camden hospital had sufficient resources to be safely delivering a service with only one doctor after 10.00 p.m.?

Ms COLLINS: It did not only have one doctor after 10.00 p.m. You would have to look at the rosters. But certainly when we recommissioned the maternity unit, an additional chief medical officer was put on overnight, so there were two doctors in the hospital overnight. As part of our bid to the Greater Metropolitan Transitional Task Force, where we submitted a request for about 900,000, we got additional hours for the Camden emergency department.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: I understand that you were not able to offer 24-hour cover for surgical registrars, is that correct?

Ms COLLINS: When Camden hospital was recommissioned in December-January 2001, the decision about what services would be provided there went to what was then called the Medical Advisory Committee, and the decisions of the surgeons related to day surgery only. Camden hospital had no surgical overnight beds and it had day surgery. It would not be unusual for hospitals of a similar size not to have surgical registrars on duty.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: On the other hand, if Campbelltown hospital was on red access, under which you cannot take patients in an ambulance to Camden hospital, that would be a potentially unsafe situation if there were no surgical cover there, would it not?

Ms COLLINS: I do not think Camden hospital would be any different to most of the rural hospitals of a similar size.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Except that it is taking patients from the outer metropolitan area in fairly large numbers, if there are red access problems with Camden hospital.

Ms COLLINS: I would not have said that they had large numbers. I do not have the figures in front of me—

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: I am speaking about the drawing population.

CHAIR: Are your questions leading to systemic issues of complaints handling?

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Yes, sure. The complaints were made about the standard of surgical cases. There were some surgical cases in the HCCC report that were sub-optimally managed allegedly at Camden Hospital, were there not?

Ms COLLINS: I cannot recall, I am sorry. I have not looked at the case reviews for well over six months. My advice would be that you would be best off talking to some of the clinicians about that.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: There were cases in the HCCC report of surgical cases at Camden not being adequately managed and triaged.

Ms COLLINS: Yes, and you may recall or you may not that there was a period where the acute care review team made some recommendations around some adverse events at Camden medical surgical ward. We undertook an audit of around 50 notes and identified some themes and based on that information—and took it certainly to the medical advisory committee and medical staff council—we made recommendations to the area that no acute medical or surgical patients be cared for overnight at Camden, and that was immediately stopped with approval of the board.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: And that was after a submission from Dr Hugelmeyer?

Ms COLLINS: No, it was one of the functions of the acute care review team. They identified a trend within the data they were collecting and we asked for a retrospective audit of about 50 notes and they came back with some common themes. No, it certainly was not because of issues raised by Dr Hugelmeyer.

The Hon. PATRICIA FORSYTHE: Also in reference to resources, in regard to the opening of the Camden maternity unit about which we have had prior evidence, do you believe, in your professional opinion, that the Camden maternity unit was opened before appropriate clinical staff were recruited?

Ms COLLINS: The Camden Hospital recommissioning happened around December 2001-January and certainly when I arrived at the health service around September 1998 there was a clear position that birthing services would return to Camden. Once we started looking at the recommissioning of Camden—I think it was around June-July 2001—we started to plan for the return of that service. One of the issues that clearly were identified through that process was that the obstetricians certainly did not have the manpower. There was certainly a shortage of that particular specialty. The anaesthetists—and I think it has been widely publicised that they were very concerned because they did not have the manpower. The paediatrics staff felt that they could, as one of them said, "Suck it and see" and if there were any problems, would come back to us basically with any additional resources. So we had a committee that was in place for probably about 18 months. From my point of view, I had no intentions of the opening that unit unless the appropriate staffing were in place. Now, I note that Professor Henderson-Smart has just done a review of that and confirmed that the processes and the staffing levels that were in place were satisfactory.

The Hon. PATRICIA FORSYTHE: Were you under any pressure from Craig Knowles to open the Camden maternity unit before the 2003 election?

Ms COLLINS: No, I had no direct pressure from Craig Knowles to open the Camden maternity unit.

The Hon. PATRICIA FORSYTHE: What advice did you receive from your executives that the Camden maternity unit could not be opened safely?

Ms COLLINS: We had ongoing meetings about it clearly and there were a number of issues that we all agreed that we would work through. As part of that process we put a document together—and I do not know if you have seen it—but we came up with round about 13 options for the model of care at Camden with the medical staff—obstetricians, paediatricians, anaesthetists and midwifes—to work through what might be the best option for Camden. I cannot recall the name of the document but there were 13 different models we could have looked at.

The Hon. PATRICIA FORSYTHE: I asked you about pressure from the Minister. Did you have discussions with the Minister about the timetable for opening it, at all?

Ms COLLINS: No, and that would not be unusual because I am a fair way down the line. What would normally happen is that the department would liaise with my CEO. It would be unusual for me, or someone at my level, to get a direct call about a particular initiative.

The Hon. PATRICIA FORSYTHE: It might be unusual but it could happen.

Ms COLLINS: No, I received no phone calls from Minister Knowles about it.

The Hon. PATRICIA FORSYTHE: You just referred to a report from a doctor. Is that Dr Lovelock's report?

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Henderson-Smart.

Ms COLLINS: It is only what I have read in the media, that he has completed that review and that based on his review the Camden maternity unit should continue as a low-risk unit.

The Hon. PATRICIA FORSYTHE: When the Camden maternity unit was opened, were you satisfied in terms of safety that it could be opened and be appropriately staffed to provide for the safety of patients?

Ms COLLINS: Yes, and that has been further confirmed by Professor Henderson-Smart. There were certainly risk management approaches put in place in regards to the contract that we put in place but my suggestion would be that you look at the option document. That could be helpful.

The Hon. PATRICIA FORSYTHE: I return to some other comments that you have made. Do you still standby comments that you made to this Committee last December when you said, "None of the issues was raised directly with me by my executive directors" and claimed that the first notification of an issue being raised was when your CEO contacted you at the start of the HCCC investigation in November 2002—and by issues I am referring to the concerns of whistleblower nurses?

Ms COLLINS: Yes, and that was in the Fraser, Martin, Bragg—

The Hon. PATRICIA FORSYTHE: Not necessarily, but the general issues, had they been raised?

Ms COLLINS: No, my understanding from the question I was asked was did any of those five—and I was just naming the nurses—ever raise directly with me any issues around clinical care and I said no. I was just clarifying that it was those five individuals.

The Hon. PATRICIA FORSYTHE: But others, Dr Hugelmeyer, had raised concerns?

Ms COLLINS: Absolutely, and certainly I have spoken about that today.

The Hon. PATRICIA FORSYTHE: You referred today about the tone of his memo. Did you in fact have discussions with him about the substance of his memo?

Ms COLLINS: As I said in here, when he returned from overseas and I spoke to him, the issues I spoke to him about were about the tone and the slanderous comments that he made about other staff members. The content, as I said, I took very seriously.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: What was the date of that?

Ms COLLINS: I think it was July 2002.

The Hon. PATRICIA FORSYTHE: What about the memo of September 2002?

Ms COLLINS: You would have to show it to me.

The Hon. AMANDA FAZIO: I want to ask you to comment on some of the information that was provided to us by the nurse informants when they appeared before us at earlier hearings, in particular to some comments made on 12 March by nurse Mary Owen. Have you had a chance to have a look at the transcripts of our earlier hearings?

Ms COLLINS: Some of them but certainly not to any great extent.

The Hon. AMANDA FAZIO: At that hearing Nurse Owen said that an additional investigation took place on 24 June 2002 and was undertaken by the director of aged care and someone from human resources:

> The outcome of the report was punitive without justice. My clinical nurse specialist status was removed. I was informed that it was untenable, according to Ms Collins, for me to work in theatre any more. I was offered alternate positions in A and E, maternity, or indeed any area where I had little or no experience.
>
> At a later meeting with Jennifer Collins and the union representatives … an offer was made for me to work in Bankstown hospital. However, this was truly an untenable situation as by now word had spread to many hospitals in the area about the events occurring at Campbelltown and, indeed, both Yvonne and I had been named in meetings in Liverpool Hospital as the nurses involved in disciplinary hearings.

They were clearly very unhappy with your role in their treatment. Have you any comments on that?

Ms COLLINS: I am not sure which particular aspects—I mean, clearly, from the investigation that occurred there was evidence that bullying and harassing did occur. My judgment at that time, in consultation with the area person, was to look at an alternative. Clearly, these were experienced clinical operating theatre nurses and there was never any question about their clinical competency. It was an issue around the bullying and harassment. So what I tried to come up with were some alternatives that may suit certainly Miss Owen and Miss Quinn. In regards to Miss Quinn, I certainly sat down with her and looked at giving her a position in the operating theatres at Camden but then, of course, I got a delegation from the staff over there who refused to work with her.

The Hon. AMANDA FAZIO: Also, Miss Owen stated that she was in poor health and informed that you would no longer allow her to take sick leave and it would be in her best interests to resign or she would be sacked. Is that an accurate comment?

Ms COLLINS: No, it is not. My understanding from that statement is that is what the union had told her.

The Hon. AMANDA FAZIO: But the union representatives told her that you had said that. So that is not correct?

Ms COLLINS: That is definitely not correct.

The Hon. AMANDA FAZIO: Earlier in your opening statement you said that you had had serious concerns about the culture in the operating theatres at Campbelltown Hospital dealing with complaints handling informally. Given that you were the manager of the whole set-up, why did you not do something about it if you had such serious concerns?

Ms COLLINS: Well, we did. A couple of things occurred. There had been a number of ongoing issues in the operating theatre in regards to the medical and nursing relationships—lots of noise going on and then, of course, the allegations came forward about two nurses bullying and harassing other staff. It seemed to me that there had been a lot of noise, so what I initiated was an independent review of the operating theatre and some recommendations came out of that review. I do not know if you have seen it but that was a review by Miss Jan Stowe. Certainly, that was my first initial idea. The other thing that was initiated was, from a management point of view, there were committee structures put in place within the operating theatre to get the teams to work together as a multidiscipline team rather than doctors and nurses, so there was a preadmission team and so on. There was this response from a review by Miss Jan Stowe plus a change in the committee structure. The other thing that we put in place was a new position called a peri-operative manager to oversee both operating theatres to try and again bring the teams together in a constructive way. I cannot recall all of that information but it was certainly extensive, the work that was done there. The other thing that we did, of course, was we brought in a psychologist to try to rebuild the team through some teambuilding processes after, but I am sorry, I do not have all of that information to hand because it was quite extensive, the work that was done.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Did you have any first-hand signed statements about bullying by Yvonne Quinn?

Ms COLLINS: Yes, I did.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Why did you choose Jan Stowe to do the investigations?

Ms COLLINS: I rang the nursing branch of the Department of Health and asked them could they recommend somebody to me who clearly had the credentials, the credibility and would be available and who they could see would be the appropriate person to undertake the review for me.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Did you have prior knowledge of Jan Stowe?

Ms COLLINS: Yes. I worked with Jan Stowe as my director of nursing at Westmead from—I worked at Westmead up until 1990—

CHAIR: The exact date does not matter.

Ms COLLINS: 1990. The last time I would have had any professional or worked with Miss Stowe would have been roughly about 12 or 13 years, but she was certainly on a number of senior committees in the State, both within the nursing profession and within the Department of Health.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: So you did not select her nor suggest her?

Ms COLLINS: Well, we came up with a group of names and Miss Stowe was available to do the consultation.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: So you were part of the people suggesting those possible names?

Ms COLLINS: Yes, tossing around names on who we may be able to find.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: And who made the final decision as to who the person would be?

Ms COLLINS: I did.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You did?

Ms COLLINS: Yes, I did.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: And you arranged for her to be paid as well?

Ms COLLINS: Yes I did. Well, I had to get approval from the area, clearly, because of my delegation, as she was classified as a consultant, so yes, ultimately.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: How many recommendations did her report make and how many were instituted?

Ms COLLINS: Off the top of my head there probably would have been about 50. I cannot give you that and I certainly do not have her report at all, so you would be best off talking to someone at Macarthur. I also understand that they have also done a review of how many of the recommendations were implemented.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Did she take advice to suspend the nurses?

Ms COLLINS: No, she did not. She was not involved in that decision.

The Hon. CHRISTINE ROBERTSON: Was the Jan Stowe report done before or after the nurses were removed from the theatre?

Ms COLLINS: After.

The Hon. CHRISTINE ROBERTSON: The nurses did not have the advantage of being involved in the report system?

Ms COLLINS: No, the review by Jan Stowe was a climatic survey. It was not a report to see if the two individuals had undertaken any harassment. That was a separate process.

The Hon. CHRISTINE ROBERTSON: We have heard a considerable amount of evidence over the last several weeks in relation to structures, the complaints process, and medical officers and nurses, and this is just not about your institution. But I am wondering how you managed to work through that the nurses were definitely at fault in this process and to be immediately removed?

Ms COLLINS: I am not sure what you mean. So you say that led to the suspension?

The Hon. CHRISTINE ROBERTSON: Why was it considered that it was the nurses' fault that there was a big problem in theatre?

Ms COLLINS: Sorry, the two nurses involved?

The Hon. CHRISTINE ROBERTSON: Yes.

Ms COLLINS: No, what they were involved in was the allegations around bullying and harassing of other staff. Other staff came to me around them. There were broader issues in regard to the management of operating theatres. I am not sure which bit. I am not saying, there is no way I have said that Quinn and Owen were the cause of the multiple problems that were occurring in the operating theatre.

The Hon. CHRISTINE ROBERTSON: Then they could well have been the result. The things that happened to them could have been the result of problems that happened in the operating theatre?

Ms COLLINS: I am not quite sure what you mean.

The Hon. CHRISTINE ROBERTSON: I will leave it there, because in the transcripts that will say something. We have also heard evidence that there was actual physical violence in relation to the use of the medical emergency team [MET]. Can you tell us what you did about that?

Ms COLLINS: I have got no information, and no-one has ever raised with me that anyone was physically assaulted from raising a METs call

The Hon. CHRISTINE ROBERTSON: The METs call system was working, in your evaluation of it?

Ms COLLINS: I think that information has already been presented to this Committee. I cannot add anything else, other than that. There was a whole, extensive section within the HCCC and I also understand that some of the other members from Macarthur were in the process of presenting that information to the Committee. I do not have detailed knowledge of that myself.

The Hon. ROBYN PARKER: What I really want to know is why, in this whole process, did you allow disciplinary action to go through without any clear procedural fairness?

Ms COLLINS: In regard to whom?

The Hon. ROBYN PARKER: Going back to Yvonne Quinn and Valerie Owen, for example?

Ms COLLINS: Right.

The Hon. ROBYN PARKER: Why would you let this process go through without any apparent procedural fairness? They were dismissed before an investigation.

Ms COLLINS: They were never dismissed, and I believe they were offered procedural fairness. It is important to say for the record that Quinn and Owen were never dismissed by the health service.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Were they not offered a deed of settlement?

Ms COLLINS: I was not involved in that. My understanding is that that was a matter that was a discussion between the area health service director of HR and the New South Wales Nurses Association. I was not involved at all in the deed of release.

The Hon. PETER PRIMROSE: Who should be responsible for procedural fairness, for ensuring that, as the manager of that area?

Ms COLLINS: Any actions that we take, certainly in my role, would always be checked with the South Western Sydney Area Health Service area HR person. Any of the decisions that we make in regard to industrial outcomes for procedural fairness I certainly have always sent up to the area for advice before making a decision.

The Hon. AMANDA FAZIO: Can I just ask you a question following on from Dr Chesterfield-Evans mentioning of the two deeds of release that were prepared? We were advised on 19 March in evidence from Mr

McGregor from New South Wales Health that the department had the policy issued in 2001, which indicates that area health services and health boards are not at liberty to enter into deeds of release. He said that he was aware that the area health service was negotiating with the nurses to secure a deed of release. They were acting outside the department's requirements that they should not enter into deeds of release without the approval of the head office of New South Wales Health. How is it that in the health service that you are running your personnel management or human resource management people were preparing deeds of release, offering them to nurses in contravention of New South Wales Health policy directive which my

Ms COLLINS: That person did not report to me. That was at the area structure. That is part of the area HR department. That was not part of Macarthur HR department. I was not involved in the deed of release.

The Hon. AMANDA FAZIO: The nurses were part of Macarthur Area Health Service, were they not?

Ms COLLINS: Yes, and it was the area health service that, on my understanding, was negotiating with the department around the deed of release. I was not involved in that.

The Hon. AMANDA FAZIO: Were you not concerned that they were trying to get deeds of release signed by very experienced staff who, I would have thought, any reasonable manager would have been fighting tooth and nail to keep within their area health system?

Ms COLLINS: Yes. It is my understanding, in my view, deeds of release are used within the health system. This particular deed of release I have never seen. I have never even seen the deed of release.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Is it not a practical reality, though, that the HR department see an impossible situation between staff and say, "Overall it is our job to get rid of this person"? Are they not really a function within the framework of the system?

Ms COLLINS: I would not think so. There are some very experienced HR managers across New South Wales, and I would think that they would not hesitate if they felt that a particular manager was not dealing appropriately with the matter that they would raise it.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: In other words the fact that they did not come to you about the deed of release, you think, is significant. It is their task rather than yours?

Ms COLLINS: No, what I said was that I have seen the deed of release. I did not say that the director of HR had not discussed the contents of the deed of release, but I never saw it. What he asked me was did I have any problems with the necessary approval for annual leave and penalty rates being included.

CHAIR: Entitlements?

Ms COLLINS: Yes. Providing it within the framework that is accepted by Health. I had no problems with that.

The Hon. PATRICIA FORSYTHE: Was that deed of release a standard document?

Ms COLLINS: I have never seen the deed of release. I cannot tell you. I have never eyeballed it.

The Hon. PATRICIA FORSYTHE: Can I just turn to a couple of other issues? You actually employed the services of a PR company?

Ms COLLINS: No. Sorry?

The Hon. PATRICIA FORSYTHE: A PR company?

Ms COLLINS: No.

The Hon. PATRICIA FORSYTHE: Do you have any involvement with Wilkinson Media?[1]

Ms COLLINS: From a personal point of view?

The Hon. PATRICIA FORSYTHE: Yes.

Ms COLLINS: Yes, I do.

The Hon. PATRICIA FORSYTHE: Could you elaborate?

Ms COLLINS: I can tell you what occurred is once I was ceremoniously sacked by the Health Department I got into a situation where I could not even walk outside of my own front door. The media were hounding me. There was one stage where I was sitting in the corner of my lounge and crying, not knowing if to put my head up because the media were just completely invading my privacy. I could not even look out my window. And it seemed to me that the media were only taking one side of the story. So what was I going to do? I could continue to live in a house where I was not game even to walk out the door because they took photos of me, obviously in my dressing gown, or I could use the experience of a very good friend of ours to help me put my side of the story across.

CHAIR: That was after dismissal?

Ms COLLINS: Yes.

CHAIR: Not before?

Ms COLLINS: No. That person has been a friend of my husband and I for a number of years. It is certainly, I would say, more a friendship than anything else. I do not know if any of you has been in a situation where the media have hounded you. I came to view it as pretty distressing and it gets to the stage where, as I said, I was even frightened to look out my window. I think that environment of where you cannot feel safe in your own home, that is pretty terrifying.

The Hon. PATRICIA FORSYTHE: What about your relationship, as well, with Graham Davis?

Ms COLLINS: Who?

The Hon. PATRICIA FORSYTHE: Graham Davis from the *Sunday* program.

Ms COLLINS: The first time I met Graham Davis was when he approached me. They were proposing to do a program on the *Sunday* program. That is the first time I had ever met him.

The Hon. PATRICIA FORSYTHE: In relation to Wilkinson Media, are you aware that Wilkinson Media employ the mediator that the Department of Health has employed to mediate with the whistleblower nurses?

Ms COLLINS: No, I do not. I did not know that.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Did you say that you did not have direct contact with Nola Fraser about her complaints at any stage, is that correct?

Ms COLLINS: The last conversation I had with Nola Fraser was on 14 July 2001; that is the last recollection. I can recall two conversations with Nola in the whole five years that I was at Macarthur. One was in the first couple of days when I started and the last one, as I said, was around 14 July 2001.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: She had a relatively responsible position within the hospital?

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[1] Please refer to correspondence received from Mr Peter Wilkinson, Managing Director, Wilkinson Media, dated 30 March 2004, available as a separate pdf document with this transcript.

Ms COLLINS: Yes, she was the after-hours manager and then became the nursing unit manager at the Camden medical ward.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: She was on the critical care committee, is that correct, at least sometimes?

Ms COLLINS: On my review of the minutes, yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: She put in complaints to that committee?

Ms COLLINS: Review of the minutes certainly this issue came up around November 2002, we undertook a review of a whole range of issues. She certainly was a member of that committee. Her attendance, on my review of the minutes, was probably less than 40 per cent and there were no significant issues that I could see in the minutes that she raised.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Were there documents that came with the minutes, such as incident reports and so on, that were discussed?

Ms COLLINS: There is a whole range of information that was presented to the committee.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: The minutes themselves may not have been, or may not have been comprehensive in terms of all the information presented about cases, presumably?

Ms COLLINS: They are in a sense that they will de-identify what the case is and what action is to be taken about a review of that process.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Did you act promptly on recommendations of that committee?

Ms COLLINS: If there were any recommendations that came forward, and a good example of that was the Camden medical ward and high dependency unit, a very good example of where that was raised at the committee. The committee undertook a retrospective audit review of around 50 cases and made some very strong recommendations to us, which we then took, obviously, to the area and the board to try to reduce or prevent any adverse events. We therefore made a policy that no acute medical patients would be admitted to the Camden medical ward.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Has Nola Fraser contacted you by email at any stage?

Ms COLLINS: Not that I am aware of.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: No?

Ms COLLINS: About the Camden medical ward?

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: About any matters of complaints or quality control?

Ms COLLINS: Not that I am aware of. Not that I can recall.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You have not received any emails from her that you can recall?

Ms COLLINS: Not that I can recall.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: The medical care committee that made those changes at Camden, was that in response to persistent lobbying from a number of sources about problems in that area?

Ms COLLINS: No, the acute care review team, which is the new critical care review team, got a number of cases. That case where the incident occurred was a Camden medical ward. The committee then undertook a retrospective case audit, as I said, and from there some things were identified as clearly issues around the care of particular patients in the Camden medical ward. A decision was made then and a recommendation was made to the area health and the board that no acute medical patients go to Camden.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: But that did not relate to Camden emergency?

Ms COLLINS: It related to the high-dependency ward, which was adjacent to the emergency department. So at the same time decisions were made about the high-dependency unit at Camden.

The Hon. CHRISTINE ROBERTSON: I am just wanting to know your opinions on whether or not you think it is possible that the obsession that health services currently has in relation to the term "bullying" can sometimes be used by teams and members of staff to remove somebody perceived to be a problem or a troublemaker?

Ms COLLINS: I do not have any strong views about it. I have certainly lectured on bullying and harassment in a number of other area health services. I think that there is confusion around the term. I think that in some cases of where management need to take, say, a firm hand around a matter staff then say they were bullied and harassed. I think that the policy framework from the department is quite clear about what bullying and harassment are. But certainly I think, in my view, it can be used if sometimes there is not an issue.

The Hon. CHRISTINE ROBERTSON: From the evidence we heard from the people in theatre who were charged with bullying, we have not heard anything that actually, in my head, describes bullying.

Ms COLLINS: I think that my advice would be that this Committee could speak to three nurses who came to me and to their union rep around being bullied and harassed. They are de-identified in the HCCC report, but those nurses sat in front of me and, to this day, I will remember the look in one of those nurses eyes for as long as I live. Those nurses have been de-identified in the HCCC report, but they would be certainly the group. The other person, of course, is the medical officer who may be worth talking to, too because clearly the inquiry so far has only heard one side of that story.

CHAIR: The Committee will have the opportunity, if you so desire, to take any of that information privately.

Ms COLLINS: I will not have access to any of their records in regard to the three nurses, or the medical officer.

CHAIR: I am referring to the names of the three nurses and the medical officer. You could give that information to the Committee privately and we can follow that up.

Ms COLLINS: Can I do that, because I am no longer working at the health service?

CHAIR: Yes, you can. You are under absolute privilege here. You can either identify them publicly—

Ms COLLINS: No, I do not want to do that.

CHAIR: —or you can write them down and hand them to me.

The Hon. ROBYN PARKER: Ms Collins, were you aware of claims of document cleansing at Camden and Campbelltown hospitals, including removing filing cabinets and relocating them to a hidden room in the pharmacy section of the new hospital?

Ms COLLINS: Yes, I certainly was involved in that. What happened was, over a period of about six or eight weeks we had a number of break-ins within the admin. floor. The matters were referred to the police. I also got the South Western Sydney Area Health Service audit team to come in and to see it. One issue related to a particular office, I will not name it, in which was a number of medico-legal files that had been closed. Our concern was that with these break-ins, cupboards were being broken and things were being pinched, we had some concerns about the medico-legal files. So I spoke to the auditors and we moved the medico-legal files out

of one office down to a new part of the building into a new safe in the pharmacy section until we got the appropriate, what is the word—

CHAIR: Secure.

Ms COLLINS: —security in place for that to occur. Those break-ins were certainly reported to the police.

The Hon. ROBYN PARKER: So cleansing did not involve shredding documents or altering documents at all?

Ms COLLINS: No.

The Hon. ROBYN PARKER: Can you give a time frame of when that occurred? Was it after the nurses had raised allegations with the Minister?

Ms COLLINS: I cannot recall the date, I am sorry, because it sort of was—

The Hon. ROBYN PARKER: Can you remember if it was before the nurses had raised those allegations or after?

Ms COLLINS: It would have been around the same time, or a bit after, I think. But there was an audit report done by South Western Sydney Area Health Service. They would give you the dates of when that whole action occurred. In regards to the destruction of medical records, I have absolutely no knowledge that any records were ever destroyed, other than if they were destroyed within the medical records destruction Act.

The Hon. PATRICIA FORSYTHE: I ask that the Committee obtain a copy of that audit report.

CHAIR: Your request is noted.

The Hon. PATRICIA FORSYTHE: Ms Collins, did you ever act on complaints raised by Dr Mary Prendergast?

Ms COLLINS: In regards to?

The Hon. PATRICIA FORSYTHE: She raised concerns with the Committee when she appeared before us, that she had made complaints as recently as during last year about problems of resources, et cetera, in relation to Camden and Campbelltown maternity unit.

Ms COLLINS: I do not know the specifics of it, but if Dr Prendergast had raised issues, there would be a number of ways she would have raised them. That would have been through the committee structure through O and G, or through lodging a complaint about a particular patient matter. If it was a patient matter it would be sent off for investigation with some feedback to the clinician who raised it, or back through a committee structure. I left Macarthur Health Service in October, so I am not sure if it was prior to that or not.

The Hon. PATRICIA FORSYTHE: Do you believe that the opening of the Camden maternity unit had any adverse impact on the level of resources available for the provision of general medical services at Camden and Campbelltown?

Ms COLLINS: No, when the Camden hospital was recommissioned we had put in a budget request for the opening of that new unit. At that stage we were unable to commission the new maternity unit, due to human resource factors. There was money set aside for the opening of that particular unit. During that period of when we were unable to open it, we used that money for other services, but on the condition that knowing that once we got it open the amount that was allocated would need to be put back across that. Each department had a submit for a budget, that budget was put to the executive and then to the Macarthur recurrent funding strategy meeting and a decision would be made about the budget allocation for that particular unit.

The Hon. PATRICIA FORSYTHE: In other words, when you say that money was set aside you mean effectively that other departments basically had to give up some of their resources?

Ms COLLINS: No. I am saying that, for example, the palliative care which had X amount of beds, would have a costing done on how much each bed would cost, the staffing, the goods and services, the RMR, for that particular unit. There would be some negotiations, obviously, around their ambit claims versus what was in the budget and we would make a determination on that. And so on, through each department. With the Camden maternity unit, the delivery side of it had been decanted across to Campbelltown for the rebuild. Once that was completed, of course, the service continued at Campbelltown because we were unable to put the appropriate resources in place. The money that would have been allocated towards the Camden maternity unit at that point is put to one side. However, in any budget year we may have used that money for some other reason, say, a special project or particular strategy we had in place for 12 months while we attempted to open the unit. There was never any spare money lying around.

The Hon. PATRICIA FORSYTHE: Ms Collins, mindful that there is an Industrial Relations Commission hearing, I have some factual questions to ask, so that we have a complete picture of your employment. Who sacked you?

Ms COLLINS: Who sacked me? I got a letter from Central Sydney Area Health Service signed by Dr Diana Horvath. In that letter she said that she was directed by the Director-General of Health. Who sacked me, I am not sure; but I think it was probably Central Sydney.

The Hon. PATRICIA FORSYTHE: How did you react?

Ms COLLINS: After I got myself back up off the floor, absolutely devastated.

The Hon. PATRICIA FORSYTHE: And the timing of that letter?

Ms COLLINS: I got that on 19 December. I had been on sick leave, clearly I was extremely distressed and very close to the edge. I received notification on 19 December at around 2 o'clock. Merry Christmas!

The Hon. AMANDA FAZIO: Ms Collins, I refer to the HCCC report into the Macarthur Health Service investigation. The report refers to disciplinary action taken against nurses in part one, page five. It states:

> The Commission investigated disciplinary action taken by Macarthur Health Service against four nursing staff at the hospitals. The Commission found that the management failed to properly apply the relevant personnel policies in the disciplinary action taken against the three operating theatre nurses. The breaches were: the investigation against the nurses was not fair, impartial or complete; there was a lack of documentation recording the decision to suspend the nurses; the serious breach of policy, given the severity of the action taken by management; the nurses were denied procedural fairness because they were not provided with proper details of allegations made against them; many of the allegations had little or no basis and should never have been pursued through disciplinary avenues; and that the Commission found that the approach adopted by Macarthur Health Service in dealing with the four nurses did not reflect a patient care focus, because it did not promote a culture of learning or a willingness to share information about error and system failure. The likely consequence of management's actions was to discourage other staff from openly and actively raising concerns about clinical care.

The report recommended:

> The Department of Health review the disciplinary action and processes taken by Macarthur Health Service against the four nurses who underwent formal disciplinary action as a matter of urgency.

As the General Manager of Macarthur Health Service what do you say about those recommendations, which, I think, are quite damning.

Ms COLLINS: Absolutely. We had our own independent QC, and his view was certainly different to that review. That review was done by the area health service. There was a draft before the section 43, so the draft prior to the section 43, we sought our own industrial views on that and that review differs from the HCCC report.

The Hon. AMANDA FAZIO: So, you believe the nurses did receive procedural fairness?

Ms COLLINS: Yes, I do. Certainly based on my recall of the situation plus our own advice.

The Hon. AMANDA FAZIO: Is it normal for an organisation like Macarthur Health Service to employ its own QC to review findings?

Ms COLLINS: No, what happened was, there was the draft then the draft section 43. We got the first draft, which related to the industrial matters from the HCCC for us to be able to provide comment on it. We provided comment, and as part of providing comment we obtained our own industrial advice in regards to that; so, an independent review of our action.

The Hon. AMANDA FAZIO: You employ a QC as part of that?

Ms COLLINS: We sent our information to a QC for his advice?

The Hon. PATRICIA FORSYTHE: Which QC was that?

Ms COLLINS: I do not know if I can tell you, he would be under contract to the area health service. I am not sure that I can name him. I may have to write down his name.

CHAIR: To clarify that, you did not, individually, seek your own QC?

Ms COLLINS: No.

CHAIR: You referred it to the industrial wing and it went and got a QC?

Ms COLLINS: Yes.

The Hon. AMANDA FAZIO: It seems odd. You said that the deed of release was handled by the HRM at South Western Sydney Area Health Service, nothing to do with Macarthur.

Ms COLLINS: Yes.

The Hon. AMANDA FAZIO: You said that you did not have many discussions with the nurses who were raising allegations but yet you go off and get a QC to review things.

Ms COLLINS: No. Once we got the HCCC draft report, we then sent off our documentation.

CHAIR: You were asked to comment on that?

Ms COLLINS: Yes. We sent it off for an independent assessment and that is what occurred from the area office to this independent person.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: When Dr Hugelmeyer came back from America, he described the response to his memo expressing concerns about emergency as a "dressing-down". Would you comment on that?

Ms COLLINS: I have certainly raised with Dr Hugelmeyer that the other members of the committee were concerned about the slanderous approach. I also reminded him of the media policy and offered him some advice on how best to construct a less offensive memo.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: The theatre nurses were escorted off the premises. Did you have anything to do with that?

Ms COLLINS: They were not escorted off the premises. They certainly came into my office and I asked someone. Clearly, it was a distressing situation for them and clearly I felt it was appropriate that someone assisted them to return to the car. They were upset. They were not escorted off the building.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: So they were being comforted as they were being escorted?

Ms COLLINS: That is correct.

The Hon. PETER PRIMROSE: Who comforted them?

Ms COLLINS: I am happy to give you that name, but I will not name the person.

The Hon. PETER PRIMROSE: Was it a security officer?

Ms COLLINS: No, it was not. It was another nurse.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: One nurse, Valerie Owen, gave evidence to the Committee that she insisted on what was policy, which was that patients coming to theatre had to be escorted from the wards, unless, I think, they were English-speaking and un-premedicated. Primarily English-speaking and un-premedicated. When she insisted on that policy she drew some flak, as it were.

Ms COLLINS: If I can go back to my statement in regards to that, Ms Owens had put in the problem report. The HCCC had identified that those problem reports within the operating theatre tended to be handled internally within operating theatre. The comment was that we should not worry the hierarchy about it. If it did not get out of the operating theatre it would be extremely difficult for the director of nursing, who the NUM of theatre report to, it would be difficult for him to be able to address it if it actually never got out of that environment.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Was she criticised for bullying when she in fact insisted on policy, which obviously may have inconvenienced the wards by having to send someone up? Presumably not accepting patients would have been seen as fairly aggressive, if she said she would not take a patient until she got the report?

Ms COLLINS: Yes. My recall of the allegations made about them did not include that issue. There were a number of other allegations about bullying and harassment. But I cannot recall that related to consent or escort of patients.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Is it not often the case that when someone kicks up a fuss about one thing, they get sacked for another?

Ms COLLINS: No. Not in my view.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Generally in management if someone is in trouble for one thing—

Ms COLLINS: I do not know; I have been sacked, so I am not quite sure. But, no, not in my view.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Do you think the nurses were subjected to procedural fairness?

Ms COLLINS: Yes, I do.

The Hon. ROBYN PARKER: I want to clarify a couple of points in relation to Ms Quinn and Ms Owen. It has been asserted to us that no interviews took place with VMOs or operating theatre staff about the allegations. Is that your view? Was there a report on those two nurses—Ms Quinn and Ms Owen—without a full investigation?

Ms COLLINS: My understanding from the Stowe report is that more than 60 people were interviewed.

The Hon. ROBYN PARKER: Did those 60 people include the VMOs—

Ms COLLINS: Yes, VMOs were interviewed, nurses were interviewed and wardsmen were interviewed. Staff were interviewed outside the operating theatre who may have had a relationship with operating suite. My advice would be to get a copy of the Stowe report from the area health service, which will identify who was interviewed. I do not have access to that information so I cannot give you a comprehensive answer.

The Hon. ROBYN PARKER: But is it your view that those people were interviewed?

Ms COLLINS: Yes. Doctors were interviewed. A whole range of people were interviewed as part of that process.

The Hon. ROBYN PARKER: I ask you before about the cleansing of documents.

Ms COLLINS: Do you mean that documents were changed?

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Changed or destroyed?

The Hon. ROBYN PARKER: Destroyed. What about the hard drives of computers?

Ms COLLINS: I certainly do not have any information about destroying a hard drive. To be honest with you, I did not even know what a hard drive was. To my knowledge, nobody deleted anything off any hard drives.

CHAIR: A hard drive is when you have to go from Campbelltown to Camden to give a bad report to someone. That is a hard drive.

The Hon. ROBYN PARKER: So you have no knowledge of changing documentation, shredding or removing information from hard drives?

Ms COLLINS: No, and if I had I would have referred it immediately to the internal auditors. In my role as general manager during my time at Macarthur a whole range of issues came to me—it is not for this Committee to know about the intimate details of that—and I automatically referred those matters to the internal auditors, such as the break-ins that occurred or whatever.

The Hon. ROBYN PARKER: You talked about how you felt about getting the sack. In view of the discussion today, how do you feel about the so-called whistleblower nurses? Have you ever described them in terms publicly that you would not want to repeat today?

Ms COLLINS: From my point of view, I am really sad that they did not come to me in the beginning before they went down this path because a whole lot of people—not just me—have had their reputations destroyed. The impact that it has had on the community and health service has been unbelievable. It is far more than just me as an individual; hundreds of people have been affected. I am very disappointed that they did not come to me in the beginning and maybe this whole issue would not have ended up here.

CHAIR: I would like to wrap this up by asking a couple of general questions.

The Hon. AMANDA FAZIO: Chair, may I ask one last question?

CHAIR: Everybody had sufficient opportunity to ask questions. Ms Collins, do you believe that you have been a scapegoat for failure within the New South Wales health system on the issue of complaint reporting?

Ms COLLINS: Yes, I do. One final point, I refer the Committee to the latest *British Medical Journal* which has an article about the English system that has developed the world's first national system for collecting reports of system failure. It is an excellent article and a world first. In talking about a problem reporting system, in New South Wales and in Australia there are different levels of maturity as to where health facilities are up to. To assume that the one standard applies right across the State, or even across the nation, is incorrect. That article is certainly worth looking at.

CHAIR: I will get a copy of it for all members of the Committee. I want to ask you about your general management style. You must have a balance between a systemic approach of complaints handling and blaming individuals. You must strike a balance. Where do you see yourself along that continuum?

Ms COLLINS: I think it depends on the circumstances. If you are to ask me about my management style I would probably say what I said five years ago when I started at Macarthur: You will find me firm, fair and friendly. I do not think I have probably gone much away from that. You have to look at each circumstance.

Where possible you try to take a systems approach to issues. That is not always possible but certainly that is generally how I would approach things.

CHAIR: In retrospect, Ms Collins, with the benefit of hindsight, what would you now do differently?

Ms COLLINS: I would never have applied for the job at Macarthur Health Service obviously. When I got there five years ago it was a system that was grossly underdeveloped. The accreditation process, while considered a world accreditation process, was not attuned to a health system. We were grossly under-resourced. I was quite shocked by the medical infrastructure at Macarthur. I remember that within the first month I had written five points on my whiteboard that were my aim for the next five years to try to improve. They sat on my whiteboard and when I walked out of there I think there were one or two issues left. But certainly it was not a healthy health service when I got there. There were two different organisations—Campbelltown Wollondilly and Campbelltown—with two very different cultures. The health service was to undertake a massive capital program in a very short period of time.

There were certainly massive problems with recruitment. The health service was reliant on locums. One of the side-effects of locums is that chances are they have worked somewhere else for the rest of the day. We used locums an enormous amount. It got to the stage where we were paying an enormous amount for locums—the higher the dollar hour went up. Sometimes we were paying up to $140 an hour to get a locum to work for us on a Saturday night, and you knew the higher the cost—you were usually being played off by another area health service, which was bidding for the services of the same doctor—the greater the chances that that doctor had worked somewhere else. We have a limit on how many hours a truck driver can drive a truck but we do not have a limit on how many hours a doctor can work. A particular area health service might say, "Yes, you can only work 80 hours." But doctors go to an agency and I end up with them in the emergency department on a Saturday night having worked already. The use of locums at Macarthur was extraordinary when I got there. Over that time certainly a huge amount of work was put into trying to reduce that. In hindsight, Macarthur Health Service was certainly a very tough area to take over. It still has all of its issues. I note that it is still flying in doctors from all over the country to staff its emergency department.

The Hon. PATRICIA FORSYTHE: What about its maternity unit?

Ms COLLINS: Campbelltown?

The Hon. PATRICIA FORSYTHE: No, Camden. Is it not reliant on locums as well?

Ms COLLINS: No, it is a contract.

The Hon. AMANDA FAZIO: May I ask Ms Collins one last question? We heard evidence from Dr Hugelmeyer the other day that he was given a dressing-down by you because he invited the Minister to look around the accident and emergency department to see how well it was functioning. Do you think that is appropriate? Is it a good management tool?

Ms COLLINS: I do not think he said it was me.

The Hon. AMANDA FAZIO: Yes, he said that he was given a dressing-down by you.

Ms COLLINS: No, it was not me who spoke to him.

CHAIR: Ms Collins, thank you for appearing before the Committee today.

(The witness withdrew)

BETH WILSON, Victorian Health Services Commissioner, affirmed and examined:

CHAIR: Do you wish to make a statement first?

Ms WILSON: My position as Victorian Health Services Commissioner is the equivalent of your Health Complaints Commissioner in New South Wales. I am here to speak on behalf of the commission and in some degree a small part of my evidence will be on behalf of all the commissioners throughout Australia and New Zealand. I would like to make a brief statement about why I have come up here to New South Wales today. First, I thank the Committee for the opportunity of being heard. The small things I say on behalf of all the commissioners are that we work very closely with Amanda Adrian, and she was extremely highly respected by all of the commissioners. When she was unceremoniously sacked just before Christmas, we took the unprecedented step of putting out a joint press release—which we had never done before—to express our dismay at what had happened. I have had a chance to read the two reports. I do not know the details of your system here but I thought they were thorough and excellent reports.

Frankly, if someone was to be sacked for not shaming and blaming enough people as Amanda was, I should have been sacked years ago. I take a much more conciliatory approach than you do here in New South Wales. All of the States and Territories—and possibly I cannot speak for New Zealand here—have a very similar model of complaints commission to Victoria, with a strong emphasis on conciliation. Our job is to receive complaints from users of health services and to resolve them with a view to improving the quality of services. We use a conciliatory approach because we find that that assists in quality improvement. I have also been a member of the working group of the Commonwealth open disclosure project, which aims to improve quality by encouraging health service providers to come forward and be able to speak openly where there are mistakes and work on improving those.

Our experience with working with health service providers is that most of them are thoroughly decent, hard-working people who come into their profession because they like people and they want to help them. Of course, mistakes will be made in places as complex as health services. You have to have high professional standards, good risk management in place, but things will go wrong from time to time and when they do we need to have good systems in place to handle those. I fear that the approach that is being taken in New South Wales at the moment, particularly with the media coverage of health service workers, is going to set quality improvement in this State back at least a decade. Frankly, I do not know how you expect to attract good people to work in your service if this is how they are treated.

CHAIR: Do you want to make a comment on the role of the Health Care Complaints Commission in apportioning blame to individuals?

Ms WILSON: The Health Care Complaints Commission [HCCC] is a slightly different model from that in Victoria. In New South Wales conciliation is conducted outside of the commission and the commission has the role of prosecuting before the registration boards. That does not happen in Victoria. Conciliation is the heart and soul of our office and prosecutions are done separately, but I work very closely with the registration boards and refer matters to them. It has always been my view that conciliation ought to be part of the commission's role. Our experience is that whilst we must respond to the aspirations of individual consumers who have had difficulties, in doing so usually the conciliation settlement has, as a part of it, a quality improvement. Most people who come to my office want to know what went wrong and why, and they want to make sure it does not happen to someone else. I have strong powers of investigation but we rarely use them in Victoria, whereas in New South Wales it is a matter of course.

CHAIR: Do you want to enlarge your comment that the New South Wales action will set back by 10 years—

Ms WILSON: I think all of the literature on quality improvement in health has shown that shaming and blaming does not work. On the contrary, it makes people more secretive, less willing to be open and share and discuss mistakes. It creates a culture of fear. The literature I have read would show that an approach that is systems oriented, that allows people to come forward and speak openly and freely, particularly if there is no fear of litigation, is much more likely to lead to quality improvements in the long run.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Would you have any general comments about the way the Health Care Complaints Commission in New South Wales is set up? Is it good or bad in the world's literature and alternative systems?

Ms WILSON: It is interesting that in New South Wales you have a commission which had a staff, when I last looked, of about 70 and a budget, if you take conciliation into account as well, of about $8 million. Victoria was handling the same number of complaints with a budget of just over $1.25 million and a staff of 25. That was always a bit of a puzzle to us, however, it did allow the Health Care Complaints Commission in New South Wales to do a whole lot of things that we are not able to do in Victoria, such as research. You also have the patient advocacy service as part of the Health Care Complaints Commission, which we do not in Victoria.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: The features that seem to have aroused public attention were the delays in the time of Merrilyn Walton. Would you say they were probably resource-based or just a work method, if you like?

Ms WILSON: I cannot say they were resource-based if I compare them with the resources I have. I think it was approach-based. New South Wales is the most litigious State in the whole country. You seem to enjoy a good fight up here compared with other places. By comparison, my commission has a very large degree of trust from both the consumer groups and health service groups. When I was asked last year to conduct an inquiry into the Royal Melbourne Hospital I was able to do that on a budget of $55,000 in three months. That was because we do not have a culture of litigiousness. My office was trusted. The chief executive officer welcomed us into the hospital. They were pleased to have us there. They wanted us to help them to get the problems that they knew existed fixed up. The board of directors and management fully co-operated with us so we were able to speak freely and openly to the nurses and other staff—my report turned out to be mainly about nursing issues—and we did not have legal challenges.

We did not have lawyers delaying things and putting the costs up. My little report with about 75 recommendations, many of which the hospital has since implemented, I think is a model for the way these inquiries should be done. Not to go in to kick heads, to find people to shame and blame, but to constructively try to help health services to improve. If people have done the wrong thing, we have in place the coroner and the registration boards to deal with that, but my approach was a systems-based approach. I have been back to visit the Royal Melbourne Hospital since the report was published and I am delighted with some of the changes I have seen, particularly in relation to drug protocols. You may be aware that the Royal Melbourne Hospital inquiry arose out of allegations that nursing staff were taking drugs on the ward and were boasting about having killed some patients. So, it arose in dramatic circumstances. A coronial inquest happened at the same time I did my inquiry, but mine was purely systems-based.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: One had the impression the Macarthur inquiry lacked resources and was not able to look at such a big question—so many deaths, such a big hospital system or two hospitals. The impression was that they had to gear up to do such a big inquiry and it used all their resources.

Ms WILSON: It was an enormous inquiry, no doubt about that. But I think we need to examine the culture that is happening here in New South Wales, because you are chucking more and more money at the complaints system but the problems do not appear to be going away. I think perhaps you are going about it the wrong way, with respect.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Certainly if you could do Royal Melbourne Hospital, which is a bigger hospital than Campbelltown, a steal at $55,000.

Ms WILSON: It was a steal. We worked very hard.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Yes, but is not much money. I will bet the HCCC report on Macarthur cost a lot more than that.

Ms WILSON: But they also did a lot more than we did. Our report is nowhere near that size and probably there were deaths and mistakes at the Royal Melbourne Hospital during the period covered by my inquiry that we did not uncover. Unfortunately, every one of our health services has these kinds of incidents, and

the evidence that I have seen is that these two hospitals were certainly no worse than any others and may have been better.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Do you think that the tort system or the threat thereof, the adversarial model, gives rise to all these costs and the ineffectiveness of the complaints system?

Ms WILSON: I think the adversarial system is a disaster in approaching health problems. That is why I favour a conciliatory approach. In Victoria, if a person is injured in a health service, they have the choice of coming to my office for confidential, free conciliation—they pay only for the medical reports—or they can sue.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: It is either/or, is it?

Ms WILSON: It is an either/or. The choice is with the person.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Once they have chosen they may forego their tort right, is that right?

Ms WILSON: If it is settled. They can withdraw from conciliation at any stage until they have settled. If they settle and sign a legal release, that is the end of the matter. We have a high degree of co-operation from all parties and particularly the medical indemnity fund, which obviously prefers our processes to the adversarial ones, because in my experience our approach is less risky, less expensive, much more effective in quality change and far more therapeutic for the patients.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Do you believe that the tort system ought to be abolished for hospital systems?

Ms WILSON: I am a child of the seventies. I remember Sir Edward Woodward's report. I still prefer the no-fault system. I do not think politically it is going to happen, but that is what I think is the best system.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Does that involve the abolition of the tort system?

Ms WILSON: Yes. You would be compensating victims rather than having a bun fight.

CHAIR: Was Amanda Adrian following down your path?

Ms WILSON: Yes. She was much more conciliatory in approach than her predecessor, who did an excellent job in her own way.

The Hon. PATRICIA FORSYTHE: Does the legal release you referred to include a confidentiality clause?

Ms WILSON: It does. The criticism of conciliation as opposed to the tort system is that things remain secret, they do not get out into the open. Whereas if the matter goes to court it is argued that things do get out into the open in the public interest. That is not a very good argument because most cases are settled before they go to court in any event and the settlements are also confidential.

The Hon. PATRICIA FORSYTHE: You said earlier that the health system contains thoroughly decent, hard-working people who are highly professional—and I do not disagree with you. What happens when there are people whose practices are seriously deficient?

Ms WILSON: Then we need to get in and do something about it. That is where the medical tribunal or other registration boards are relevant. At the moment the registration boards are under review in Victoria to look at a whole range of issues, including whether there should be mandatory reporting of doctors suspected of sexual abuse of patients, for example.

The Hon. PATRICIA FORSYTHE: In general, do you believe that commissioners should have a health professional background or they should be more objective and be external to the system?

Ms WILSON: I have seen excellent commissioners who are from the health profession. Amanda Adrian brought a wealth of experience from her nursing background to her role. I am a lawyer by training rather than by inclination. So I cannot pretend to have clinical knowledge, but when I need it I ask the experts. Really what is important is the person, the legislation they work to, of course, and their personality.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Fiona Tito made the same comments about blaming and shaming in her evidence. I want to refer to Fiona Tito's seminal paper about the number of mistakes made in hospital system. She made that statement in about 1995, I think.

Ms WILSON: 1996, I think.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: On her evidence her career in the Health department ended when she stated that. Do you think that the issue of 18,000 unnecessary deaths in Australia has been adequately addressed by the existing complaints system over the past decade?

Ms WILSON: What a difficult question! Any adverse event is terrible for everyone involved—for patients who are injured, their families and carers, and for health staff as well. The thing that has really heartened me in recent years is the open disclosure project that has been undertaken by the Commonwealth. That I think is the most important quality initiative that I have seen. I have been interested in these matters since the early 1970s. We have all been saying these things; the open disclosure project is actually trying to find a way of doing it. What we do know is that trying to blaming individuals when there are systems problems does not help to reduce those incidents. Until we have frankness and openness and staff feeling that they can report things, that things will be acted on, it is not going to happen. I think there have been some improvements.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Fiona Tito said that to her understanding, and she has been out of the system, there has been no-one following the type of methodology that she used to show if there has been progress in terms of the number of adverse incidents. Do believe that is the case?

Ms WILSON: I do not know of any research that has tracked that in the systematic way that Fiona did in her work on professional indemnity liability.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: If it is so important, which it obviously is, why do you think no-one has tracked the adverse events?

Ms WILSON: Possibly because of what happened to Fiona.

The Hon. ROBYN PARKER: We have heard from a number of people about doctors and the medical profession not being trained in complaints handling. We have heard about their medical training. Is there a capacity for that training within the Victorian system of medical training for doctors particularly and also for the ongoing training of nurses?

Ms WILSON: One hundred per cent of the complaints that I receive have as a component of them communication failures. We do not train our medical people well enough in communication. The literature, particularly from America, shows that there is something toxic about the way that we do medical training in terms of communication skills. In the United States doctors who do not communicate well cost the indemnity funds a lot of money, so they have invested in researching this area. The research shows that young doctors starting out have amongst the top communication skills but by the time they finish their training, particularly after being in the hospitals, they are way down the bottom. The medical indemnity funds are making it a condition of reinsurance that they go back to "be nice" school. It is being shown you can actually improve those skills a little bit but you never get them back to where they were.

Important initiatives in medical training include having interviews on people's motivation and communication skills rather than only on their exam results. That may help but it will not completely solve the situation, as the United States experience has shown. The problem is that we train these young professionals and we expect them to go out into the health services, which are heavily enculturated with role models who sometimes I would not want anyone to have as a role model, and we expect them to be the front-line troops who fix up the whole system. That is a huge ask. Medical and nursing education has to be at all levels so that the consultants, the senior people, are involved, as well as the new people. That is what we are working towards. At the university I teach communication skills, ethics and law to first year medical students. I see them again at

third year and fifth year and I do a lot of work with nursing staff. We just have to keep trying. Most are very amenable to that.

In Victoria we have 150 or more complaints liaison officers who work within our health services. They are employed by the hospitals but I see it as a very important part of my duty to provide training and support for those people. They come into my office for orientation. We actively participate on their committee and in seminars. We have worked with them to produce excellent material on complaints handling. They are often quite isolated in big services because it is a very difficult job that they do. The effectiveness of it depends very much on how much support they get from senior management in terms of culture but also resources. A big challenge is to make sure that what we learn from consumer complaints feeds back into the quality loop so that we can improve standards. I hope that was an answer to your question.

The Hon. ROBYN PARKER: With the registration of nurses in Victoria, is continuing training required for reregistration?

Ms WILSON: Yes, it is. There are new reforms being implemented at the moment.

The Hon. AMANDA FAZIO: You are aware that the Health Care Complaints Commission in New South Wales is responsible for the investigation and prosecution of complaints, which does not allow a great degree of scope for conciliation, and that is a point of difference between the Victorian and New South Wales systems. I presume you are also aware of the report of Bret Walker and the comments he made last Friday about his special commission of inquiry into Camden and Campbelltown hospitals. On Friday Mr Walker criticised the Health Care Complaints Commission's 13-month investigation into the two hospitals saying it had not done its statutory duty. He said:

> The HCCC is our accountability agent for health care complaints. It is said that it's failed. I'm going to say that it failed. The law required a determination which the HCCC simply had not made.

Do you have any comments to make about that?

Ms WILSON: The Victorian model is different from the New South Wales model and everywhere else is different from the New South Wales model. New South Wales is unique in having the commission have that that prosecutorial role. The only thing I have seen of Bret Walker's comments is in the media. My experience with some sections of the media makes me a little cautious in that regard. I note that he was very concerned about the standard of documentation of medical records. That is a problem in Victoria as well as in New South Wales. It is certainly something that I put a lot of effort into in my Royal Melbourne Hospital inquiry. As to his comments about the HCCC failing to make a determination, it was my understanding that was to be the next thing that Amanda Adrian did. I may be wrong about that.

The Hon. AMANDA FAZIO: Bret Walker found that the Minister's dissatisfaction with the HCCC report was justified. You said that you have had a look at the HCCC report, the one that came out in December. Do have any comments to make on that report?

Ms WILSON: I think it is a terrific piece of work. It is thorough, detailed and comprehensible. My office has never ever produced anything as detailed as that. I and my fellow commissioners are completely puzzled.

The Hon. AMANDA FAZIO: Do you think it is fair to have an inquiry into an area health service as detailed as that and then not find that any individual should be held to account for deaths that occurred which should not have occurred?

Ms WILSON: My understanding is that was to be the next step, but I do not know. Occurrences of deaths in Victoria would go to the Coroner for determination rather than to the complaints commission.

The Hon. AMANDA FAZIO: They go either way in New South Wales depending on the circumstances.

CHAIR: Does your emphasis upon conciliation and systematic approach to complaints remove from the individuals their responsibility in terms of efficient practice?

Ms WILSON: No, I do not believe so because individuals are held responsible but in conciliation. It may be that a surgeon, for example, might not want to co-operate with conciliation processes but usually the medical insurer, who is responsible for paying the bill at the end of the day, will persuade the surgeon to do so. The surgeon will have to front up to the relatives or to the consumer at a meeting or several meetings and talk through exactly what went wrong and why. As I mentioned, what most people want is a quality outcome. They will want to know what is being done to make sure it does not happen again. The kinds of things that can happen in conciliation could be very serious complaints—for example, a wrong side procedure. That is a euphemism where a surgeon has chopped off the left leg instead of the right leg. It is legally indefensible but unfortunately it happens. In fact, we had one last year where a surgeon was supposed to be doing some work on the left side, realised halfway through the operation he was doing the right side, so did both. What really annoyed the patient was that he wanted to charge her for both. In conciliation he was persuaded to apologise most sincerely, forgo all of the bill, pay for compensation and reassure the lady what processes he and the hospital put in place to make sure that would not happen again.

CHAIR: So that people can read "L" and "R" quite clearly.

Ms WILSON: Exactly.

The Hon. PATRICIA FORSYTHE: Do you have a benchmark on the timing of complaints handling?

Ms WILSON: The legislation gives us time limits. I have been in office since 1997 and it has been my aim to get our waiting list right down. We have done that but it has taken me a long time. Amanda was only in that job for, I think, three years. It took me five years to get the office working to the standard that I would like and I am extremely proud.

The Hon. PATRICIA FORSYTHE: What is that standard?

Ms WILSON: Our waiting list in conciliation does not exist any more; all the files have been dealt with. I have eight conciliators—some of them are only part time—who worked flat out on those files. We can do all kinds of fancy things like research, but ultimately, if we do not get to a complaint and handle it quickly, it will be just like a wound: it will fester and infect and get worse.

I mentioned the serious complaints that we have. But we also take seriously things that would never get within a bull's roar of a court room but are very important to the individual concerned. For example, a lady had a stillborn baby. She was very pleased with the service she received in the hospital from the nurses, the midwives and the doctors, but on the day of her baby's funeral she received an invoice that was addressed to "The Foetus Smith". That kind of insensitivity is very hurtful to people. We needed to arrange a meeting with the hospital very quickly, so that they could apologise and assure her that nobody else would get a letter like that. Those things matter to people.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: May I come back to the question I was pursuing earlier. In 1995 or 1996 Fiona Tito had written a paper saying that there were all these adverse events. It would seem extraordinary that with this complaints mechanism being set up, still no-one is looking at the number of adverse events.

Ms WILSON: It is not true to say that no-one is doing so.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: No-one is collecting an overall view, as Fiona Tito did.

Ms WILSON: Her work was not a paper so much as a tome; she worked on that for a very long time. A lot of goodwill on the part of health workers went into that report. But, unfortunately, the report was tabled in Parliament just before an election, amid a media frenzy, which did a lot of damage and some of that still prevails.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: In a sense, the nurses are saying, "We have found cases in our hospitals," and the *Sunday* program said that Campbelltown is no worse than anywhere else. I think Fiona Tito's original report said that half of these cases are preventable if you have a good complaints system, did it not?

Ms WILSON: I believe so, yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: So they are saying that there are a lot of preventable cases that are not being adequately prevented?

Ms WILSON: Yes, and what we need to do is to have a culture and systems in place that allow those cases to be dealt with adequately. I think it is probably the role of the Australian Patient Safety and Quality Council to be taking up Fiona's challenge and making sure that we have that data.

The Hon. CHRISTINE ROBERTSON: What do you know about the quality program in New South Wales?

Ms WILSON: Probably not terribly much in detail, but I suspect it would have the same kinds of problems that we have in Victoria—that is, a lot of people in hospitals collect lots of bits of paper and make reports, but they seem to go into some kind of black hole. We are all facing the challenge of trying to close that loop, to make sure that the information we gather about incidents is acted on to improve systems.

The Hon. CHRISTINE ROBERTSON: Do you know anything about how the New South Wales systems work and who operate them?

Ms WILSON: No, not really. I would not feel qualified to comment on that.

The Hon. CHRISTINE ROBERTSON: Do you know anything about the Barraclough report about Camden and Campbelltown hospitals?

Ms WILSON: I have not read Bruce Barraclough's report; I have only had discussions with people about it. So I feel a little uneasy about commenting on it.

CHAIR: Thank you for the evidence you have given. I would like to know your secret of doing so much more in Victoria than we do in New South Wales, so much quicker, without any waiting lists and at a price that any department would be pleased to pay.

Ms WILSON: Thank you. But some people would say that we are not as thorough as you are in New South Wales.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Is there data on outcomes that suggests one way or the other?

Ms WILSON: It is very difficult to compare, because we are doing something so different. I am conciliating individual complaints; whereas New South Wales is out there bashing heads.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: But who is killing the most people?

Ms WILSON: Doctors are hardworking people who work in a high-risk environment. As I said, they must have high professional standards, but from time to time they will stuff up because they are human beings working with human beings, and the way we deal with that when it happens is what is important.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: It was not a flippant comment. Can I ask you about the numbers? Ultimately, does your system deliver fewer adverse outcomes than the New South Wales system, or is there no data one way or the other?

Ms WILSON: I would not know how to measure that. That would be a research task that would certainly be beyond the resources of my office.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: But there are no data elsewhere measured by the comparative statistics?

Ms WILSON: Not that I know of, no.

(The witness withdrew)

KATHERINE McGRATH, Deputy Director-General, Health System Performance, New South Wales Health, Miller Street, North Sydney, and

ALLAN DAVID SPIGELMAN, Director Clinical Governance and Cancer Services, Hunter Area Health Service, Newcastle, sworn and examined:

CHAIR: At the commencement of today's session I made a series of comments about the governance of this inquiry and its authority, and also about the privilege that extends to you while you are giving evidence. If you wish to have further detail about that, I will provide it to you privately rather than go through it again.

Parliamentary privilege covers you absolutely while you are giving evidence. However, once you have given your evidence, if you make comments to the media, even about what you have said in your evidence, the privilege does not cover you. Do either of you wish to make an opening statement?

Professor McGRATH: Yes, we would both like to make an opening statement. Chair and members of the Committee, I would like to briefly touch on three issues: first, my roles and experience in the health sector; second, the background to the establishment of the Clinical Governance Unit at the Hunter Area Health Service, which is considered a leader in New South Wales; and third, some of the key components of a complaints handling system that underpin patient safety in the Hunter Area Health Service.

Firstly, to my qualifications, experience and roles in the health sector and NSW Health. From 1997 to March 2004, I was Chief Executive Officer of the Hunter Area Health Service and Professor of Pathology at the University of Newcastle. My background prior to that was as a senior clinician and academic with senior management experience in both in New South Wales and Victorian health systems.

The Hunter Area Health Service provides services to over 8 per cent of the New South Wales population. It has an operating budget of more than $565 million and is one of the largest employers in the Hunter, employing more than 9,000 staff. The Hunter local government areas include Newcastle, Lake Macquarie, Scone, Muswellbrook, Cessnock and Singleton. The Area manages 15 hospitals, three mental health facilities and more than 20 community health facilities.

In March this year I moved to the newly created position of Deputy Director-General, Health System Performance, at the Department of Health. While I was at Hunter Health, we established Australia's first clinical governance unit in 1999. The unit initiates, manages and evaluates strategies to ensure the safety of patients. Maintenance of clinical performance also falls within its remit. We were very lucky to recruit Professor Allan Spigelman as director of the unit since its establishment. Allan will outline in more detail the role of the unit.

Under Allan's leadership, Hunter Health has become recognised as a national leader in patient safety and complaints handling. The key elements of an effective system of patient safety are to have an effective incident monitoring system and to use complaints from patients or staff as a valuable source of insight as to where our delivery of health care may not be as optimal as we think it is.

Along with the establishment of the unit we introduced the Australian incident monitoring system in the Hunter. We required directors of medical services and quality managers to focus on patient safety as a priority. We also made it clear that patient safety was the responsibility of all line managers, no matter where they worked in the system.

We learnt along the way that there are lots of small things that have the potential to cause problems when you are delivering health care, and that you need to address these as part of any preventative strategy. We introduced a range of new policies, and Allan will outline these in more detail. They include policies for open disclosure, for assessing the competence of clinicians within the health service, for the introduction of a range of new clinical procedures, and for transfer of patients between hospitals, to name but a few. We also introduced communication training for senior doctors and compulsory training for junior doctors.

The need for these preventative strategies was identified by undertaking investigation of the potentially serious events identified through the incident monitoring system. Once identified, incidents can be subject to root cause analyses to identify and rectify the source of the problem. Root cause analyses need both clinical and

managerial expertise. Most often they identify system problems, but at times they identify non-professional conduct or incompetence of clinical or managerial staff.

Points which other witnesses have raised on which I concur are the need to broaden training in patient safety to involve groups such as junior doctors, medical students and other health profession students, and to assign responsibility for managing serious incidents to a specific unit, such as the clinical governance unit, as we did in the Hunter.

Using this approach, we made significant strides forward in managing complaints and incidents in the Hunter. However, it is not an easy task, and I would not claim that the Hunter has got it perfect yet. It requires a major cultural change across the health system and health staff. As such, it will take time, energy and focus.

The health system has successfully made dramatic shifts in culture before. In the Hunter, for example, we changed the culture about staff injury from one of ignorance and apathy to one where everyone acts to prevent staff injury. Fostering and building cultural change in complaints handling to prevent potentially adverse events will take a similar concerted effort.

CHAIR: That was a very helpful statement. I remind both of you that your statements are being made public. Dr Spigelman?

Dr SPIGELMAN: Thank you very much, Chair, and members of the Committee. As Professor McGrath mentioned, I would like to outline some of the work that has been undertaken by the clinical governance unit in Hunter Health in relation to complaints handling and incident management and why I became involved in this difficult and sometimes controversial area. I trained as a doctor and then as a surgeon in New South Wales, leaving in 1985 to pursue further clinical research and teaching experience in England, where I ended up staying for 12 years before returning to Australia in 1997 to take up the Chair of surgical science at the University of Newcastle. My experience as a consumer, medical student, doctor in training and as a surgeon in two countries, coupled with multiple examples of evidence from around the world of recurrent failures in healthcare with regard to patient safety meant that I found it a very logical progression to help establish Australia's first clinical governance unit in 1999, with the strong support of Hunter Health Board and chief executive officer. I have been its director since that time and more recently have taken on the role of director of cancer services, an area where quality and patient safety issues have been highlighted by NSW Health's recent Framework for Optimising Cancer Care publication.

Recognising that the delivery of safe patient care is our core business, if you like, the clinical governance unit tackles the difficult task of improving systems and reducing the number of errors. We have introduced many improvements and initiatives, some of which have been adopted statewide. We do have in place systems and policies to capture sources of clinical risks, to evaluate and treat risk and to follow up on risk treatment recommendations. What are some of the things that are being done?

We clearly need to know when things go wrong so we introduced the Australian incident monitoring system [AIMS], a computerised system of reporting adverse events and reporting on progress all the way to the board. The system was piloted in 2001 and rolled out in 2002. Over 10,000 clinical incidents were reported by clinicians in the first 14 months, with less than 1 per cent being of the most serious kind requiring detailed root cause analysis. AIMS is also now used to log complaints not just clinical incidents.

Other sources of information in the context of needing to know when things go wrong are our analyses of medico-legal claims, the notifications we get from the Health Care Complaints Commission and media and coronial reports, as well as audits of patient medical records. These are all in use in Hunter Health and all are reported to our board. With regard to the complaints made to the HCCC by consumers, the number in the last financial year was half that of preceding years. Hunter Health ranked 17th in the list of 17 area health services when the number of patients receiving treatment overall was taken into account in terms of patient complaints, that is, Hunter Health had the lowest number of complaints notified by HCCC to us per patient treated.

Yet Hunter Health ranked in the middle of the field when the total number of complaints per patient was recorded in the statewide database then in use. What this implies is that a large number of complaints were dealt with successfully at the local level using the principles of open disclosure and apologising where necessary, reducing the need therefore for complaints to go to the next level, namely, the HCCC. We also need to act when errors are reported, so we have a system, which means that all major errors are analysed in detail—so-called

root cause analysis. We systematically work out why they happened and monitor the changes introduced in order to reduce the risk of errors happening again. Errors or near misses, which of themselves may cause minimal or no harm—which are the majority—are also evaluated to determine the presence of common themes and opportunities for prevention.

The Hunter's use of root cause analysis predated NSW Health's broader program by around 16 months. We monitor the implementation of all recommendations arising from root cause analyses and report the implementation or otherwise of these recommendations in quarterly reports to our area's quality council and our area health service board. The system gives managers also access to data, allowing them to improve patient care at a local level. Additionally, managers have ownership of their own data, while the area reviews overall trends. An added bonus has been involvement of general practitioners by having them fax any issues on a "GP feedback form", which are then collated and added to our database.

Our experience suggests that clear lines of accountability for complaints and safety are needed to turn policies into actuality. Making the data accessible to managers and committees has resulted in the following improvements to patient care, ultimately making Hunter Health a safer place. We have heard of some of them but I will list them and a few more.

Communication skills training for all staff; improved systems for informing doctors of abnormal results; increased and improved resuscitation training for general practitioners and their trainees; the making available of CT scanning at one of our peripheral hospitals; replacement of ageing anaesthetic and foetal monitoring equipment; the introduction of red coloured syringes in all operating theatres in our area following two incidents at separate hospitals, in order to distinguish them from other syringes used by anaesthetists so that we can reduce the risk of muscle relaxants being given prior to induction without an anaesthetic being administered—in other words, the patient is awake and the procedure is going on—scrutiny of falls minimisation programs, which has been developed as a result of examining overall trends in the data; drug use evaluation in terms of reducing medication errors; and sponsorship of a clinical guidelines site within our area health service.

We also need to keep learning. If things go wrong and people are punished for unintentionally harming patients, staff will stop reporting, so we focus our analysis on improving the system. We identify and act on things such as the need for more training, more staff, better equipment and equipping checks, and better communication between staff and between staff and patients. This approach is not blame free. Where issues of competence, performance or negligence occur, we have introduced and used appropriate policies. It is because we need to deal fairly with those staff whose performance or behaviour has been questioned that we developed Australia's first policy to do so with regard to medical practitioners. This, too, has been adopted across New South Wales and is now applied to all health care professionals.

We need to be sure that new technology is introduced safely and the patients know that it is new and what the risks are, so we again developed Australia's first policy on this. This has been adopted across NSW Health and also by the Royal Australasian College of Surgeons as a model policy. We need to inform patients and families in more detail and with greater understanding than ever before, so we introduced communication skills training for all clinical staff and introduced a policy of open disclosure to patients and their families if an adverse event occurs. We consult regularly with our local health consumer councils, and consumers sit on our area quality council.

We need to support our staff in training and maintaining skill levels, so we have established a clinical skills laboratory and fund attendance at external skill maintenance courses, as well as purchasing educational material for staff. We fund and/or provide training in risk management, in team working, in informed consent and communication skills for clinicians, as outlined before.

We need to be able to report on how we are doing for outpatients, so we provide guidance and assistance to help clinicians record what happens to patients—the clinical audit and peer review process—and developed and published earlier this year the world's first method of measuring compliance with these guidelines. We sometimes need to change established ways of delivering care so Hunter Health has invested in a new program called Perfecting Healthcare Delivery to redesign our systems around the patient and the patient's journey, and to encourage true teamwork.

We sometimes need to challenge established ways of delivering training to provide local solutions to national work force shortages, so we work with the University of Newcastle's faculty of health to provide local

training across the spectrum of health care, which has sometimes involved the questioning of powerful professional colleges. The Hunter Area Health Service has almost weekly inquiries or visits from within the State, as well as national and international visitors who wish to use our processes themselves and learn from Hunter Health's experience.

In 2003we published our framework for managing risk and maximising patient safety and health care, complementing our Clinical Quality Plan, introduced in 2000. Each institution within Hunter Health must take all reasonable steps to comply and all clinical and managerial staff must participate. The framework consists of an outline of the requirements for governance, which includes accountability and having the right structures and policies in place, quality and risk management processes—the doing and learning. This includes initiatives that prevent incidents, and the reporting, analysis and learning from incidents, and audits and reviews of performance.

While much has been achieved, challenges remain. We need to improve the feedback of AIMS and root cause analysis data to our clinicians. The responsibility of management to ensure that we have a safe system competes with fiscal and activity requirements. Cultural barriers in the health professions and management still need to be overcome. In conclusion, issues around the quality and safety of health care have been discussed in the health care literature and lay press for many years. They are not unique to this State or to this country. Hunter Health has made gains, despite some discomfort and opposition, simply by viewing the care from the patient's perspective. I am happy to answer any questions Committee members may have.

CHAIR: That was a very impressive presentation. We congratulate you on the achievements made. Let us now examine some of the issues that members have.

The Hon. ROBYN PARKER: In terms of the process, it sounds as though every step has been taken. We have heard evidence about the time it takes to go through a root cause analysis investigation. That is not one of the things that you mentioned being a problem. Could you comment on that?

Dr SPIGELMAN: It is a very good question indeed. I would like to quote a Queensland philosopher who said, "If you keep on doing the things the way you always have, you will always get what you have always got", that is Wayne Bennett—not a very popular figure in New South Wales. Essentially, what I have said is that issues around healthcare and patient safety have been around for a long time and many methods have been used to try and improve performance. We cannot use those methods any more; they do not work.

Root cause analysis has a track record certainly in the United States and within the United Kingdom it is very much aligned to a philosophy of systems analysis looking at the basic causes—not looking at the sharp end but looking at what the factors are within an organisation that contribute to things going wrong. If you are going to do that, it is going to take more time and resources and that is an issue and a decision for health services to make. It is made easier for us as we view things from the patient's perspective because patients do not expect things to go wrong and when they do, they expect us to know why. To go down the path of continually disciplining staff where it is not appropriate will mean that our national work force shortage in many areas will be simply exacerbated.

That is not to demean the time that is required, and when we get serious adverse events we look at each of them critically to see: have we been there before, is it appropriate to commission a root cause analysis. In the early stages, certainly yes, but we are cognisant of the burdens this places on all levels of staff, clinicians and management, and opposition sometimes comes from other clinicians perhaps because of the time and from management because we are now getting to the real basic root causes that management are challenged to fix, to redirect resources where appropriate. It can be uncomfortable for many.

Professor McGRATH: Could I add that there are a lot of resources. When we were confronted by this issue—how do we go down this path and how do we resource it—it was at a time when there was no additional funding to do so. What we looked at was what was available with our own internal resource and we immediately saw that we had already directors of medical services in most of our facilities and we had quite a significant number of quality managers. Our first decision was to say: Well, in terms of clinical quality, what is our first priority? We decided that this incident monitoring and investigation of the issues it threw up was the first priority. We redirected their time into this activity. I think that as you focus on this as a high priority, there are the resources; it is a question of prioritisation. I think, that once accreditation processes such as what the ACHS are doing come to take this as a number one priority, then the resources that we currently put in, in terms of

getting hospitals and facilities accredited, will be redirected to focus on this issue. The second component of that is, as Alan pointed out in his opening statement, we have had some 10,000 incidents now—and there are a lot—but only about 1 per cent are serious.

You grade the response to the seriousness of the incident, so much of what you need to fix is a local issue in a ward, in an operating theatre that does not require a full root cause analysis, that requires a fairly simple investigation, identification of a problem and a strategy to solve it. So much of the work does not require the full hand, if you like, of investigation or a whole system-wide policy to resolve it. Much of the most important work that comes out of this is what happens at the local ward and unit level.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: It would seem the Victorian model we just heard about has as its driving force, if it needs a driving force, that the tort law is not given up, it is merely suspended while the conciliation process is going on and if doctors do not want to co-operate, the medical defence organisation persuades them that it would be a good idea, which seems a very nice way of putting it. In fact while they are getting conciliation they may be avoiding the system and, presumably, the medical defence would have the sanction of saying, "Look, mate, if you don't go through conciliation with the Victorian HCC [whatever it is called] we may not back you in the tort that follows from your miscommunication." Would you say that the coexistence of those two systems of tort and conciliation help each other or hinder each other? Or is that beyond where you would make comment?

Dr SPIGELMAN: It is certainly beyond where I would make comment. I would hesitate to comment on the law. In terms of what you mentioned, without talking about tort law reform and linkages, certainly within New South Wales in order for practitioners to maintain a coverage for public patients, Treasury-managed fund coverage, they must participate in risk management processes and quality initiatives within their area health service, and so there is a link there certainly for public patients and some private patients.

Professor McGRATH: I am happy to have an answer to that. I do not believe you need to suspend potential legal action to get doctors to participate. We have not done that and they have, actually, by and large participated extremely well. I think that there is a lot of good news in this system for health professionals. Many of the problems that we identify they, if you ask them, are the same problems that have been causing them enormous frustration for long periods of time, and they have found the system difficult to get to respond. So there are a lot of wins in this for health professionals because they are aware of the risks in the system for them and if you come in and help them, even if it is a matter of explaining to them about their communication style as being part of the problem, they feel that once you get over that initial anxiety reaction you sit down and work with them, they actually come to realise that this is a benefit to them; it acts to protect them. So I do not think you need to go to those extremes to get the participation of doctors. Once they get a bit familiar with this system they realise that this is actually going to help them far more often than it is going to identify individuals who have an individual performance problem.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: The number of unnecessary deaths, we have had evidence that Fiona Tito identified some but that method has never been replicated, or that methodology of assessing how many deaths there are has not been replicated so it is not clear how much improvement there has been. Would you say that there has been progress in this area, or would you say it is not known?

Dr SPIGELMAN: I would say that overall it is not known. The findings of the Tito study replicated in New Zealand, the United States and the United Kingdom subsequently. Within Australia there are moves to certainly do another national snapshot. Speaking from the Hunter Area Health Service perspective, we use a selection of the criteria used in that study for ongoing monitoring and reporting within our area health service, so that we can look at trends over time. But that data is not very mature at the moment.

Professor McGRATH: If I could add, we use two methodologies, and I think this is important. We look at the number of incidents. We are actually wanting the number of incidents to rise because you cannot fix these problems unless you know about them, and you want them reported. There is no doubt at the moment they are being under reported. But we look retrospectively at medical records, which is, if you like, the gold standard. That will tell you how many actual events are actually happening. It has taken us a while to get methodology that is practical, but we have just introduced that as a standard measure. We report to our board and the goal is that that will trend downwards. If your incidents are going up, if your investigating and your addressing the problems is working then the number of actual events you pick up of retrospective record analysis will fall, and

we think you have to marry those two indicators and that will address whether we are actually making a difference with this process.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Do you think the nurses are, perhaps, taking the view that the emperor has no clothes? There has been the Tito report. There has been no report since. There have been some managerial changes, which may or may not have been effective and they are saying, "Look, there are still a lot of people dying."

Professor McGRATH: I think in a health system, first of all, you are going to have a lot of people who come to hospital where they are acutely ill. There are avoidable deaths, and the studies in the US, the UK and here have shown that. The cultural change that needs to happen, the getting in and addressing this issue, health systems around the world have never had a system. Health systems around the world are now struggling with how to introduce this, and as you have heard already heard in the inquiry, New South Wales is at the forefront of leading those initiatives. Over the past two years over 2,000 staff across New South Wales Health have been trained in this approach. It takes time to roll such a system out. In New South Wales there are 90,000 health staff; in the Hunter health there are 9,000. To get this type of training down to this level of detail and get it down into each detail is going to take time. I think events in Macarthur are likely to ensure there is a more rapid implementation, but I think to expect overnight success is not to understand the human nature of the industry we deal in, the very complex environment, the very pressured environment and the number of health professionals, patients and their carers who need to become familiar with this process. I believe that a very good start has been made in New South Wales. I believe that the system as occurs in the Hunter is the way forward, and that is where New South Wales Health is heading.

The Hon. ROBYN PARKER: Can I just turn to your previous role and get some clarification on something in relation to some other services that we are comparing with? The Port Stephens Polyclinic, can you explain the nature of that, how it operates and how it is staffed?

Professor McGRATH: Yes, Port Stephens Polyclinic is a facility at Nelson Bay up on Port Stephens. It has—for give me, I have sort of forgotten the numbers now—a small number of inpatient beds, it has an emergency area, it is staffed with nursing staff, allied health staff from Hunter Health and the medical input is provided by GPs in the area.

The Hon. ROBYN PARKER: What role does Hunter Area Health Service play in ensuring that there is a high level of health care maintained there?

Professor McGRATH: We manage the facility, so the policies that you have just talked about apply at the Nelson Bay Polyclinic as they do everywhere else. It is more complex where the medical staff are not our employees to get their participation, but they are on contract with us and as part of their VMO contracts they are required to participate in this process.

The Hon. ROBYN PARKER: Can you tell me with Hunter Area Health, do you think that is a good way to operate that service with doctors who have worked a full day of work then going to being on call working at the polyclinic afterwards? Do you think that that is an appropriate way of managing that service?

Professor McGRATH: It is a model that applies in most of the rural towns around New South Wales. It is an approach that has worked well for many years. I think there are stresses in the system now that there is a shortage of medical work force in rural areas and that was also true at the Nelson Bay Polyclinic.

The Hon. ROBYN PARKER: Do you think Hunter Area Health Service plays a constructive mediatory role when one of the practices said that they were unable to offer care during the week because they had to turn around the next day and work in their practices, but that they could do rosters during the weekend?

Professor McGRATH: What you are referring to there was a dispute within the medical community at the Nelson Bay Polyclinic. I do not believe there were any adverse events as a consequence of that, and therefore I do not know that it is precisely relevant to this inquiry. However, the issue was that there was going to be fair share of the after-hours on call and there was a particular practice that was not prepared to do what their colleagues saw as a fair share. And so there was a decision made that if they were not prepared to undertake fair share of the on call then they chose to resign from working within the polyclinic. That was supported—

The Hon. AMANDA FAZIO: Point of order: I think this—

CHAIR: It is very interesting, but it is not really within the terms of reference, is that what you were about to say?

The Hon. AMANDA FAZIO: Yes, that, plus also I do not know if it is appropriate at this stage for the Hon. Robyn Parker to declare any vested interest in the question she might be asking, given her husband's work as a GP in the Port Stephens area.

The Hon. ROBYN PARKER: To the point of order: My husband does not work as a GP in the Port Stephens area. It is totally relevant to this inquiry because it is about resources, it is about complaint handling and it is about whether we are managing services in an area and whether we are handling the number of resources. The question to Professor McGrath was the role of Hunter Area Health in handling complaints. It is very relevant to this inquiry.

The Hon. PETER PRIMROSE: It is the difference in managing services.

The Hon. ROBYN PARKER: No, I asked the question about Hunter Area Health's mediatory role, and I still have not got the answer to that question. I do think it is relevant to this inquiry.

The Hon. PATRICIA FORSYTHE: To the point of order: I would have thought it is relevant, in that part of what we are trying to understand is how you deal with not only individual complaints about individual incidents, but systemic issues as well, whether it is to do with system failures from time to time and part of it is to understand the issues are raised and how they are dealt with. And that is the very nature of the question that the Hon. Robyn Parker was approaching.

CHAIR: I take the view that, on the first instance, the relationship between Robyn Parker's husband's medical practice and Port Stephens, that that was openly stated by her at the beginning of this inquiry, and it was not Port Stephens at all. The second issue is whether this is relevant to the systematic process of complaint handling. I would feel that if you are getting around to putting that question very directly then that question ought to be allowed.

The Hon. ROBYN PARKER: The question was: do you think Hunter Area Health acted appropriately in managing the complaints of those doctors?

Professor McGRATH: Yes I do. It was within a difficult environment of medical work force shortage, and our paramount priority was to make sure we could sustain the maximum number of medical staff involved in the after-hours on call by whatever means was available to us within the resources available to us. So, yes, I think we did. The polyclinic is now fully supported after hours by the remaining doctors. It was their decision that they would prefer to take the on call themselves and share it across the remaining practices rather than to have one practice doing a lesser amount of on call. There were a number of other options raised, such as recruiting full-time CMOs et cetera, but in terms of the difficulty in getting work force to fill those positions that was not considered a viable option, so I do believe that Hunter Health played a facilitatory role with what was essentially a dispute amongst practices within the Port Stephens area and we did it with the intention of ensuring sustainable medical on-call service at the polyclinic.

The Hon. ROBYN PARKER: Do you think that that service now is adequately staffed and resourced, and safely staffed and resourced?

Professor McGRATH: Yes, I do. We are supporting the GP practices to recruit further GPs for their practices, which they wish to do and which Hunter Health would support. We are supporting that through supporting the area of need process.

The Hon. AMANDA FAZIO: I wanted to follow up on comments you made about resource allocation in terms of looking at incidents that are reported, whether it is necessary to undertake a root cause analysis, et cetera. I be interested in your comments on this, is it not the case that if there is a serious incident you are going to have to investigate it any way, so is it not far better to have a systematic way of dealing with it, as outlined in the new policy that was introduced a couple of years ago in New South Wales Health of incident reporting and

root cause analysis and if it is a SAC grade 1, 2, 3 or 4? Is that not a far better way of using the resources that would have to be used anyway than just doing incident reporting on an ad hoc basis?

Professor McGRATH: I absolutely agree with you. The issue is to make sure you learn the lessons, so these events do not recur. Over time the number of incidents will reduce and so the resources consumed will also reduce. However, the issue remains that as you get this process of capturing and holding management accountable for solving them and preventing them in future, in the early phases the number of incidents in the ward and at the clinical level is quite substantial. It is a matter of building them into the normal measurement process; that is what management should be doing at that level. We have to go there and it will take more effort and energy upfront to get it working effectively. Over time it will become less resource intensive and we will have less adverse events and all consequences of that.

The Hon. CHRISTINE ROBERTSON: In your current role, and people will know why I am able to ask this question, is there still collection of across-the-board data on indicators or adverse events, such as the return to theatre readmission rates for surgeons? Is that still sent out to the areas from a central level?

Professor McGRATH: Yes, it is. That data is captured centrally.

The Hon. CHRISTINE ROBERTSON: Could you explain the process and explain why it came to be, to address the belief that nothing has happened in New South Wales since the Tito report?

Professor McGRATH: Yes, I am happy to reiterate—and I was not in this position for all that time—but the response in NSW Health followed fairly quickly on the reports of the mid-1990s. Certainly our action in appointing and creating a clinical governance unit followed very clear instructions from NSW Health that boards and CEOs were accountable for the management of patient clinical quality within area health services. That was a very explicit direction. At the same time, the Institute of Clinical Excellence [ICE] was established, the quality branch within NSW Health, and Alan can give more detail about how people from the areas, such as Alan with expertise, have been involved in planning the processes that have gone into place. Certainly the capturing of readmission rates and a range of other system-wide indicators have been in place for quite some time now, as a response to that.

In addition, they have been looking at what are the best models to put in place to try to capture the incidents and make sure they do not recur. That is why, today, we are in a position to say 2,000 staff across NSW Health have been trained in root cause analysis, which is quite a major training exercise. Many who have attended those courses are the senior management and many, many senior clinicians. Engaging very busy clinicians in undertaking an additional and time-consuming process is a very challenging task. It is very much to the credit of NSW Health and ICE that the level of engagement and involvement at those senior levels has been achieved. It is a bit like a snowball effect; you have to do the proper groundwork, the proper planning, you have to get the right systems, you have to bring together the resources and then you have to roll it out. Getting engagement at that senior level is very challenging.

Alan and I are aware at times of how persistent, often in the face of antipathy, opposition and flak, one has to be to get this stuff working. But once the 2,000 are trained the snowball is on the downhill run. The number is growing and, I believe, growing extremely rapidly. There has been a lot of very good systems and processes developed, a lot of very good engagement and training, and that is the secret to success in introducing a major change in culture like this right across the system.

The Hon. CHRISTINE ROBERTSON: Professor, you are responsible for the performance section of the department. How do you feed that amalgamated data to the individual areas? Who actually gets it when it hits the area?

Professor McGRATH: That side of the feedback of data has not worked well to date. As you know NSW Health in the last few months—and forgive me, I have been in the job only for one month and do not have all those dates in my head—has a set of dashboard indicators, and that has been agreed to. They form part of the dashboard indicators. They will be fed back to areas in their performance assessment. They will be made available publicly on the web site. They are available in the areas through what is known as the HIE system.

The Hon. PATRICIA FORSYTHE: Professor McGrath, earlier you referred to medical records. I do not wish to misquote Bret Walker, but there was some media coverage on Friday that he has some view about

some inadequacies in medical record keeping that he has uncovered as a result of his special inquiry. Is there a system approach to what should be included in terms of medical records completeness and something as fundamental as legibility?

Professor McGRATH: No, I think that is an area where the policies on medical records are quite old. They do exist but some are 10 years old. We in the Hunter have become aware of systemic problems in medical record keeping and recently Alan and I were discussing that there is a need to revisit those policies and modernise them, update them. We are moving towards more electronic-based record keeping, and that is the way we need to go. Now there is a need to review those policies as a matter of urgency and it will be very time-consuming because medical records are kept not only by doctors but also by a whole range of people. We have to get a process that is streamlined and efficient, that records essential data as well as fitting in with the modern health care delivery system. People are extremely busy, they change frequently, they change shifts, and personnel change, et cetera. It is a mammoth task but we have to do it.

The Hon. ROBYN PARKER: In this Committee a lot has been spoken about Camden hospital. Recently in the Hunter area, the Belmont hospital maternity ward closed. What was the reason for that?

Professor McGRATH: No, the Belmont maternity ward did not close. There was a discussion about closure and an internal review was done to see whether the maternity ward should close. The reason for that was that anaesthetists were no longer prepared to support the unit, so there was a medical workforce shortage issue. We had to revisit the situation to see whether it was safe to continue the service as it currently exists. Also there was an issue about getting paediatricians who were prepared to take on-call at Belmont, because they were so busy in other parts of the system. That review has been completed and the decision, as I understand, recommended to the board was that it continue in the future as a midwife-only service. I think that is still in the final stages of being bedded down.

The Hon. ROBYN PARKER: Is it your view that there is such a thing as a low-risk birth?

Professor McGRATH: Yes, I think clearly there are such things as low-risk births, but also there are such things as a chance that things will go wrong, even in a low-risk birth. What needs to be in place are very clear systems, processes and protocols so that everybody knows what to do and for when those processes are to be triggered. You have to have a very clear protocol and strong training of staff in that unit. The mothers who choose to have their babies in that system need to have the information up front as to the nature of the service, what will happen if things go wrong, and that there is a certain level when they may need to be transferred during labour to a higher level of service.

The Hon. PATRICIA FORSYTHE: What is the ambulance time between John Hunter and Belmont?

Professor McGRATH: The issue is not so much the ambulance time, which is 30 minutes, but by the time the ambulance is called and the ambulance arrives then make the transfer, et cetera, it is probably between one and two hours. Our experience in the Hunter has shown that people make these changes to services, often without thinking through the systems and protocols that have to be in place to make it a safe and sustainable service. People think they know, but unless you document it and make sure there are training processes for the staff, and recognise that there is a regular turnover of staff and that you have to cover staff and locums and medical students, and you have to make sure that the mothers and their partners fully understand, it becomes a very, very big exercise to ensure that those systems are in place and working well and keep them working well. In the past, Health has frequently underestimated the size of that task.

The Hon. PATRICIA FORSYTHE: Does Belmont have a pathology unit?

Professor McGRATH: It has an on-site, small service at the moment. Part of the redevelopment of Belmont, which is part of Newcastle strategy about which I have spoken before, is to expand that. It was part of the Hunter area pathology service, so will never be a stand-alone pathology service.

The Hon. ROBYN PARKER: What emergency precautions need to be in place to run a service such as that if something did not go according to plan? There has been a recommendation to the board to go under a midwife service.

Professor McGRATH: It is very similar to home births and birthing units that are not co-located with a tertiary level service. Essentially, firstly, the mothers need to understand that they will be allowed to deliver there only if they meet the low-risk criteria, and that can be specified. Secondly, should something go wrong, they need to fully understand, and there needs to be informed consent, that they will be transferred to John Hunter from Belmont. The staff need to know the criteria under which to accept patients, what things can go wrong, at what point to trigger a decision to transfer, what is the protocol for that transfer, who do they ring so that they know that the person will be accepted at the other end. There is a whole range of things like that. It is possible, and a lot of mothers who, looking at that, would not want to have their baby there.

One of the issues for midwife-only maternity services is that when mothers are aware of that full range of issues many of them choose not to do that. In the Hunter Area Health Service we closed the service at Cessnock for precisely that reason; not enough mothers wanting to have a local midwife service. At Belmont the information is that probably there are sufficient mothers who, with all those constraints, want that service, and, therefore, it is probably a good idea to have the low-risk in a facility like that so that the tertiary level facility is kept for the high-risk pregnancies.

Dr SPIGELMAN: Has there been a complaint about the Belmont birthing service that has not yet commenced?

The Hon. ROBYN PARKER: No, my question goes to a comparison with Camden hospital and resourcing. I preface my questions in that way: We are comparing resources in a probably similar situation.

Dr SPIGELMAN: There has been a very formal risk assessment of all alternatives within the Hunter presented to the board with regard to the Belmont birthing service.

The Hon. CHRISTINE ROBERTSON: A lot of this debate about Camden hospital relates to decisions in relation to role delineation, which is pretty precise in relation to maternity services. Perhaps you have a lot to do with that, and the district hospitals across the State have had to deliver on that. Can you outline exactly what sort of processes are related to making sure that something is maintained as a district hospital?

Dr SPIGELMAN: As I think you have said, there is a formal role delineation set of documentation that is very comprehensive that allocates levels. That is what we use in the Hunter and I believe it is in use across the State. It goes into very significant detail of pathology services available, imaging services available, intensive care, high dependency, numbers of staff, staff on site and so on. So each hospital should be sure that it is working within its credentials, and that is checked periodically. So too the clinicians working in those hospitals need to be working within the limitations of that particular facility as well as their own personal credentials.

The Hon. AMANDA FAZIO: In relation to the Belmont issue that we have been talking about, do you think it is acceptable in terms of providing health services in a planned way for that planning to be undermined by groups of medical practitioners—whether anaesthetists, obstetricians or anybody else—who act as visiting medical officers and who say, "Well, we don't want to provide a service there so the public cannot have that service"?

Professor McGRATH: It is not as simple as that. Look at the situation at Belmont. I went down and looked particularly at this situation when the anaesthetists said that they were no longer prepared to provide a service at Belmont. My reaction first of all was to ask why not and to ask whether that was an appropriate response from the anaesthetists. I do not think that we in the Hunter have a reputation for shying away from the difficult issues, particularly in relation to medical staff. When I drilled down into it, first, they were extremely busy. They had very heavy workloads. The second issue that became clear very rapidly is that they did not do enough obstetrics to maintain what they felt was an adequate expertise in obstetric anaesthesia. I think now that the increasing medical indemnity issues have brought home to doctors more than anything that, if you do not feel comfortable with the service you are providing and you do not feel that you have the set of skills to provide that particular service, you should not be doing it—particularly when it relates to obstetrics and some of the major pay-outs that have happened as a consequence of adverse events or poor outcomes in terms of obstetric services.

The third issue was that there was not enough work on down there to have more than one anaesthetist on call but there was tension between being available in the operating theatre as well as being available in the labour ward. You were often needed in both places at once. When you started to understand the reasons for them

issuing that edict I think it became very apparent that it was a sensible clinical decision that the work force we had down there, with its skills and competencies, was not the right work force to provide obstetric anaesthesia. You could increase it. We looked at doing that but the medical work force shortage became an issue in that we had great difficulty recruiting. Indeed, as became public some time ago, in recent times we had to cover a period of shortfall by going overseas to get locums from South Africa to fill in for a time. We have re-recruited up there but I think the problem in the obstetric service at Belmont is that you need anaesthetists who have a skill in obstetrics but in the level and complexity of obstetrics there is not enough to make it an attractive place for a skilled obstetric anaesthetist to work.

When you start to say "Well, there isn't enough work to attract and keep a motivated work force of the right nature", how do you handle that? That is why the decision came down to saying, "Well, we don't believe we can provide obstetric anaesthesia at Belmont any longer for both the work force shortage and the volume and mix of work done at Belmont. Could you rotate them from John Hunter?" That was an option but we still do not have the numbers to be able to do that. Therefore, the best option was to look at having a midwife service, if that was going to be a sensible, practical, achievable and safe option, and to have the anaesthetic service available at John Hunter, where there is 24-hour, seven-days week and sufficient volume of obstetric anaesthesia required to maintain skills.

The Hon. PATRICIA FORSYTHE: I want to get this issue in a time frame. Dr McGrath, you talked about surveying mothers, understanding need and ensuring that the protocols were in place in the units. You also just talked about making some decisions based on available obstetric anaesthesia support. When was the decision taken to have Belmont as a low-risk birth centre and over what period of time was it reviewed to enable you to draw that conclusion? What are we talking about?

Professor McGRATH: It was probably about a six-month period. This issue with the Belmont anaesthesia staff came up in the middle of last year. That triggered an investigation of what were the issues and the problems—it was a sort of root cause analysis approach; it was not a full root cause analysis—because the anaesthetists made this complaint and this statement. So we went down and looked into the issues behind why they were doing that. We talked to them. It became very clear within three months that there was not an easy solution to continuing an anaesthetic service of the appropriate type in which the anaesthetists were skilled to the level that we needed. Then the decision was made as to where we go with obstetrics at Belmont. Belmont is undergoing a redevelopment so the decision was made then to fully investigate the options. One of those options included closure; we could have closed it. It could have moved all those services to John Hunter. That would have been doable. That was certainly an option that we had available to us. I left before the final decision was made. Allan's unit, as he said, was involved in doing a full risk analysis of those options and the result was taken to the board in March.

The Hon. CHRISTINE ROBERTSON: So the Camden people in their decision-making had the obstetric people—this is what I can glean from the evidence that we have been given—in that particular geographic area make a decision that they were not going to back the hospital, having Camden working as an obstetric hospital. So the area health service employed contract obstetricians who offer services everywhere—but they obviously have some decent measures of quality or they would not get any work. The reason why this is all being carried through so far is people perceived that that was not an appropriate thing to spend the area health service's funds on. In relation to ensuring the delivery of service for those people, do you have an opinion on the decision?

Professor McGRATH: No, I do not. I am not familiar enough with the detail of the issues at Camden and Campbelltown to make an appropriate comment.

The Hon. CHRISTINE ROBERTSON: Do you think the two relate in any way?

Professor McGRATH: Which two?

The Hon. CHRISTINE ROBERTSON: The comparison—or you do not know enough about it to compare—

Professor McGRATH: I really do not know enough about the Camden and Campbelltown local issues to make a decision. You really have to be in the thick of it to understand the issues.

CHAIR: Can I take you along a separate path? With all your experience in developing quality systems and looking at complaints handling and so on, do you have an opinion on the effectiveness and efficiency of the HCCC?

Dr SPIGELMAN: The answer is yes.

CHAIR: Would you like to expand on that a little?

Dr SPIGELMAN: We have had some dealings with the HCCC and, more recently, I joined the medical board and was made familiar with some of the dealings at that level as well. Clearly there have been issues in terms of timeliness. We have referred a number of cases to the HCCC, with much delay in terms of response.

CHAIR: That is what I meant by "efficiency". So you are saying that the delays were too long.

Dr SPIGELMAN: Part of that has driven the maturity of our own processes to look into things more deeply at a local level, which has created antagonism amongst some locally who believe that these things should be referred out. The difficulty is that that just allows the problem—if there is one—to fester. So we have been very proactive in that regard. Communication has been good but in the few cases we have referred that I am aware of my personal experience is of having to chase the HCCC, not the other way around. There were certainly concerns about that issue.

CHAIR: The other half of my question concerned the effectiveness of the HCCC.

Dr SPIGELMAN: Because of the delay the efficiency and effectiveness would be limited in that particular area. In the last year we paid great attention to its annual report and publications. They are very useful documents and we acknowledge that that has been a very useful contribution to the maturity of our own program, in learning from them and from the lessons in some of the documentation. But in relation to the on-the-ground, practical, day-to-day issues the experience has not been good from our perspective.

Professor McGRATH: I think I should add—sharing those concerns; we have discussed them—that when we sought HCCC assistance with a problem that we had at one of our nursing homes we found that the response was less than adequate.

The Hon. AMANDA FAZIO: You talked about conducting risk assessment and so on in a non-punitive environment so that you can ensure that there are system improvements and that those incidents do not reoccur. How do you balance that against the need for accountability on the part of individual practitioners who have caused bad patient outcomes?

Dr SPIGELMAN: That is a very good question that goes to the heart of the culture within the health care system—and probably outside it as well. I was very pleased last Friday to get a note from a fellow surgeon concerning an issue that we have conducted a root cause analysis on—it is still in progress—and that was also discussed separately at a clinical audit and peer review meeting. We support that and have put in place a process whereby if there are issues of concern arising from such meetings that the peers do not feel competent or able to address they bring them to the attention of management and, when sufficiently serious, to clinical governance. That is an example. As I said, that root cause analysis is currently in progress. It may well have independently brought up this issue but within our system another methodology has now brought this to our attention where there are concerns about a particular health professional and that health professional's role in the adverse event that is currently under investigation. There are two separate paths. As a result of receiving that correspondence we will now invoke our policy on the management of complaints or concerns about a clinician. That is a three-level policy: level three is immediate referral to the medical board, level one is local investigation and level two is senior management investigation. This would be a level two, and that has now commenced.

The Hon. ROBYN PARKER: We are using you as a comparison today. It is very helpful for us. We have heard evidence about area health services not having sufficient budgets. Professor McGrath, my reading of the last annual report for the Hunter Area Health Service is that it came in under budget. Is that correct?

Professor McGRATH: Marginally, yes. We have come in on budget for almost 10 years now.

CHAIR: You do not want to be too much under budget or you might have to give it back.

Professor McGRATH: My predecessor, Dr Tim Smyth, who came in after a major budget problem in New South Wales, put things on the right track. But I have always driven the very strong philosophy that health services need to come in on budget otherwise you are managing in a crisis environment. I am pleased to say that that always happened in my seven years. I come from the Victorian era under Kennett, where I saw the consequences of not doing that.

The Hon. ROBYN PARKER: When you say that you were marginally under budget do you been $1 million or $2 million, for example?

Professor McGRATH: I think it was less than $1 million. I cannot remember the details of the figures now. But that was out of a total budget of close to $700 million, including revenue.

The Hon. ROBYN PARKER: Is there an incentive for a CEO to come in under budget?

Professor McGRATH: No, not at all. There is no particular incentive to come in under budget. You keep the funds; you do not have to give them back. But there is always so much demand that I do not quite see how you come in under budget. It is really just a wash-up of the timing of when you close the books as to whether you are within $1 million or $2 million of the budget.

The Hon. CHRISTINE ROBERTSON: When the project funds arrive.

Professor McGRATH: That is true too. There are always rollovers and so on. There is so much demand and so many things you can spend your money on that I do not know how you would ever come in under budget.

CHAIR: Thank you for your attendance before the Committee today and for some very enlightening words. We wish you well with what seem to be very good systems that you have developed in Hunter area health.

(The witnesses withdrew)

(Luncheon adjournment)

DIANA GLEN HORVATH, Chief Executive Officer, Central Sydney Area Health Service, and

MICHAEL PATRICK WALLACE, Deputy Chief Executive Officer, Central Sydney Area Health Service, sworn and examined:

CHAIR: Would either or both of you like to make a statement before we commence?

Dr HORVATH: I would like that opportunity, if I may. At Central Sydney Area Health Service we have designed our whole clinical structure around quality outcomes of care. For the past nine years the clinical services have been structured into clinical streams of care which revolve around groups of patients rather than craft groups of healthcare professionals. These streams of care are led by senior clinicians, medical, nursing and allied health, and cross over the boundaries of the individual hospitals, community health centres and private practices, including general practice. This has enabled our resources to be spread according to patient need rather than based on historic ownership. All facilities within Central Sydney, including community health, submit themselves to voluntary accreditation by the Australian Council on Healthcare Standards, and managers, doctors and nurses are involved in surveys of hospitals in other States of the Commonwealth in particular. Despite the rising standards required to achieve this, all facilities are currently accredited.

Central Sydney has set up two major councils to assist its decision-making: the Clinical Council and the Clinical Quality Council. Each is composed of the area executive, clinical directors, hospital and other facility management, allied health, nursing and general practitioners, together with representatives of the broader community and consumers. The Clinical Council advises on the allocation of resources across the clinical services as a whole. The allocated funds for Central Sydney are spread on a needs basis across the clinical streams of care and additionally are rolled up vertically into individual hospitals and health centres. The Clinical Quality Council, on the other hand, supervises the quality of patient care. It does so within the clinical streams of care and, importantly, as care crosses into the community by general practitioners, domiciliary staff of the area health service and informal carers. Both of these councils present reports directly to the area board and are chaired by me as the chief executive officer.

The Clinical Quality Council has set up programs for sentinel event monitoring; clinical indicators reporting; implementation of root cause analysis techniques; and monitoring of complaints database, specifically by the consumer representatives. Since 1995 Central Sydney Area Health Service has progressively been replacing its paper-based medical records with an integrated electronic medical record. This started with the establishment of a unique patient identifier across all its loci of care. At present, we have eight years of data elements in these electronic systems, which greatly enhance the ability to access information wherever the patient happens to be. This has reduced the mislaying of results, the need to redo tests and unnecessary x-rays.

CHAIR: That includes all medical records, does it?

Dr HORVATH: That is right, right across mental health, acute care and emergency care.

CHAIR: So the patient would have one number no matter where they presented?

Dr HORVATH: Yes. We have kept the previous numbering system. We link them behind the scenes, and it does not matter where the tests are done across the area, all the x-rays, we have now implemented picture archiving and retrieval systems across all of Prince Alfred hospital and Balmain Hospital and the general practitioner casualty there. So, people can see the MRI almost before the patient arrives back in the ward bed or at the intensive care unit.

CHAIR: It is like a national identity system?

Dr HORVATH: No, we have done it within our services and we have done that because we are a single corporate entity and we have been very careful.

CHAIR: You will not get any argument from me on that one. It is a good system.

Dr HORVATH: We have a clear-cut confidentiality and privacy framework but I have always wanted people to be able to access whatever is there for me so that I can be treated with the right things at the right time.

CHAIR: Is that linked to Medicare claims as well?

Dr HORVATH: No, it is not.

CHAIR: It seems quite logical.

Dr HORVATH: I certainly can, and I am very keen to do that. I have been talking with the Health Insurance Commission about that same thing, so we can do that within the context of legislation into a safe harbour environment, and work is going on with that at present. I used to be a commissioner and was well aware of what help that could give.

CHAIR: Thank you. We should not be losing people in the systems then?

Dr HORVATH: We are trying not to. We put a lot of effort into it, because that is the real focus. The business we are in is looking after sick people.

CHAIR: We did have evidence given earlier—and this is not a major issue and I do not want to go down the track—and it surprised me how many patients can be lost in hospital.

Dr HORVATH: Yes.

CHAIR: Mr Wallace?

Mr WALLACE: I have no comments.

The Hon. PATRICIA FORSYTHE: Dr Horvath, when you appeared before this Committee as an estimates committee in November, you said that the Central Sydney Area Health Service had a somewhat different structure from most other area health services. Today in your statement you talked about designing a clinical structure around outcomes of care, groups of patients, not craft groups of health professionals. Is that what you were talking about?

Dr HORVATH: Yes, it is, and the fact that it crosses over all those hospitals and centres, et cetera, means that even in the very small hospitals the care has to be provided in a single protocol right across that. So, it is not in the hands only of individuals who might only practice in one place and not be aware of the other things that are going on. That has been progressive, of course, but a really important aspect of it.

The Hon. PATRICIA FORSYTHE: When you gave that evidence you provided it as background for why you needed to have someone in place who could provide what you said was data in a consistent fashion and that you had developed a position and that you had a position description. On that occasion you told us that Ms Collins had filled the position. Is that a position that has now been filled?

Dr HORVATH: At the present time we have had to maintain the position being filled in a way it was before we appointed her, because, of course, there is an appeal, an industrial appeal, pending. At the moment that work is still being shared between four or five people—a real problem to us.

The Hon. PATRICIA FORSYTHE: At the time you also suggested that you had money set aside in your budget for such a position. I presume therefore there is still money in that budget for that position?

Dr HORVATH: We still have the position and we are still wanting to fill it. Moneys do not ever get totally reserved, you understand, so when we have patients who come in, we tend to spend it on them.

The Hon. PATRICIA FORSYTHE: What is the current budgetary situation at the Central Sydney Area Health Service?

Dr HORVATH: About $575,000 favourable at the present time.

The Hon. PATRICIA FORSYTHE: How much is currently owed to outstanding creditors?

Dr HORVATH: We are certainly within our 45-day requirement, but I could not tell you how much is in the pipeline. Can I come back to that?

The Hon. PATRICIA FORSYTHE: Under the resource distribution formula [RDF] does the Central Sydney Area Health Service lose out in funding terms to other area health services?

Dr HORVATH: We have been RDF neutral for three years now. That has meant that we are not expected to further reduce our share of the State allocation.

The Hon. PATRICIA FORSYTHE: What do you expect the Central Sydney Area Health Service budget position to be at 30 June?

Dr HORVATH: We expect to be on budget and we will try to be as close to that as humanly possible.

The Hon. PATRICIA FORSYTHE: This morning Ms Collins suggested that a notice of termination came on 19 December and it was a directive from the Director-General to you, I take it, for her termination. Was that an unprecedented directive?

Dr HORVATH: There is a power of direction under the Act which is held by the Minister. The Minister a few years ago—in fact, I think three Ministers ago—formally delegated that power to the Director-General. That power has been exercised on a number of occasions, not always in relation to Central Sydney. It has certainly been exercised in the situation of Central Sydney at least three times since the Director-General held that delegation.

CHAIR: Did the Director-General direct you to terminate Jennifer Collins or did the Director-General empower you to terminate her?

Dr HORVATH: Directed.

The Hon. AMANDA FAZIO: I want to ask you some questions about the complaints handling procedures. Would you tell us how you handle complaints in the Central Sydney Area Health Service?

Dr HORVATH: We have a number of different mechanisms and a flow chart in place and a series of procedures as to how that occurs. We receive complaints verbally, written complaints and through our patient representatives who do rounds within the actual inpatient institutions. We encourage patients and carers to complain so that we can make improvements to the system. In the past many years ago there has been a sense in which patients felt that they ought not to complain, but that is no longer the case. We have at least one patient representative or nominated complaints officer at each facility and Royal Prince Alfred hospital has 1½ full-time equivalent because of its sheer size. We also have a set of procedures for trying to deal with the complaint while the individual is in front of the officer. So a lot of training goes into these complaints officers and patient representatives. Because anyone who is complaining, if the patient or relative is still in an inpatient situation, it is a very distressed individual you have in front of you. We want our handling officers to be competent at dealing with that situation and at resolving complaints so that they do not turn into a major stream of concern, particularly in a health care therapeutic situation.

We act on those complaints. We get about 6.9 per cent of the total complaints of all area health services and we represent 9.2 per cent of the funding. So that gives some degree of comparison. We investigated last year 99.88 per cent within 35 days and 89 per cent of complaints are recorded directly from the complainant. Of these 99.72 per cent resulted in an explanation and 74.8 per cent resulted in a formal apology with the explanation. We have got an analysis of complaint trends, and those come through our quality unit. We are looking very hard at whether we have more issues in a particular category than others and getting out consumers to follow that up to see if we are being fair about the way we behave. We also look at things we can do either systemically or if we have to look into whether a staff member has made a bit of a habit of certain types of actions.

From that we have a whole series of improvements that have occurred, particularly in things like falls and pressure ulcer care. That then lead to a whole statewide initiative to do something about pressure ulcers, looking at scheduled waiting times in clinic areas and so on—the sorts of things that people have put in place

over the years with all the best of intents but they can actually form barriers that are either confusing or intensely frustrating to patients and their relatives.

The Hon. AMANDA FAZIO: How do you see the role of the board of an area health service fitting into a complaints mechanism? I have been told by some board members that at their regular board meetings they are given an overview of incidents and complaints that have been made and at other boards it does not seem to be a regular entrenched event. What do you think the role of the board should be?

Dr HORVATH: I think the role of the board is to ensure that there is a complaints handling policy that is fair and sound and is acted upon. The board should also ensure that it is aware of the quality of their handling and the way that fits into the overall quality of care agenda. Our board receives information that has been looked at by the quality council and by particularly the consumer representatives on a council. As I say, they have been looking at it in terms of where it fits in the overall State framework and the board receives this type of information on a number of things, such as, how are we travelling in comparison to similar groups elsewhere. Of course, there are some complaints that get raised directly with the chairman or individual board members, so they get the opportunity to see how that works in action almost as an internal audit focus. I think those are the proper roles of boards—making sure we have got it, making sure we follow it and making sure that there is a fair and open process that is being monitored in relation to the way others are behaving.

The Hon. ROBYN PARKER: Returning to your discussion of your budget, in order to achieve your budget is it true that you have closed or are about to close 10 orthopaedic beds in the orthopaedic ward at Prince Alfred hospital?

Dr HORVATH: We have over the last 18 months been opening and closing 10 beds in the traumatic orthopaedic ward at Prince Alfred totally related to our ability to recruit nursing staff. At the moment we have a considerable number of vacancies in that ward. It is not a particularly popular ward with nursing staff because we find that many of the patients and their relatives are rather abusive both verbally and physically of the staff. There has been a difficulty in maintaining a level of nurses. We have closed the 10 beds recently because that level of vacancy has gone up. We believe that it is better for us to consolidate rather than to only fill them or overfill them with the agency nurses. It is not a budget strategy.

The Hon. ROBYN PARKER: Mr Wallace, at the estimates committee hearing on 1 December you stated that Jennifer Collins would be "a great loss to the health service". Do you stand by that statement?

Mr WALLACE: I made it in connection with a question on my knowledge of Jennifer. It was based on the review that was undertaken later in 2003. That was certainly the way I felt about the work that I had seen her do in her area, yes.

The Hon. ROBYN PARKER: Do you believe that the Central Sydney Area Health Service has a level of exposure to making a payout to Ms Collins?

Mr WALLACE: I could not comment, I am sorry.

The Hon. ROBYN PARKER: Have you made any contingency in case that is so?

Mr WALLACE: No, we have not.

Dr HORVATH: It is before the courts.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: The job that was created or came to fruition at the time Jennifer Collins was appointed, I understand from Dr Hovarth, is still vacant. Is that correct?

Mr WALLACE: That is correct.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Depending on the outcome of the court case that job will be filled either by Jennifer Collins or by somebody at the same salary?

Mr WALLACE: That is correct.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: That job that was created at the same salary level will be ongoing indefinitely?

Mr WALLACE: That is correct.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: That is the envisioned situation?

Mr WALLACE: For as long as the need is there, yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: I assume if you just set it up it will be ongoing for the medium term?

Mr WALLACE: That is correct.

The Hon. CHRISTINE ROBERTSON: Dr Hovarth, as to the complaints system, we have heard evidence about the community being encouraged to complain. It would seem that there is a difference between how the community perceives it is getting that right and how the health people perceive they are giving that right. Would you tell us how you have structured it so that people who come into the hospital know that they have that right? If there is paperwork, has work been done on the literacy level of forms?

Dr HORVATH: I can certainly do that for you. One of the most difficult areas for complaints is mental health in any mental hospital system. To facilitate communication and open complaints there we have employed consumers as patient representatives in Rozelle Hospital for 10 years. This has been most helpful in getting a system where the patients do not feel that they are risking anything. They can go to a patient representative and discuss the things that are concerning them about the care and bring complaints through that mechanism in a way that has led to quite a number of very distinct improvements in both our communication and the way they feel empowered about this process. That is my most difficult one. We then have set up a framework where people are not only encouraged by the material they are given at the point of entry to the hospital—and that is not always at admission but also coming to clinics, going to specialist rooms, coming to the emergency department—they are given information which includes how to access a patient representative.

We found that when people are distressed, even that is not quite enough. So we send our patient representatives to go on around the wards and liaise with people, particularly in the waiting rooms and walking through the wards, to see if there are matters people want to raise. That has also brought forward a group of people who were feeling concerned about raising issues and who felt perhaps that they did not understand what they were hearing, or that it was being done in a manner which was too abrupt or too technical and was above their head.

You asked about literacy. We have done quite a lot in relation to that. Forty-two per cent of our people in our community in Central Sydney speak a language other than English as their first language at home. That has meant we have been really at the forefront of not only getting things translated but also our interpreter service being well across them. The literacy levels we use depend upon taking a level below what is expected because of this issue of people with other languages, in addition to the fact that at the time when they are sick they are sufficiently stressed that a lot of things leave them.

The Hon. CHRISTINE ROBERTSON: In the smaller country hospitals, specific groups have great difficulty with the complaints process because of the potential to be excluded from the service in future. Do you have any thoughts on that?

Dr HORVATH: We have not found people who feel that way. In particular, we have taken a lot of trouble, for example, with the Aboriginal Australians and their access to services, and we have employed a considerable number of Aboriginal Australians in order to create a means of communicating which is regarded as fair and proper, although we do have the great joy of a number of our medical and nursing staff who have very close and ongoing links with specific Aboriginal communities.

We have also set in place an agreement with the Redfern Aboriginal Medical Service to facilitate that; quite a bit of our work is done there in conjunction with them. We have found that Prince Alfred, in particular, is very much a preferred entry point in the city for Aboriginal people because of the extent to which they feel they are going to get a fair hearing and they will not be treated as having any different access to complaints

handling and care than anyone else. It has been quite gratifying to get that sort of feedback from a group of people who have traditionally been reticent about coming forward.

The Hon. PATRICIA FORSYTHE: When the director-general appeared before the estimates committee hearing in November, she said, "Can I stress, it comes to the heart of the matter. I have no employment relationship with Ms Collins." Given that, how was it that the director-general was able to direct you to sack Ms Collins?

Dr HORVATH: She has the delegation from the Minister, the Minister has the power to direct the area health service, the direction to the area health service goes to the board, and I have the delegation under the Central Sydney delegations manual to handle matters that might come by way of direction. That is under section 25 of the Health Services Act. I was directed, pursuant to that Act, to terminate her employment.

The Hon. PATRICIA FORSYTHE: Was that a direction in writing, and when was it given?

Dr HORVATH: It was a direction in writing, and it was given—I am trying to recall whether it was actually given on the 19th or the 18th. It is dated, and the direction was given in writing. I could come back with—

CHAIR: Jennifer Collins says it was the 19th.

Dr HORVATH: It was on the 19th that I conveyed it; I just could not recall whether the matter was directed on the 19th.

The Hon. PATRICIA FORSYTHE: Earlier in answer to a question from the Hon. Robyn Parker you spoke about financial estimates on payouts. Could you clarify whether you have made any financial estimates on the payout and whether you have any legal advice to this effect?

Dr HORVATH: No, we have not. No, we have not. The matter is before the court. We have not made any estimates or provisions at this point in time.

CHAIR: May I clarify a previous answer. When the director-general of the department said, "I have no employment relationship with Jennifer Collins," but she then directed you to terminate Ms Collins's employment, your response was that the line of process goes from the Minister to the director-general, who then instructed you. Are you saying that to your knowledge the Minister gave the direction?

Dr HORVATH: I am sorry. You are quite right to draw that to my attention. Under the Act the power lies with the Minister. The Minister has formally delegated that power, so that the exercise of that delegation was what the director-general did in relation to the area health service. It just so happens that I have delegations under the area health service as well, although I did consult with my chairman.

CHAIR: About the termination of Ms Collins's employment?

Dr HORVATH: No. I advised him that I had received this directive.

CHAIR: If you had received the directive, I would not have thought it was necessary to advise the chairman.

Dr HORVATH: I prefer to keep my chairmen are appraised of matters like that, which are directed to the area health service as a whole. It was not legally necessary, but the chairman of the board, I had no doubt, would want to be appraised of it.

CHAIR: I have two viewpoints in mind. The director-general is given the power to terminate a person's employment. As you explained, that power is passed down from the Minister. But we also have the fact that the termination did occur, and we also have the director-general's statement, "I have no employment relationship with Jennifer Collins." I simply cannot balance the two.

Dr HORVATH: She does not have the power to dismiss but she does carry the delegated power to direct the area health service to do things.

The Hon. PATRICIA FORSYTHE: Did you have any discussions with the Minister's office before you took the action?

Dr HORVATH: No.

The Hon. PATRICIA FORSYTHE: You had a letter from the director-general. Did you then have any discussions with the director-general before you took the action?

Dr HORVATH: I got a directive. I would discuss matters with the director-general fairly frequently. I had no discussion on this matter at all with the Minister's staff or with the Minister. I had limited discussion with the director-general, but I did have some.

The Hon. PATRICIA FORSYTHE: Did that include discussions about budget implications for the Central Sydney Area Health Service?

Dr HORVATH: No, it did not.

The Hon. ROBYN PARKER: Who is the chairman of the board?

Dr HORVATH: At the moment the chairman of the board is Mr Dick Persson.

The Hon. ROBYN PARKER: Is your standard explanation about patient mistreatment that they were going to die anyway?

Dr HORVATH: No, that is not my standard answer about patient mistreatment.

The Hon. ROBYN PARKER: Have you ever said that before?

Dr HORVATH: That someone was going to die anyway?

The Hon. ROBYN PARKER: Yes.

Dr HORVATH: I graduated in medicine in 1967. It is not inconceivable that I would have said that someone who had received poor patient care may have not benefited from receiving good patient care, yes. I tend to be fairly open with patients.

The Hon. PETER PRIMROSE: Can you tell us about your experiences with the Health Care Complaints Commission? Have they been positive, have they changed recently, and what were they up until, say, December last year?

Dr HORVATH: I have been involved with the Health Care Complaints Commission since its inception. At the time it was set up I was on the selection committee for the first commissioner, along with the then Director-General of Health, Dr Bernie Amos, and I have had ongoing relationships with the commission since that time.

I have had both good and bad experiences. There have been mostly times where we have worked together on matters. In fact, more recently, perhaps five or six years ago, I had cause to make a direct referral to the Health Care Complaints Commission. In fact, we investigated some very serious matters in parallel because I believe I have a non-delegable duty of care to ensure that there is a proper and safe working environment.

I am trying to remember whether there have been any adverse experiences. I think someone raised a complaint about me at one stage, and I do not think we had any particular issues over the way that was resolved either. I have certainly more recently had concerns about some of the delays that were occurring in the investigation of complaints. It seemed to me that that was probably related to the volume of the complaints, and the resources and how they were allocated. We have done quite a considerable amount of the investigation and resolution work on behalf of the Health Care Complaints Commission over the last six or seven years as our processes have come to have some degree of concordance with the Health Care Complaints Commission.

More recently, in the very recent times, there has been an interim head of that and I do not think it has had a great deal of impact on the complaints that we are sharing between us at the present time, but there are not a very big volume of those.

The Hon. AMANDA FAZIO: Last week in evidence it was put to us in regard to both clinical governance and complaints handling that rather than try to teach doctors, nurses and other health professionals about those concepts once they are actually working in the health system, it would be far more productive to include that in the training that they receive, in with all their clinical training. Have you any comments to make on that idea?

Dr HORVATH: Yes, it is and, in fact, some of that has been started. It is very interesting to look at what has occurred within the framework of the medical school with which I am associated or on the faculty of, and that is Sydney, where there has certainly been a huge emphasis on communication skills in the graduate curriculum which is in place and, more recently still, we have had the opportunity to work very closely with a previous health care complaints commissioner, Merrilyn Walton, who is now an academic at the University of Sydney working on the same matters in relation to both the students in the graduate program and the work of the Central clinical school in working through with graduates in their early years.

What we are finding is that many of the processes that people have grown up with, they keep, so that people who graduated as long ago as I did grew up with a set of approaches to complaint resolution which were vastly different from the circumstances of today. It is, to my mind, extremely important that the younger practitioners not simply pick up those old habits but they are themselves products of a much different social environment in which they have been taught to ask why all the way through their schooling and we explore the boundaries that much further when they reach medical school and the hospitals themselves. It is a very productive relationship and a very fertile field.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: I would like to talk about ongoing training of medical staff. Presumably in the teaching hospitals at the salaried level it is fairly competitive and everyone goes to the training meetings. Do you have a system of updating non-teaching hospital staff or GPs in your area? Are you plugged into that at any level?

Dr HORVATH: Yes, we are. We have two divisions of general practice in Central Sydney and we are fairly actively involved with some of their continuing medical education work and, more recently, they have come to us—the Central division which has been restructuring—to increase that involvement with their CME. What we have been doing is with the executives of the divisions initially and then as we go into shared care arrangements, there is a much more active process of working through how people handle complaints that particularly come through GPs that people are very comfortable with; that is, they then come to their GP about some concerns they may have and the GP gets in touch very quickly. We have facilitated that and we are keen to get that improving as we get more and more electronic, so that the data flow will aid some of that complaint resolution too.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: If you have people in non-teaching hospitals—

Dr HORVATH: Yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Does the performance monitoring feed back into an individual program of updating, either in response to complaints or, ideally, just as a function of passage of time? In other words, you do an update in this area after so many years. Presumably, you have a large reservoir of teaching going on anyway, which people could plug back into on a program either because of an incident or because of passage of time.

Dr HORVATH: It is more because of an incident that people become involved because some people are particularly good at it anyway, particularly—I hate to tell you—the women. They are much better at complaint resolution, we find, than the older men.

CHAIR: I do not know whether I should allow that kind of sexist comment.

Dr HORVATH: That is a mere fact and it is not sexist if a woman does it. But it is interesting. It has, in fact, been visible in general practice that one of the factors leading to the relative shortage of practitioners in

medicine has been the feminisation of the medical work force and a part of that has not just been the whole-of-life practice and hours of practice; it has been the tendency to longer consultations that the women, as a gender set, have provided. It is just one of those facts. What we do, though, is feed that back in so that people generally become interested in it if they have had a complaint or problem or if they have been notified of a legal issue. Those sorts of spurs are far more likely to mean that they will set aside the time for what they generally will regard as a bit boring in terms of CME updates, so we do find that most GPs are not as interested in that form of CME as others.

We do, however, have a lot of traction with the medical staff in our institutions and in our community setting and we do get a lot of involvement in that follow-up loop from them, and that is done at practice level as well as at departmental level within the institutions and because of the clinical streams, it does not have to be limited in the way that people in the smaller hospitals get access. So that those clinical streams cross over that smaller hospital and if you have someone who might be a general physician, they will still have patients who may be in a cancer stream or in a geriatric and rehabilitation stream and they will be party to that update process within that clinical stream of care.

The Hon. CHRISTINE ROBERTSON: Recognising that you have said a lot of really good things about what is happening in your institutions in relation to complaints handling and some equity in the process, we have had a lot of evidence over the last week or more that points to the hierarchical power structures within the health sector, both between nurses and doctors and within their own structures, which tend to cause some issue in relation to the way that complaints are dealt with, particularly from staff themselves.

Dr HORVATH: Yes.

The Hon. CHRISTINE ROBERTSON: You are telling us you have done a lot of work but I cannot imagine that the whole thing is resolved.

Dr HORVATH: No.

The Hon. CHRISTINE ROBERTSON: Would you be able to give us some ideas on how you think this should go to resolve this problem? I was not attacking you.

Dr HORVATH: No, that is okay. I have not specifically dissected the stream of it, which is the staff complaints and the grievance process, which is taken a little differently from the formal processes for complaints handling of patients and relatives. Once you get to dealing with staff complaints—complaints that they themselves generate—you have really got to have a process which is fair to both parties and does ensure that those sorts of complaints are not dismissed. I think probably my first really powerful message about this came some 20 years ago when I was dealing with a series of non-English-speaking cleaning staff, who were being—I think bullied is probably too light a word for it—they were being subject to considerable harassment by a series of well-placed managers—and that went right up the system and included the Department of Health and included the Department of Public Works and Services.

At that stage they came to me about it because they could not get through that hierarchy. It was a very clear picture to me of how important it was to ensure that they had that access, and they still have. We got the police to stop the torching that was going on of homes and we dealt with that and it has created a milestone. It is a bad way to create one, but it certainly means that you are very aware of the need for that process and the need for people to be able to stop you as you are walking through a place and say, "I need to talk to you privately."

The Hon. ROBYN PARKER: You have talked about communication quite a bit today. Do you think that it is acceptable for your patients to be told that they are a waste of taxpayers' money?

Dr HORVATH: I do not find it an acceptable phrase for any of my staff to use with patients or their relatives. I have, however, limited control of what they might say in the middle of the night when someone is being unreasonable or they are unduly stressed. When I get complaint like that, I look at both sides of it. We have had some patients and their relatives whose treatment of the staff has been less than admirable and it is important that we investigate those things and are fair to both.

The Hon. ROBYN PARKER: What sort of steps, though, would you take to make sure that staff do not speak like that? Have you taken any steps at all?

Dr HORVATH: Of course. We have done quite a decent body of work in how to handle that type of thing. There are two parts to that answer, though. One is in how to treat people as human beings, how to treat someone the way you would like to be treated in that circumstance. So we have got an officer whose role is very much to actually give people handling skills in those circumstances: keep smiling when they are asking you again, because most of the time you are just dealing with scared people. But at the other end of it, we have had to put in some very impressive programs in how to handle violence against staff. We get intimidation and harassment, and a nurse who has been spat on and kicked is not to be ignored either.

We do have to be even handed as we deal with this, and we also have to expect that some of the complainants may be less than reasonable in their expectations. It is not our first belief, but we have discovered that as we have worked our way through that environment. Both are human, but our nursing staff in particular and our young doctors and our allied health have to be superhuman in their efforts to be understanding and caring.

CHAIR: We have reached the end of our time for this. Is there anything that is very pressing? If not, I thank you, Dr Horvath and Mr Wallace for being with us and for the clarity of your presentation.

(The witnesses withdrew)

MERRILYN MARGARET WALTON, Associate Professor of Ethical Practice in the Faculty of Medicine, University of Sydney, affirmed and examined:

CHAIR: I have read statements earlier in the day concerning the privilege that your evidence is now under while you remain at this table. I should, however, remind you that once you leave the table here your right of privilege disappears, and it is upon your own head what you should say to the press or others on this occasion. In what role are you here at this inquiry?

Ms WALTON: I am here because you invited me here.

CHAIR: Would you like to open with a statement?

Ms WALTON: No.

CHAIR: We will just open it to questions?

Ms WALTON: Yes.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: When you were commissioner you were renowned as relatively activist, I think. But there was a long tail: the complaints took a long time to resolve. Would you say if that was so and, if so, why was that the case?

Ms WALTON: The commission has always had very high case loads, and there is not a lot of room to move in terms of what gets investigated or not. Bearing in mind five years, my knowledge of the Act is little bit dim, but I think section 23 required the commissioner to investigate any complaint that raised significant issues of health and safety, significant clinical issue in relation to treatment. Once you actually apply that test there are many complaints that fall into that arena. We had a tail of around up to three years for a percentage of complaints, and I annually and routinely reported that to the parliamentary committee that oversaw the Health Care Complaints Commission. The resources when I was there at the time, I think our budget was around $1.8 million or $2 million and we had staff of around 50, I cannot recall the details, but we did have delayed cases and that was known publicly. We had an Ombudsman investigation of some of our delayed cases at the time when I was commissioner.

When I was in my last year we were looking at developing a system that could make more transparent the delays, and by saying that I mean there are clearly cases that are so significant in the public interest that they have to be resolved quickly; there is a second tier probably where there is no threat to health and safety, but need to be investigated because they raise professional conduct issues; and there is the third tier where probably there is no risk of danger but we need to look at it to make sure that all the components have been examined. When I left that is the sort of direction we were going in, and some of that model was in evidence in America. Some of the boards over there had huge case loads and had to be responsive to the public interest. How you determine that was the question. That is where I left it, basically. It was to try to manage that tail.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: It was not a definitional problem where you felt that you had to investigate them in a slightly legalistic framework without sufficient resources and, thus, the tail was going to be there by definition if either the cases you had to investigate or your resources do not change?

Ms WALTON: I never thought of taking the legalistic approach. There was just the method of appropriate investigation of complaints that had been deemed that fitted section 23, and that investigation included getting all the facts, getting all the evidence you could gather, bearing in mind there were no production powers of the commission. I am not sure about now, but we were never successful in getting production powers. So you were dependent on people being co-operative and there can be installing processes during the process of getting someone to co-operate and write a report. Indeed, we had no access to medical records outside the subpoena process. We had subpoena powers under the Act, but used them only in very serious cases because of the environment at the time and nor could you go to judges all the time to get warrants on every investigation. So the processes were voluntary. The way we approached it was just getting the facts, getting the clinical expert reviews, determining the weight of the evidence, looking at the appropriate forums. If that is legalistic, that is what we did.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: There were people, were they not, who could not work because they had this thing hanging over their heads. If they had an argument with the employer they had in a small town, for example, and the employee did not want to take them on again while the investigation was pending they would be effectively unemployable for that period in that area?

Ms WALTON: What happened to employees during complaint investigations was not the jurisdiction of the commission, but we had no power to say this person should continue to work or not on pay or no pay. Those were the decisions made by others.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: But they were consequential on the delay?

Ms WALTON: I am sure it has an impact on the respondent, yes. I cannot recall a case which caused great significant harm to anyone in that process during my time, but there may well have been.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: I was aware of a nurse who could not be employed effectively because a complaint had been made that she gave the patient the wrong medication. She did not work again, and I do not think she has worked again to this day. She could not work for three years while the complaint—I do not know if it has been resolved, I think it has—was being resolved.

Ms WALTON: I just think there are probably many factors inherent in that example.

The Hon. AMANDA FAZIO: When you were the Commissioner of the HCCC the patient support service was established in 1996. Can you give us some background to that decision and what you hoped to get out of having a patient support service?

Ms WALTON: The Health Care Complaints Act established a conciliation registry and separate process to conciliate complaints. The Act came in in 1994, and I think over 12 months we could see that the uptake was not significant. In the meantime New Zealand had established a Health and Disability Commissioner and within the legislation there was provision for patient advocates. Many of our complaints could be resolved by getting the parties together to try to get information, get the parties talking together. I did not think that was possible to happen without the facilitated process to help patients because by the time it got a complaint the relationship had been pretty much damaged. I thought one mechanism we could introduce in New South Wales was not to call them patient advocates but to have some patient support officers who could work with patients and resolve it locally. In effect, I think they replaced our reliance on the conciliation functions.

The Hon. AMANDA FAZIO: Following on from that, did you ever see that there might have been conflict of interest between having a patient support service and the other main function of the commission, which was to investigate and prosecute complaints, particularly against individual clinicians?

Ms WALTON: No, I did not. There are many mechanisms to resolve complaints, and it is about appropriateness of the mechanism for the complaint and the type of complaint. It is appropriate to deal with serious complaints through other than anything but investigation, and it is inappropriate to investigate matters that should be dealt with locally.

The Hon. AMANDA FAZIO: Now in area health services they have patient advocates of patient representatives who go around and talk to patients and their families about any problems they have about the quality of care and patient outcomes. Do you think it is better having them located in the hospital system like that, or do you think it is better to have them as a stand-alone patient support service?

Ms WALTON: I am on the record as being a strong advocate for saying patient representatives have a strong conflict of interest being employed by the hospital to work with patients in the very hospital that there could be a problem with. In the past I have argued that all patient representatives should be part of the Patient Support Office, part of commission staff. That was never accepted by anybody.

The Hon. AMANDA FAZIO: Would you see that they would have a role to work in the hospitals, even if they were employed by the HCCC?

Ms WALTON: Yes, I think they should they be placed in hospitals, definitely, but not employed by them.

The Hon. PATRICIA FORSYTHE: Underpinning all of this inquiry has been whistleblower nurses. I am wondering what your views are on the role of the need for whistleblowers. Is it a sign that the system was not working well?

Ms WALTON: We need whistleblowers, to answer that question. When I was at the commission I think only about 7 per cent of complaints were ever made by health professionals and I think that that is an indictment on the health professional system: their failure and reluctance to make complaints when clearly corners are being cut and things are being done with potential risks to patients.

I was going to go off on a tangent about violations, but that will be too complex. Will you repeat the question?

The Hon. PATRICIA FORSYTHE: Given that whistleblowers—

Ms WALTON: I've got it! It is unfortunate that they have that name, whistleblowers. If it was routine for people to report, they would not be marginalised and given the name "whistleblower". My research with junior doctors has clearly shown that junior staff are very reluctant to complain, even medical students are very reluctant, and they are the most idealistic, when they observe or see a potential for patients to be harmed. They are certainly concerned about it and in my research they talked about it at length. The consequences for their careers cannot be underestimated. There is a culture within the health system and it is not just one culture; there is the medical culture, the nursing culture, and the hospital culture, which is broader. From my personal experience, when there are attacks on Health the system is very good at closing ranks and protecting itself. When there are attacks within Health that is where the real blame culture comes in.

CHAIR: I appreciate your emphasis upon dialogue and discussion with complainants and the fact that you do not want to go down the track of legal action. What do you think about the appointment of a judge as the new commissioner?

Ms WALTON: It is only a caretaker position, as I understand.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: No, the caretaking is over and the judge is the new commissioner.

Ms WALTON: Even that position is a caretaker position, as I understand.

The Hon. AMANDA FAZIO: That is correct.

The Hon. CHRISTINE ROBERTSON: He is an acting-commissioner.

Ms WALTON: For a limited period.

CHAIR: Even so, what you think of a judge being appointed as commissioner?

Ms WALTON: Long term? Short term there are things that need to be fixed up. But long term, I think it is inappropriate for a judge to be the commissioner of the Health Care Complaints Commission.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Do you think that this episode with the nurses and with the response of the system to that, has been a blame and shame approach?

Ms WALTON: There has been a blame and shame approach in Health long before the commission even started. In the 1930s when Harvey Cushing, an eminent clinician, started to use mistakes or adverse events with patients to teach, there was an openness at that time in literature and the media. After the 1930s came a change in the culture to do not only with the requirements of journals, which went down the pathway of randomised control trials and a different way of reporting, but also the malpractice environment in the United States which led to a silence around mistakes and errors. Today we mistakenly believe and will say that people will learn by their mistakes.

We tell all our junior health practitioners, nurses and doctors, "You will learn by your mistakes", and that is just bunkum. They do not learn by their mistakes, because there is a silence around mistakes. There is a whole fear of litigation, fear that their careers will be affected, fear that they will be blamed if they have made a mistake. In the health system we are very well aware that medical error, or health care error, is just a subset of human error. In a very complex environment where the designer systems are pretty old-fashioned, archaic and inadequate, there will be error.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Junior staff might be aware of their own mistakes, but may not be able to learn from other people's mistakes.

Ms WALTON: You can only learn from your mistake if you can talk about it and if you are able to see how you can avoid repeating it. Also the system can change to reduce the opportunity for error. Those sorts of things do not happen routinely.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: But some people never learn from their mistakes. Obviously the system needs to impinge upon them.

Ms WALTON: The reason we are in this mess is because there is a misunderstanding of the no-blame culture and professional responsibility. It is not one or the other. Part of the quality and safety agenda, in which we focus on no blame, and I am an exponent of that, is to try to get the system to start reporting errors, to redesign systems, and look at better ways of doing things. With professional responsibility we have never had a strong accountability system anywhere in the Western world, because the medical profession has been very reticent to support regulatory authorities. They look down on people who report other colleagues; that they are dobbers-in, and that sort of culture. There is no clinical autonomy rule. There has never been a strong infrastructure of support within the profession for professional accountability. Just look at how patient complaints were dealt with in the 1980s and 1990s.

Quality and safety is the right way to approach it as a no-blame thing, but it does not mean that people do not have to be accountable. With the investigation of individuals, I can think of every doctor and nurse who was struck off, there was always a systems problem as well: poor accreditation, poor training, poor something. If you approach investigations I would be amazed if you did not find systems problems needing improvement.

CHAIR: Do you think that the Government is on the right track by suggesting two approaches: first, focus upon individual culpability; and, second, systems error?

Ms WALTON: The public needs two strong mechanisms. One does not replace the other.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Do you think we should abolish tort law in this situation, as a quid pro quo for a regulatory system? Or do you think they could be complementary? If so, how?

Ms WALTON: I will talk about medical negligence, or negligence. Yes, there needs to be serious reform to medical negligence. I am on the record as supporting no-fault compensation. If you go down a no-fault path there needs to be very strong professional accountability mechanisms. Some problems with the New Zealand model of no-fault compensation have been the weak regulatory frameworks underpinning it.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Something of a money handout issue, is it not?

Ms WALTON: I do not think it is much money. If you ask the New Zealand victims, I do not think they would be very happy with how much they get.

The Hon. CHRISTINE ROBERTSON: I recognise the excellent work that you have done in quality and directions, and you have just concurred with the Chair about the two structures that New South Wales is setting up, and I know that you were the Health Care Complaints Commissioner in the past. The legislation says that the Health Care Complaints Commission is responsible for investigation and prosecution, and that is a powerful structure.

Ms WALTON: Yes.

The Hon. CHRISTINE ROBERTSON: Do you agree with that process?

Ms WALTON: Totally. We need a very strong Health Care Complaints Commission which focuses on the profession, it is a co-regulator. This is not just a body to look at it. In my view there is only one Health Care Complaints Commission and it co-regulates with the registration boards. There are many organisations doing quality and safety. We need to have the commission focused on it. There will be systems improvements necessarily, and very detailed and strong recommendations which come out of the commission. They need to be supported and someone else needs to look at them and do them. My view is that the commission should not look at systems generally.

The Hon. CHRISTINE ROBERTSON: Are you somewhat excited from your academic base about the processes that have been structured in NSW Health for quality? Or do you feel that there is a lot more to be done, or that the direction is not appropriate?

Ms WALTON: There is a lot more to be done. We are talking about redesigning whole systems of care and dealing with complexity. I have been working with the health department for some years and chaired the culture change committee that led to the root cause analysis initiatives. Yes, I support that.

The Hon. AMANDA FAZIO: Do you think the direction that NSW Health has taken with complaints handling mechanisms, including root cause analysis, SACS reporting and incident investigation, et cetera, is the best way to go in order to overcome some of the problems created by both hierarchical structures within the health system? The fear is that people believe that if they come forward and make a complaint it will be all blame and no gain by improving things.

Ms WALTON: I still think we need to do a lot of work in getting managers and organisations to understand the difference between the no-blame culture and professional responsibility. We do not have strong enough mechanisms in place at the moment. It is one thing to tell staff that we want them to report because we want to do a root cause analysis and make improvements, and then, if something appears in the media and Ministers or health department heads or whoever, say, "We want to report who did it", it immediately can undo so much good work. Having said that, the system has not got it yet. When a patient makes a complaint, he or she is entitled to a detailed description of what happened to them, who treated them, and whether they met the standard of care.

Whether it is a complaint to a hospital or the commission, or whoever, that will determine whether the person was treated appropriately and whether there was a lot of other system issues. It may well be that no-one is responsible, the system is responsible. It is very different from a root cause analysis. I do not think that complaints should be automatically handled through a root cause analysis process. The root cause analysis is where you identify up-front systems problems, and that is what you are going to find. They are not to replace proper complaint examinations.

The Hon. ROBYN PARKER: In giving people skills to change that culture, recently you wrote an article about interns not being trained well enough. Can you comment on how to prepare our health care professionals to handle health care complaints?

Ms WALTON: I wish I had that answer in one sentence. The problem about our current training for junior doctors is that there is tension between a hospital's need for service delivery, which is to have a cheaper workforce, and the training requirements of junior doctors who are still in training. They are only conditionally registered, for example, as an intern. And there is the belief that they learn from experience. The problem is that junior doctors are being left in positions of great responsibility at times in the health system when we know they are vulnerable—overnights, weekends, changeovers, getting out of department consultations. That is not from the literature, that is from my own research.

The United Kingdom is going down the track of a consultant-led service. They are looking at investing a huge amount of money in having senior clinicians on the wards 24-hours a day. America has examples of introducing a position called a hospitalist; that is a specialist doctor who is employed by the hospital but 75 per cent of the time is with junior doctors, teaching rather than hands-on patient care. There is a role in this country for looking at simulation centres. The days of the first time a doctor does an operation is on a patient are going very quickly. The days when we do not tell patients the doctor's level of experience are going very quickly. We are teaching medical students and junior doctors to tell patients, "I have not done this before, but I will be supervised. Do you consent?" Huge changes are driving the necessity to change training.

The use of simulation centres, having more focus on transparency, training requirements for junior doctors with patients—if you go to a teaching hospital it is reasonable that patients know they will be treated by junior staff. That is a good thing, we need a future workforce to be experienced. But we need a lot more transparency about it. I do not have the answer of how to fix it, I just know that the system we have is struggling under the demands of technology and the potential for risk is great with inexperienced staff.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: It seems to me that root cause analysis is a management analysis tool and that patient representatives are an advocacy from the bottom. What do you say about the relative places of those two resource allocations within the system?

Ms WALTON: I see them as totally different. One is a method for resolving complaints. Root cause analysis, or clinical practice improvement methods, or any other sort, is really a method for improving health care and getting better outcomes, finding out the causes of problems and solutions to them. They are certainly not in contradiction or conflict.

The Hon. AMANDA FAZIO: This morning we heard some evidence from Bethia Wilson, the health services commissioner from Victoria. She was quite critical of the way in which we deal with health services complaints in New South Wales. She is very strongly in favour of the conciliation system rather than investigating and prosecuting. She stated that she thought New South Wales was out of step with the rest of the country in that regard. What is your view on the conciliation approach that the Victorian commissioner talked about? Given that when people sign off on the conciliation process there is a confidentiality agreement, do you think that may be an easy way out for health care practitioners not to be brought to proper account for their actions?

Ms WALTON: New South Wales is out of step because it is a co-regulator. The other commissions have nothing to do with regulation or prosecution. They refer all their investigations to the medical board or to the nurses board, which will investigate and prosecute them. To me, it is like oranges and apples. Having said that, there is no way that I would agree with matters hiding under conciliation. I think the public interest demands of every complaint that your first port of call has to be whether there is any risk to public health and safety. It is not about a private agreement with the parties. Whilst I support conciliation, I do not think it is necessarily in the public interest for that to be the first port of call.

The Hon. AMANDA FAZIO: The Victorian commissioner also stated this morning that she thought that research was an appropriate activity for the Health Care Complaints Commission to be undertaking. I am interested in your comments on that given that new resources are going into the Health Care Complaints Commission to try to overcome the backlog of complaints registered with it to date and also given the fact that once the new complaints handling mechanism in health goes up it is expected that there will be a huge rise in the number of incidents reported that may lead to complaints investigation. Do you think research is a legitimate activity for the Health Care Complaints Commission to be involved in?

Ms WALTON: One of the ways to try to reduce the potential risk to patients in the health system and the way we learn about this is from many systems—from Coroner's reports to litigation reports; from root cause analysis to complaints handling. It would be a tragedy if we were not able to look at de-identified lessons from complaints, and that involves research. I think there is a minefield of lessons for us bedded in those patients' stories.

CHAIR: Can we learn any lessons from what happened recently at Camden and Campbelltown and the Macarthur Health Service?

Ms WALTON: For me, it brought out starkly the confusion and misunderstanding about the dual responsibilities of professional accountability and the quality and safety agenda. The quality and safety agenda rightly focuses on systems improvement, redesigning systems, work force and so forth. Professional accountability is not in conflict with that. It reminds professionals that they need to know what they are injecting. They need to know that they have to reply to a call when they are on the roster. They need to know that they cannot leave a junior doctor in charge of the board because they are unsafe. They are professional responsibilities. There may well be systems issues that need to be dealt with as well though. So I suppose the message is to the system: We need to bone up on understanding and getting better mechanisms for making sure that people are accountable.

I am part of a national project that is developing core competencies on patient safety education. It is for everyone in the health system. Part of that includes fitness to practise: What are your own responsibilities for maintaining competence? It also includes ethical practice: What are your responsibilities about how you practise ethically? We are bringing into the safety agenda ethics and professional responsibility as much as we can.

CHAIR: Is there a third stream that somehow or other cuts in every now and then—not just professional responsibility and patient safety issues but a third part of the triangle that cuts in only occasionally that might be called political expediency?

Ms WALTON: I agree with that. But it is a problem worldwide. How leaders deal with error is one of the saddest experiences that I have observed over the last decade. In the United States and England when there are catastrophes around patient care the media leads clearly with the stories—that is what they have; it is their job to tell stories—but the health system has not been very good at explaining to the community, which I think leads to the politicisation of what happens.

CHAIR: Does that lead us then to scapegoating?

Ms WALTON: Yes.

CHAIR: If we can find one or two sacrificial lambs that solves the problem.

Ms WALTON: Yes. I think I read in a newspaper in the United Kingdom that the CEO of a trust was sacked. There are clinical governance issues and responsibilities for those people as well.

The Hon. CHRISTINE ROBERTSON: Have you had much to do with role delineation in the hospital sector?

Ms WALTON: No. I know what it is but I have not been involved in it. It is saying who can do what, when and where.

The Hon. CHRISTINE ROBERTSON: I am interested in your thoughts on the process because, if you are working towards having a senior doctor on every ward, under the role delineation process you would be saying that many hospitals across New South Wales should not be functioning because they do not necessarily have a senior doctor there at any time.

Ms WALTON: The doctor does not necessarily have to be on the ward but needs to be on site. There needs to be a senior doctor on site in peripheral hospitals. Having said that, when I was consulting with indigenous communities some hospitals were like rehabilitation hospitals or respite centres. The people I was consulting with believed because it was called a hospital there was an intensive care unit. When I told them that it was sometimes better to get an ambulance to take them to a bigger hospital they did not quite understand. We need to educate the community about the complexity of the health system and why sometimes the level of care needed cannot be delivered at any hospital anywhere; it is just too expensive for our community.

CHAIR: I know from my experiences around Sydney wearing other hats that when a hospital puts up a sign saying, "No accident or emergency facilities available at this hospital; the next nearest is such and such", the community does not understand. It is a big educational problem.

The Hon. AMANDA FAZIO: I have two questions. The first relates to an article that you wrote about hospitals needing a remedy for neglect, in which you talk about both the hierarchical medical model and the way in which we train and educate junior doctors. It was put to us the other day by a junior doctor—I think he was a junior psychiatrist—that it would be far preferable to have things like clinical governance, complaints handling and those sorts of issues dealt with as part of their medical training so they are prepared before they go into hospitals rather than picking it up while they are working on the wards. Do you agree with that concept?

Ms WALTON: Yes, and we teach that at Sydney university medical faculty. In third year they have a whole year on it—I am the chair of personal and professional development—including complaints management, managing mistakes, adverse events, open disclosure, communications in hospitals, and the different methods of quality improvement. When the national patient safety education framework is completed—and our faculty of

medicine got that tender—all universities will probably be required to make sure that their curriculum includes those competencies.

The Hon. AMANDA FAZIO: Have you had any feedback as to whether doctors retain that information so that when they hit the health system and come across an issue where their clinical governance or health complaints training could assist them they can use that training?

Ms WALTON: I think they retain it but the first two or three years in a hospital for a novice health practitioner are pretty overwhelming. I think the culture is so strong that whatever we taught them is sometimes quickly undone—outside the scientific, technical stuff. They just fall into what is expected of them.

CHAIR: Thank you for appearing before the Committee today.

(The witness withdrew)

AMANDA MARY ADRIAN, Private consultant and former Health Care Complaints Commissioner in New South Wales, sworn and examined:

CHAIR: Ms Adrian, I have already read at the beginning of the day a statement concerning your rights under examination, for the witness that you care to give and the privilege you have here. I just warn you, however, that that privilege ceases when you leave that table. If you later talk to the press, even in terms of what you said here, what you say then is not under privilege.

Ms ADRIAN: Thank you.

CHAIR: Would you care to make an opening statement?

Ms ADRIAN: I would very much welcome an opportunity, thank you. Honourable chair and honourable members of the Committee, I note at the outset that I am not speaking in any official capacity. My appointment as Commissioner of the Health Care Complaints Commission ended on 11 December 2003 and I am no longer a public servant in New South Wales, having been one for approximately 30 years. I have used the terms of reference for this inquiry as the framework for my opening remarks today. I have also prepared a more comprehensive statement that the Committee may find useful as it prepares its report. I will make reference to the Macarthur investigation, the final report and the plans that are in train for the secondary part of the process that was aiming to make substantive and sustained improvements in the delivery of health care in the Camden and Campbelltown region and in the New South Wales health care system as whole. It is very difficult to summarise such a complex process as the Macarthur investigation and it is my view that many of the misunderstandings that have arisen are as a result of these attempts to condense the outcomes of the process.

I was appointed to the position of Health Care Complaints Commissioner in 2000 with the following as my platform: providing the community with an effective, independent watchdog agency for the health system; developing the commission as an organisation that was taking a more systemic view of the challenges to safety and quality in the health system; and introducing a significant change program aimed at changing the perceptions of many health professionals that the commission was solely an instrument that was bent on seeking out the "bad apples" in the health system, humiliating them by investigating them and taking disciplinary action through a formal prosecution for professional misconduct. In my view, this new approach would lead to a culture of learning and a willingness to share information about errors, and the failures of the system, and it would encourage open and active discussion and improvement in health care. This is fundamental to a safe system providing high quality care, as Ms Walton was saying earlier.

Despite this refocusing by the commission during my tenure, it should be noted that the commission did not overlook its vital role in taking disciplinary action against individual health practitioners when their conduct fell short of what was expected by their professions. The statistics published in the commission's annual reports show a consistent rate of prosecutions in this area. The commission staff, numbering about 80, were in my experience, professional, committed and very passionate about the work they did. I acknowledge this and put it on the record on this occasion. However, the system they worked with and within inhibited the production of consistent, transparent complaint resolution, good policy development and systemic change. This posed major challenges and a plethora of subsidiary issues. First, as you all know, an enormous backlog of delayed investigations that had been accumulating from the days of the complaints unit; inability to meet the expectations of some parties such as complainants and respondents with matters under investigation; an organisation that required more robust systems and quality measurement in a number of vital areas.

Arguably it was the imbalance of the ratio of resources to the workload that contributed to the difficulties. The annual reports demonstrate a steady increase in the workload of the commission over the period since its commencement. The commission in its "Values, Strategic Directions and Organisational Model" booklet was working through and seeking to develop strategies for enhancing the quality of investigations, seeking to address the backlog of investigations and to expedite the investigation process. It was also endeavouring to attract people with appropriate skills and qualifications to resource it. The appropriation from Treasury was not commensurate with this growth in activity, despite constant requests for additional funds. I note with great interest the recent injection of significant additional funds by the Minister for Health to assist in reducing the backlog of investigations. These funds are equivalent to nearly 100 per cent of the previous appropriation. I make reference later in my statement to the resource implications of the Macarthur investigation.

While I acknowledge the toll of delayed investigations upon all parties, I state that the backlog of investigations that had accumulated at the beginning of my tenure —some 1,000 outstanding—had been reduced to 600 at the time of my dismissal, and there was an ongoing commitment at that time to reduce the time of all investigations to a 12-month period. The investigation into Macarthur Health Service and the report released in December 2003 was a significant milestone demonstrating the way that the Health Care Complaints Commission [HCCC] was moving towards a more systemic view of the health system, with a focus on leadership, governance and the criticality of adequate intellectual resourcing as well as financial resourcing. The report is a thorough and comprehensive account of a very complex investigation that was conducted by the HCCC over a nine-month period. The focus upon the systemic issues in this report is consistent with international best practice in this area.

Once the focus shifts to individuals and individual acts there is the serious risk of losing sight of the long-term and far more pervasive systemic changes that are needed requiring bipartisan support and long-term commitment. I believe that the demand for "heads on plates" that has been the outcome of the Macarthur investigation has indeed removed the heat and emphasis from the work that needs to be done to ensure that the communities in the Camden and Campbelltown areas have a first rate health service. As I have said before, other health service providers will also benefit from the lessons learned during this thorough investigation and careful analysis of issues. Of course, I will be most interested to consider the outcomes of the current Inquiry led by Mr Brett Walker SC.

I have outlined some points about the Macarthur investigation in the tabled submission and I will draw your attention to several of these. Firstly, as you well know, the complaint came about after the then Minister for Health, the Hon. Craig Knowles, met with four nurses from Campbelltown and Camden hospitals on 5 November 2002. The nurses made allegations about management and clinical practices at Campbelltown and Camden hospitals. The Minister referred the matters to the Director-General of the New South Wales Department of Health for investigation. The director-general made a formal complaint to the commission on 18 November 2002. This complaint is summarised in the commission's report. The issues raised by the complaint fall into three broad categories: the standard of health care provided to patients; the adequacy of systems to ensure safe and quality care—that is, clinical governance, risk management, performance and incident reporting and investigation, training and support; and allegations that management had intimidated and disciplined nurses who reported problems and errors.

The commission's first task was to define the scope of the investigation as multiple and wide-ranging issues were raised. The commission examined: the standard of care provided in 47 clinical incidents—all incidents where patients were able to be identified at that time; clinical governance and integrated patient-focused care at Macarthur Health Service; how management responded to and addressed problems of clinical care; how management dealt with people who alerted them to the problems, including the disciplinary action taken against some of the nurse informants. The outcomes of an investigation such as that undertaken in Macarthur are regulated by the Health Care Complaints Act, which you will be aware covers in detail the conduct of investigations and the way that outcomes and recommendations are managed. I will draw your attention particularly to sections. 40 and 43 that require that the respondent, whether health service or health professional, must be given an opportunity to comment before any actions other than termination of the investigation are determined. The commission complied with all of these requirements throughout the investigation.

The Act imposes requirements to ensure procedural fairness before disciplinary action is taken. The investigation of clinical incidents primarily adopted audit and document review methodologies. Given the very serious public health and safety issues identified early in the investigation, the commission's primary focus was on addressing the systemic issues consistent with its terms of reference. It was an imperative to address these so that remedial action could be taken by the health organisations involved to ensure safe care to patients. For the purposes of this investigation the respondents were Campbelltown and Camden hospitals, Macarthur Health Service and the overall governing body, the South Western Sydney Area Health Service, with no individual person named as a respondent.

The investigation did raise questions about the performance of individual registered health providers. The commission was reviewing these at the time of the release of the final report, in conjunction with the relevant health professional registration boards, to determine if further action was warranted in the public interest. I think Ms Walton was covering the co-regulatory role of the commission. I emphasise that the Act requires that

stringent standards of confidentiality are maintained by the commission during the course of any investigation. In relation to individuals this is covered by section 37. This limits the HCCC making comments about identifiable individuals in a report that was clearly going to be made public. Any investigation of individuals deemed necessary would be conducted in a confidential manner. Hence no naming of individuals could occur in the report of the investigation, which was destined to be made public.

I am disappointed that the public statements made by Government representatives following the release of the final report did not clarify the legislative requirement that confined the information that could be released to the public during the course of and following the investigation. The implication that the investigation took too long ignores the fact that the scope of the investigation grew over time and became enormous and across a raft of serious and complex issues, and at the conclusion was probably the equivalent of a approximately 80 "normal" investigations. The obligation to ensure that the South Western Sydney Area Health Service was given a reasonable right to reply essentially took three months of that 13 months. In the run up to the election in March 2003 a great deal of political interest and community debate was generated about the circumstances of this investigation. Some misinformed and at times blatantly incorrect media reporting added a complexity and brought further issues into the investigation that had not been raised in the original complaint. This was despite the commission being open and transparent as to what stage its investigation had reached. For instance, one newspaper and several of the commercial radio stations continued to state that the HCCC had completed the investigation at that time.

An interim report had been sent in January 2003 to the area health service detailing the particular issues surrounding the disciplinary action taken against some of the nurses. It was the hope of the commission that the area health service and the Department of Health would commence early negotiations to repair the damage caused by poor administrative processes. Sadly neither took this opportunity, and it is my view that we continue to see the consequences of this inaction. The original informant nurses were also led to believe by these media reports that they were being denied the right to be interviewed by the panel of experts that the HCCC had convened.

The Macarthur Area Health Service and the South Western Sydney Area Health Service were given an opportunity to respond to the complaint initially and on a number of occasions as the investigation proceeded. I note particularly the following dates: firstly, in June 2003 information about all the clinical incidents was provided to South Western Sydney for it to review and respond to; and, secondly, in August 2003 a preliminary investigation report was provided to Macarthur Health Service and South Western Sydney Area Health Service on a confidential basis as required under section 43 (1) of the Act, and this was yet another opportunity for clinical staff and management to review the information collected by the commission during the course of the investigation.

This preliminary report had raised serious concerns about the safety and quality of care being provided to patients at Macarthur Area Health Service and serious deficiencies in the systems that should have been in place to identify these risks and improve the care. Following receipt of the preliminary report, the Director-General commissioned a contemporaneous review in response to the concerns raised by the commission. Under the Act the respondent has 28 days to provide submissions addressing the commission's findings. I exercised discretion at that time to grant an extension to South Western Sydney Area Health Service on its request because of the amount and complexity of material that had to be reviewed in the preliminary report. This detailed response was taken into consideration in the preparation of this final report.

In October, an unsourced leak created further misinformation and a sensationalised media response. The commission was unable to make any public statements at this time as the investigation and report was not yet complete. I will refer you here to my tabled submission and, of course, the report itself for further information, which I hope you all have. However, I will emphasise for the purposes of this particular parliamentary inquiry that the quality and safety systems at Macarthur Health Service failed to ensure that all adverse events—that is, incidents where patients suffered harm as a result of health care—were investigated, lessons learnt, actions taken and outcomes evaluated. Staff were not encouraged to report safety concerns and in some cases were actively discouraged.

The commission found that the approach adopted by Macarthur Health Service in dealing with the four nurses did not reflect a patient care focus because it did not promote a culture of learning or a willingness to share information about error and system failure. That went for the other nurses as well. The likely consequence of management's actions, which in the case of the operating theatre nurses became widely known at the hospital,

was to discourage other people from openly and actively raising concerns about clinical care. The investigation found a flawed and underdeveloped system of organisational management at the Macarthur Health Service, and the commission found the following problems with quality and safety systems at Macarthur Health Service: a variability in staff reporting adverse events due to the culture and behaviour of different professional groups; a lack of feedback from management to staff who reported issues of quality and safety; delays by management to monitor and evaluate the implementation and effectiveness of any remedial action recommended; and the inadequate resourcing of key quality and safety systems and personnel.

The commission found that Macarthur Health Service failed to recognise and respond to quality of patient care issues raised by the nurse informants. The credibility of the nurses was repeatedly challenged by South Western Sydney Area Health Service and Macarthur Health Service during the commission's investigation. This is not conducive to a culture that promotes safety through open discussion of adverse events. The commission found that management at South Western Sydney Area Health Service and Macarthur Health Service made errors of judgment and failed to recognise signs of a system in distress. The commission found that the key challenges for Macarthur Health Service and South Western Sydney Health Service were in improving the culture and clinical leadership and addressing the inadequacies in the clinical workforce at Macarthur Health Service. The management structure at Macarthur Health Service required immediate attention.

The structure of South Western Sydney Area Health Service divides health services into isolated sectors. The result is that there were minimal cross-area clinical networks and support systems for clinical staff working at Camden and Campbelltown hospitals. The organisational structure at the Macarthur Health Service level left too few people responsible for clinical operations, a problem that was exacerbated by the inadequate number of appropriately skilled staff. Professional barriers and the hierarchy of professions was the prevalent culture, reinforced by management's ad hoc approach to problem solving. It needed to be replaced by effective teamwork where the collective objective was providing safe care to patients.

The commission also fulfilled its function of facilitating the maintenance of health service and professional standards by investigating the performance of registered health practitioners for the purposes of protecting the public. The Macarthur investigation has raised questions about the performance of individual registered health providers, as I said before. The commission, having submitted its final report in accordance with its terms of reference, was taking the next step and anlaysing the conduct of these individual health professionals who had come to its attention during the course of this complex investigation. This step in the process is also regulated under the Act and requires stringent application of the principles of procedural fairness, privacy and confidentiality. It is my view that this part of the commission's work was also unfortunately compromised by the pre-emptive demands for "heads to roll". I am of the view that the act of the Minister for Health on 11 December 2003 in announcing the immediate termination of my contract at a major press conference that had been organised for the purpose of making the investigation report public, raised serious questions about the investigation, the Health Care Complaints Commission and my own credibility without substantive reasons being given. The statement in the news release from the Minister for Health was:

> … for an investigation that took 13 months to complete, the HCCC simply does not go far enough in terms of finding anyone accountable for these failures. For this reason I have taken the following actions:
>
> The appointment of the HCCC Commissioner, Amanda Adrian, has teen terminated …

It was not a fair or complete representation of the HCCC activities in relation to its investigation, consequent recommendations and further planned actions. It is my view that this statement has brought the actions, findings and recommendations of the commission and the commissioner into disrepute without the opportunity for informed explanation. I would urge the committee to look carefully at the Act, particularly section 81 dealing with Ministerial control which states:

> The Commission is subject to the control and direction of the Minister, except in respect of the following:
>
> the assessment of a complaint;
>
> the investigation of a complaint;
>
> the prosecution of disciplinary action against a person;
>
> the terms of any recommendations of the Commission; and
>
> the contents of a report of the Commission, including the annual report.

Primarily this is an important issue for the community in having an effective, independent watchdog agency, and the commission in being able to carry out its role without fear or favour. 1 cannot fail at this time to acknowledge that the Government's actions in response to the final report of the Macarthur inquiry has also had a profound impact upon my professional career and reputation. I will conclude with a reminder that my public platform as the Health Care Complaints Commissioner was to bring my considerable experience and knowledge in quality and safety in the health system to make long-term and substantive changes to the way the system deals with complaints and focuses on the critical issues for the delivery of safe, high-quality health care in this State. I am now prepared to take questions from the Committee.

CHAIR: Thank you, Ms Adrian, for a comprehensive and clear presentation.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: It was said that you had done some preliminary investigations at the request of the Minister and had closed the investigation early in 2003 finding no fault, is that correct?

Ms ADRIAN: It is incorrect. I said that to this committee before. The investigation at no time was closed. I think there was some misunderstanding about the nature of the early interim report that we sent to the area health service about the disciplinary action pertaining to the nurses. The investigation was closed the day that I sent it to the Department of Health and to the area health service, which was 9 December 2003.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: When the nurses were first interviewed they said they were interviewed by a solicitor and there was also an officer of the commission present. The nurses' impression was that the solicitor was conducting most of the interview in terms of its content and was very threatening, saying there was high risk to them in making detailed complaints. Would you like to comment on that?

Ms ADRIAN: Yes, I am happy to comment on that. The solicitor concerned is a long-term member of the staff of the commission and had been actively involved in many investigations over the years that she had worked for the commission. One of the things she was particularly concerned about was that the nurses, despite our attempts to provide them with information about the protective disclosures protections had not actively sought to follow that up. They were providing to us some documents that we felt would make them vulnerable. It was actually trying to assist them to ensure that their safety was guaranteed. However, once it was clear that they were not going to pursue that we moved right away from that. I guess what we have to do—I need to talk in the past now—the commission needed to make sure that the information that was obtained that made up the bulk of the evidence was, in fact, collected in an appropriate way and did not put their safety at risk because we recognise the problems with them being a whistleblower.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: I am not a lawyer but my understanding is that one of the defences of defamation is that you gave the information to the appropriate person to receive that information. If one took a medical record to the Health Care Complaints Commission, you would say it is appropriate that the commission would get a medical record if it is taking a medical complaint.

Ms ADRIAN: I think what we were trying to do was make sure that they had taken the preliminary steps that enabled them to feel safe and comfortable about that. The area health service was, in fact, warning them about prosecution or some activity if they had made disclosures they should not have been able to.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Do you say that you were answering the threat that had been made by the South Western Sydney Area Health Service that the nurses had stolen the records and, thus, were vulnerable to prosecution?

Ms ADRIAN: We were attempting to make sure that the nurses were safe.

The Hon. PATRICIA FORSYTHE: In your professional opinion do patients of Macarthur Health Service have access to a first-rate health service?

Ms ADRIAN: I think we made it very clear in our report that we had serious concerns about the quality of care and the safety and quality systems that existed at Macarthur. I do not resile from that.

The Hon. PATRICIA FORSYTHE: Would you take the Committee through your role in the HCCC investigation?

Ms ADRIAN: As with many or all of the complaints that come through the commission I sit on the assessment committee. I am sorry, I need to be reminded it is in the past. I sat on the assessment committee. In relation to this investigation I had just returned from a period of sick leave when it arrived and my deputy at that time was seconded to the Cabinet Office to assist with some policy work there. So we were a little light on the ground at a senior level.

We did appoint a senior officer of the commission to develop the investigation plan, as is normal procedure. Essentially, at that time I was briefed at various points along the way. I did go down to Macarthur, and I made it very clear to them that an allegation of a conflict of interest had been made about my relationship with Jennifer Collins. I have dealt with that in front of this Committee in the past, and I stand by what I said at that original meeting.

As the complexity of the investigation evolved, as it often does, we realised that there was a need to have a much more robust management steering committee for that investigation, and I certainly chaired that committee in relation to looking at what was being done by the investigation team and the processes and outcomes that they were coming up with. Each area of the investigation had somebody who was nominated as the co-ordinator. I did not co-ordinate any of the particular parts of the investigation.

The Hon. PATRICIA FORSYTHE: On 23 March Bill Grant said in his evidence to the Committee, "The former commissioner had control over this investigation from the beginning. From the material that I have looked at and examined, it is obvious that the former commissioner determined matters all the way through the investigation from the start to the end. Individual officers had input into some of the decisions from time to time, but the beginning and end of responsibility for what happened during the investigation rests with the former commissioner." How do you respond to that?

Ms ADRIAN: It is the case in every single investigation that was undertaken by the commission. As the prosecutor in front of disciplinary bodies, I had to sign the prosecution complaint, and that was exactly the same as would have held true for every single investigation conducted by the commission in my tenure and, I am sure, in the tenure of Ms Walton.

The Hon. PATRICIA FORSYTHE: In your opening statement you suggested that the Minister, on 11 December at a press conference, announced your immediate termination.

Ms ADRIAN: Yes.

The Hon. PATRICIA FORSYTHE: Was that your source of information of your termination, or were you given prior notice that this was to occur?

Ms ADRIAN: I was summoned to Mr Col Gellatly's office at 9.00 a.m. that same morning and given a letter of dismissal. That was the first knowledge I had that my position was being terminated.

The Hon. PATRICIA FORSYTHE: Have you received any payments under the Public Sector Management Act following your dismissal?

Ms ADRIAN: Not as yet.

The Hon. PATRICIA FORSYTHE: Is that the subject of legal action?

Ms ADRIAN: No. At this stage I have made a personal decision that, for personal and family reasons, I do not want to pursue legal action, despite the fact that obviously my financial situation has been compromised significantly. I had breast cancer 12 months before the Macarthur report, and I am very clearly of the view that there are more important things in life than having to litigate something like this.

The Hon. AMANDA FAZIO: In your opening statement you said you were appointed to the position of commissioner with part of your platform being a refocusing of the role of the commission so that it took a more systemic view of challenges to safety and quality in health, and the changing perception that it was only an

instrument bent on seeking out the bad apples in the health system. Was it your own agenda that you brought with you to that job, or was it sanctioned by someone?

Ms ADRIAN: If you like, it made up a lot of the questioning in my recruitment interviews, of which there were about five over the seven months of recruitment, and that was the issue that we came back to over and again. That was the expertise I brought, because I have spent many years in the health system working in that area of quality and safety, initially as the clinical manager of a very busy operating theatre suite but ultimately working in clinical quality improvement, and quality and safety. It was my role in the Department of Health when I worked there to set up the New South Wales Ministerial Advisory Committee on Quality Health Care, which I did. For many years I was a foundation member of the Australasian Association of Quality Health Care. While I have been with the commission it has been very active in supporting open disclosure projects. We have been working on developing the complaint guidelines for the national council. If you read some of the articles that were written about my appointment, they all point out that that was what I had been appointed to do, and I do not resile from that.

The Hon. AMANDA FAZIO: Last Friday Bret Walker, SC, stated, "The HCCC is our accountability agency for health care complaints. It is said that it failed. I am going to say that it failed. The law required a determination which the HCCC simply had not made."

Given that the Health Care Complaints Commission is responsible for the investigation and prosecution of complaints, do you agree with Bret Walker's statement that the HCCC failed its statutory requirements under section 28 of the Act in relation to the Campbelltown and Camden investigations?

Ms ADRIAN: I have not yet had the privilege of reading Mr Walker's preliminary report, and I will be interested in that because I am not sure what are his intentions in saying that. I did say in my opening statement on several occasions that we did not move away from our responsibilities in looking at the conduct of the individual health professionals. My very clear intention in putting this report on the systemic issues out—which I knew was going to be made public—was that I knew that the individual accountability issue would possibly derail the very important messages that are in this about the systemic responsibility, the responsibility of the department and the area health service. I was very aware of that. However, the commission had not completed the work that it was doing concerning the conduct of the individuals.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: The criticism of the report seems to relate to what was not in the report. Your contention is that this was the first report, which was more systemic, and the sorting out of the individuals would be done in a confidential way later.

Ms ADRIAN: Let me make it clear. The issues around the individuals related to individual acts at one time or another concerning their contact in dealing with clinical assessment, clinical management or follow up. When you put those together, the question is: What was the system doing to support or not support the individual clinicians in that particular case? Our view was that the systemic gaps and problems were of such significance that they needed to be put on the table, without the distraction of, if you like, "heads must roll" or "heads on the platter"—unfortunately, the scapegoating that has subsequently gone on, and I am very sad about that.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Presumably, you would agree with Fiona Tito, Bethia Wilson and Merrilyn Walton, who basically say that the non-blame culture has taken a big battering as part of your dismissal. Presumably, Jennifer Collins would also say that about her dismissal. Would you say that the blame and shame has come back as a major policy focus at the moment.

Ms ADRIAN: I think we were seeing some very real signs that the health system was starting to open up and to be much more responsive and able to report what had gone wrong. I think all the work that has been done around the root cause analysis requires that people can explore what has happened and why. As I said, I do not resile from the fact that there is an issue of professional accountability, as well as systemic accountability. I guess what we were saying in this report was that the systemic accountability was of primary importance.

I would like to refer you do my foreword in the report, in which I quote from one of the most eminent scholars in this area, James Reason: "Trust is an important element of a reporting culture, and this in turn requires an existence of a just-just culture, one possessing a collective understanding of where the line should be drawn between blameless and blameworthy actions. Engineering a just culture is an essential early step in

creating a safe culture." I go on to say that there is much work to be done across the health system in developing that collective understanding of where the line should be drawn between the blameless and the blameworthy actions so that individual health professionals, the community at large and the health system have an understanding of the boundaries. I think this investigation has brought that into focus, and certainly the questioning I heard earlier of Ms Walton—

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You are now advocating a no-blame culture—

Ms ADRIAN: A fair culture.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Although your report did not name individuals, it was a pretty strong indictment of management generally, would you agree?

Ms ADRIAN: It was a strong indictment of the government structure that was not functioning adequately, and that government structure starts at the top.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: So the blame, prima facie, would be greater for the people at the top and less for the people at the bottom, if one were making a general statement?

Ms ADRIAN: I think the Government's issue shows that there was demonstrable responsibility down all the lines.

The Hon. ROBYN PARKER: In your opening statement you referred to the interim report being leaked.

Ms ADRIAN: The preliminary report in October, yes.

The Hon. ROBYN PARKER: Who do you think leaked that report?

Ms ADRIAN: I have absolutely no idea. One must remember that the documentation that was provided to the South Western Sydney Area Health Service required careful analysis by many people. The commission sent two copies to the South Western Sydney Area Health Service, obviously for it to provide to the relevant parties—the clinicians and the management—the information they needed to critique and respond to. But I have no idea, and I have not been able to locate the source of that.

The Hon. ROBYN PARKER: Did you refer that matter to the ICAC?

Ms ADRIAN: The leak of the report?

The Hon. ROBYN PARKER: Yes.

Ms ADRIAN: No, I did not. At that stage the ICAC had several references from me concerning the Macarthur investigation.

The Hon. ROBYN PARKER: Also in your opening statement you said that you are now a private consultant. For whom are you working, and what does your consultancy do?

Ms ADRIAN: I have today received my allocation of a business name from the Office of Fair Trading as Amanda Adrian and Associates. I am doing some policy writing, submission writing, and providing advice. I am doing some teaching for the University of Technology Sydney, as well as the University of New South Wales. I have a law degree and I have extensive experience in the health system, and I have continued to lecture in those areas.

The Hon. ROBYN PARKER: Are you doing any work for the New South Wales Government or the Department of Health?

Ms ADRIAN: No.[2]

The Hon. ROBYN PARKER: You spoke about the ICAC referrals. What referrals did you make to the ICAC?

Ms ADRIAN: In March I made the referral concerning the conflict of interest in relation to Jennifer Collins, because I had been concerned that it was a problem. The department had referred issues concerning corruption, and we had been having dialogue with the ICAC in relation to corrupt conduct that had been referred to us and to the ICAC.

The Hon. ROBYN PARKER: That is all?

Ms ADRIAN: Yes.

CHAIR: On page 9 of your report you discuss the release of the final report and refer to section 81, which deals with ministerial control. Did Minister Iemma contravene the Act in criticising those areas of your report?

Ms ADRIAN: My view is that the report had no opportunity to be out there and criticised robustly. The Minister's action in dismissing me was on the grounds that I did not do several things, including investigate the complaint adequately and make adequate recommendations. These were all part of this report. My own view is that there is some question around that. I do not wish to discuss it any further; it is a legal question.

CHAIR: You may discuss it here, even though it is a legal question. You are under absolute privilege. My question was: Did Minister Iemma contravene the Act?

Ms ADRIAN: It is my view that his actions, in taking a differing view to the commission, did actually intervene, if you like, in the contents of the report and the terms of the recommendations.

The Hon. PETER PRIMROSE: Is that a yes or no? What part of the Act did he allegedly breach?

Ms ADRIAN: Section 81.

CHAIR: Which deals with the investigation of a complaint.

Ms ADRIAN: The Minister's role.

The Hon. PETER PRIMROSE: After you had presented your report?

Ms ADRIAN: Yes. I have an opinion that that is—

The Hon. CHRISTINE ROBERTSON: I would like to ask you in relation to the legislation as it stands in New South Wales. We have heard considerable evidence about how the legislation operates in other States. The legislation in New South Wales in relation to the HCCC actually talks about complaints management and it actually delivers the professional accountability section. In New South Wales the qualities structures are set up separately. How do you tell us that this particular report of yours delivers what the legislation says should be delivered?

Ms ADRIAN: I would just like to make two things clear: The commission has a role to facilitate the maintenance of standards of health services in New South Wales and it also has a role in looking at the individual conduct. It has a dual role. I would also like to point out that the quality systems that have been set up in New South Wales post-date this legislation. In 1996 I was the officer in the Department of Health that established the quality and health care committee in New South Wales, which was really, in New South Wales, the beginning of the establishment of those quality structures and I think there is some misunderstanding that those structures have been parallel all the way. They have been evolving over time and, as Ms Walton said, they

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[2] Please refer to correspondence received from Ms Amanda Adrian, Amanda Adrian & Associated, dated 31 March 2004, available as a separate pdf document with this transcript.

have a long way to go. The commission in its watchdog role has a watchdog role over the health system, health services and individual practitioners.

The Hon. AMANDA FAZIO: The emphasis that you are putting on the role of the bill, when you said first "to facilitate the maintenance of standards of health services", that is a quote from the second reading of the Health Care Complaints Bill—

Ms ADRIAN: It is actually one of the objects of the Act.

The Hon. AMANDA FAZIO: But when you go down and look at what the functions of the commission are, they go through in much more detail and that is not given a high importance in terms of the legislative function of the commission.

Ms ADRIAN: Will you take me to the provision in the Act?

The Hon. AMANDA FAZIO: No, I am referring to the second reading speech. The Minister who introduced the legislation said: The commission's functions are clearly delineated in the legislation to receive and deal with complaints, to assess complaints, to make complaints concerning the professional conduct of health practitioners, to report to appropriate persons following the investigation of a complaint, to monitor, identify and advise the Minister on trends in complaints, to publish and distribute information concerning the means available for the making of a complaint, to provide information to health service providers and professionals regarding complaints, including concerns on complaints.

Ms ADRIAN: But the complaints can be about health services or health practitioners and the commission receives complaints about both. There are different ways and division 7 of the legislation, which is quite a considerable part of it, deals with the approach that the commission has in relation to health service complaints, so I think there is a misunderstanding there. The complaints are about both. They do come about both.

The Hon. AMANDA FAZIO: What I am saying is that given there is such a strong emphasis when the legislation was introduced on the functions of investigating complaints, when you were looking at the Macarthur Area Health Service—

Ms ADRIAN: This was a complaint. If I can make it clear, the Macarthur health service issue arose out of a complaint to the commissioner from the director-general about three aspects of services at Macarthur.

The Hon. AMANDA FAZIO: That is right, but under clause 11 the commission will have two distinct divisions: a complaints and preliminary inquiry division and an investigation and prosecution division. Even though it is fair enough to look at the systemic issues, should not the main and principal role of the commission be to look at individual health practitioners and clinicians whose actions have led to poor patient outcomes and a drop in the health standards in that area? Have you not taken it the wrong way round, according to what the functions of the commission were intended to be?

Ms ADRIAN: No, I disagree. I have a very differing view of it. I see that the role of the commission is to investigate complaints about both. There is no discrimination, if you like, in relation to the complaints against health professionals and health services.

The Hon. PATRICIA FORSYTHE: I have two questions, first of all in relation to this issue of the preliminary report. In the statement provided to the Committee you say that a preliminary investigation report was provided to the Macarthur health service and the South West Sydney Area Health Service on a confidential basis in August 2003. Then you say that the CEO of the area health service provided a copy of this report to the Director-General of the New South Wales Department of Health. Are you suggesting that it was not appropriate for it to be—

Ms ADRIAN: By no means. It meant that there were some allegations at the time that the commission had provided it to the director-general and I was just making the point that, in fact, the CEO, who was able to provide it to whoever he wanted to, if you like, as the governing body of the organisation—I was rebutting the suggestion that the commission had provided that.

The Hon. PATRICIA FORSYTHE: In relation to the issue about a potential ministerial breach under section 81 of the Act, you say in your report that you urge the Committee to look at the Act and you highlight section 81. Had you sought legal advice on the Minister's actions in relation to that?

Ms ADRIAN: I had.

The Hon. PATRICIA FORSYTHE: Is that advice that you would make available to the Committee?

Ms ADRIAN: It is advice that I am not acting on myself so I probably will not.

The Hon. PATRICIA FORSYTHE: I am sorry?

CHAIR: Ms Adrian made the point that she was not taking any legal action owing to a health situation.

The Hon. PATRICIA FORSYTHE: But you do have legal advice?

Ms ADRIAN: Yes, I have oral legal advice that has not been documented because I am not taking it any further.

The Hon. ROBYN PARKER: Following up on my earlier question about the referral to the ICAC, can you tell me the date that you actually made that referral?

Ms ADRIAN: I am sorry, I am no longer with the commission so I do not have the correspondence, but it was in early March 2003.

The Hon. ROBYN PARKER: Given your comments about Macarthur health service, do you believe that Jennifer Collins should have been sacked?

Ms ADRIAN: My view is that the governance structures of the organisation needed to be looked at internally. I have certainly no view about that. As I said in my opening statement, the conduct of the individuals here was being looked at. I am not party to, nor have I been party to the ongoing discussions around that, so I had no idea, so I do not wish to comment.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Does that mean that the HCCC is still looking at that?

Ms ADRIAN: I do not know.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: If no-one has changed the course that it was previously set on?

Ms ADRIAN: My concern is that the opportunity to do it may have been compromised with the demand for individual names and naming. I am afraid that my connections with the HCCC ceased on 11 December. I have made it my business not to contact or connect with the staff because I know that they have been involved in a number of inquiries. I did not want to compromise their position in any way so I certainly do not have any of the correspondence that I either received or sent at that time. I do not know.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: It would seem that there has been a conflict between the investigation and the prosecution functions here presumably in the actions of what we are discussing?

Ms ADRIAN: At this stage the decision to prosecute is at the end of an investigation. It is not in conflict, as I understand it.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Well, there has been difficulty in the sense that the people who have been sacked have been, kind of, prosecuted or acted on already, so that the investigation function—

Ms ADRIAN: I think it would probably be looked at as mitigation if, ultimately, they were prosecuted under the Nurses Act or the Medical Practice Act.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: I think you were here this morning when Bethia Wilson was speaking?

Ms ADRIAN: No, I have not been here.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: She said that the New South Wales HCCC had an investigation and prosecution function which the Victorian one did not and she felt that the Victorian model was preferable. Would you have a comment on that?

Ms ADRIAN: I certainly have a view on that and, like Ms Walton, my own view is that one needs different mechanisms for complaint resolution available. Conciliation, as the Victorians use extensively, is a very important approach to resolving complaints, however, when you have issues of professional misconduct, you require the prosecution function to be able to take the appropriate disciplinary action. One of the things that I do not think has been pointed out—and I know Ms Walton raised it but did not continue with it—is what happens in Victoria and all other States is that the investigation is conducted by the professional regulatory boards themselves and this came under some significant criticism in New South Wales, if you remember, after the Chelmsford inquiry. There was a view that there was no independent investigation of complaints and that the commission was there to be that independent investigator, so it actually creates a division between the nurses board or the medical board investigating, then acting on the complaints that come before them. It is a separation of power.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: You have referred to your lack of resources and so did Merrilyn Walton in her evidence, and Ms Wilson from Victoria basically said that she did an investigation in Melbourne hospital for, I think $55,000, she said, which was, I gather, almost similar in scope term to the Macarthur one.

Ms ADRIAN: No, it was not.

The Hon. CHRISTINE ROBERTSON: She said it was not.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Was it, in effect, in terms of analysing the culture? It may not have been in terms of the number of complaints investigated, and she did seem a little envious of the fact that you could do such a mammoth report—

Ms ADRIAN: It was a small component of it only.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: Yes, but the conclusion she reached about the management problems in Melbourne and the conclusions you reached about the management culture in Macarthur seem to have been similar?

Ms ADRIAN: Exactly.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: If the individual investigation still has to go ahead later, would it not have been better to do the small investigation on the culture that she had managed more cheaply and not had the huge time lag—

Ms ADRIAN: I think we are talking about chalk and cheese here. The Melbourne hospital investigation was a very different creature from the complaint that was laid with us about the Macarthur health service and I am going to resist trying to make any comparisons between the two.

The Hon. Dr ARTHUR CHESTERFIELD-EVANS: I agree with saying they are chalk and cheese here, and we have different Acts and different methods of getting there, but if the problem was a hospital culture with a problem, is that quicker model of diagnosis of a problem culture a good one for New South Wales to follow?

Ms ADRIAN: It was only one small part of this investigation and it would not have been able to deal with it.

The Hon. AMANDA FAZIO: On 23 March we heard evidence from Bill Grant, who was also a former acting commissioner for the HCCC. He talked about a deficiency he identified in the commission, which related to the way in which people's knowledge of what was happening in the complaints system had been dealt with. He said:

> I have found it to be deficient in giving proper explanations for certain decisions made by the commission. Staff of the commission are looking at those template levels to make them a little more user friendly [that is standard communications] and to give people a bit more of an explanation. If we are not going to investigate matters we have to tell people why, otherwise they will not get closure. They will want to have appellate processes in place to do that. If we can be a little more expansive on why we did not think it necessary to investigate, or even why after investigation it has not resulted in someone being taken, for example, to the medical tribunal, perhaps we can get more effective closure for some people.

What are your comments in relation to this area that he identified as being a deficiency, as he sees it, in the commission's operations?

Ms ADRIAN: I totally agree with him, and it was in fact a work in progress that I had identified and had been already doing some work on. We had been spending quite a lot of time with a consumer consultative committee as well as registration authorities in relation to the correspondence that we provided to people, and I think I raised in my opening statement that I was dealing with a number of issues in relation to the systems that were in place in the commission over time. However, I also make the point that my interest was in developing sustainable solutions, not quick fixes.

The Hon. PETER PRIMROSE: If I can just ask for your comments on some other comments, like my colleague the Hon. Dr Arthur Chesterfield-Evans I am not a lawyer, but Bret Walker, SC, is and in his opening remarks last Friday he made a couple of observations about the HCCC's report while on your watch. Basically, there has been a thorough loss of confidence in the HCCC; the commission undoubtedly let us down; dissatisfaction with the HCCC is completely justified; very alarmed at how the Health Care Complaints Commission conduct can be justified; not one of the Health Care Complaints Commission cases reviewed contains an outcome or recommendation as required by section 39 of the Act; it failed. Do you have any comments on those?

Ms ADRIAN: In my opening statement I said I would be interested to read the report. All of those statements, they give no reasons why Mr Walker has reached those conclusions. I will wait before I make any comment.

The Hon. ROBYN PARKER: Sorry to keep going back to the same issue, but I was not present in this Committee when you discussed this issue before. I wonder if you could explain the nature of the conflict of interest that you referred to the ICAC?

Ms ADRIAN: I made a formal statement at the time. It is on the record of the Committee, and I stand by that statement. Essentially, there was an allegation that Jennifer Collins was a close friend of mine at the time that this began, and I was concerned that this raised the perception of a conflict of interest. I dealt with and refuted that. I had, as a senior person in the health system over many years, worked with numerous people, including Dr Chesterfield-Evans when he was a registrar in the cardiothoracic theatres at Royal Prince Alfred Hospital, and will have and have had connections with many people. That does not make them a close friend, and Ms Collins is not a close friend. I note that Ms Tito did suggest that she was a friend of mine, and it was because of our common interest in quality and safety in the health system that we became friends.

The Hon. PATRICIA FORSYTHE: In your opening statement you referred to appropriation from Treasury and the appropriation, you say, from Treasury was not commensurate with the growth in activity despite constant requests for additional funding. What reasons did Treasury give for not providing you with additional resources?

Ms ADRIAN: Essentially Treasury regarded the commission, as it does many of the watchdog agency's—the commission is the watchdog for a $9 million, $10 billion system—as a minnow, in fact, probably plankton in the scheme of things, and we were not in Treasury's sites. That was my personal view.

The Hon. PATRICIA FORSYTHE: As commissioner, in the annual review of budgets did you seek on each occasion when you were commissioner for enhancement of budget?

Ms ADRIAN: Yes, and on interim occasions as well.

The Hon. CHRISTINE ROBERTSON: While not exactly agreeing with you about the role of the HCCC in this, I personally believe you have produced a report that is of considerable value for other reasons. One of the issues that I would like to pick up on, that you picked up one during your quality survey of the place, related to people actually having a handle on when they should transfer people to the next level of hospital and the people who work there understanding of what the level meant. This word I have used several times here is "role delineation" that nobody seems to have a handle on, but you have articulated it quite well. Can you just tell me what you actually found in relation to the attitudes of the staff in these hospitals as to what they could deliver at the centre?

Ms ADRIAN: My view is, and the commission's findings in relation to this was, that it was a bilateral issue and it was chicken and egg type stuff. Those of you who have worked in the health system will understand what I am saying here. The request comes from a smaller district hospital to a larger hospital to take a patient. The larger hospital is busy and, perhaps, does not have formal connection, does not have a system in place to ensure that those patients can be transferred so the answer is, "No, we cannot take them. We are too busy. Our ICU is full", or whatever. After a while people stop asking and try to manage things themselves. In the case of Macarthur, although it was nominally an intensive care unit during the course of our investigation, clearly, it did not provide intensive care services and it did not have a director of intensive care.

The Hon. CHRISTINE ROBERTSON: So it was a high dependency unit?

Ms ADRIAN: Essentially and with not even all the requirements of a high dependency unit so the role delineation there, the reality and the rhetoric were obviously—

The Hon. AMANDA FAZIO: I do not really want to belabour this point too much, but it is just something I would like to try to clarify. In the comments made by Bret Walker last Friday, he said that of the 69 cases that were referred from the Macarthur Area Health Service to the HCCC the commission had only looked at 48, leaving 21 cases where no evidence was found or no action was taken. He has advised that he found evidence in 12 of these 21, cases that 8 cannot be identified and work is continuing on 1 case. Can you tell us why the commission only looked at 48?

Ms ADRIAN: Sure. At the time, despite the very best endeavours of the commission, Macarthur Health Service and South Western Sydney Area Health Service we could not match the information provided by the nurses and the individual information of patients that have been cared for at Macarthur Health Service. We had to make a decision and what we were seeing was a consistent pattern anyway in those 47 incidents, and I think the report outlines that quite well. We had to make a decision: do we continue to try to find that information, bearing in mind that there was already criticism about the time of this investigation and that was a tension that we had to deal with. We established that there was enough information in the 47 incidents. We had several matters under other investigations relating to these issues anyway that was giving us information that, thankfully, had not received the same publicity that this has. We felt that it was time to get the investigation into manageable form. I am not surprised that Mr Walker, with further time, and we would have too, if we had kept at it, probably found more of those incidents. Incidents happen. Adverse events happen in every single health service in New South Wales. I think that we had to be careful in identifying the very incidents as being a problem. The issue we were investigating was what were those incidents telling us and how had the area health service responded to them?

The Hon. PATRICIA FORSYTHE: From your investigations do you believe that the Camden maternity unit was opened with the appropriate level of staff?

Ms ADRIAN: We made a recommendation around the Camden maternity service because during the course of our investigations it came to our attention that there were concerns by the staff about Camden. I will just try to take you to the recommendation if I may and I will reiterate that. Our recommendations, I would like to point out, followed the recommendations of the review committee, so it reiterates what the review committee said, that the maternity service at Camden should continue to develop as a low-risk primary health care model,

and that was in relation to the particular recommendations that Professor Barraclough had made, not a full steam ahead obstetric service offering all levels of service because of the inability of staff to service it.

The Hon. PATRICIA FORSYTHE: You said "it should continue as"?

Ms ADRIAN: They had already started to develop it as that when this report was finalised and we did not want to ignore, obviously, that raft of recommendations that Professor Barraclough and his team had made. It would have been foolish. And at that time we had information that that is what they were recommending. I do not know whether that has continued that way, and I have no further knowledge on that.

CHAIR: Thank you very much for being with us. May I just say we wish you good health.

(The witness withdrew)

(The Committee concluded at 4.56 p.m.)