I·C·A·C

INDEPENDENT COMMISSION AGAINST CORRUPTION

Report on investigation into various allegations relating to the former South Western Sydney Area Health Service

ICAC REPORT

SEPTEMBER 2005

ICAC

INDEPENDENT
COMMISSION
AGAINST
CORRUPTION

Report on investigation into various allegations relating to the former South Western Sydney Area Health Service

ICAC REPORT

SEPTEMBER 2005

This publication is available in other formats for the vision-impaired upon request. Please advise type of format needed, for example large print or as an ASCII file.

ISBN 1 920726 50 0

This report and further information about the Independent Commission Against Corruption can be found at **www.icac.nsw.gov.au**

Independent Commission Against Corruption

ADDRESS	Level 21, 133 Castlereagh Street Sydney, New South Wales, Australia 2000
POSTAL ADDRESS	GPO Box 500, Sydney, New South Wales, Australia 2001
TELEPHONE	02 8281 5999 1800 463 909 (toll free, for callers outside metropolitan Sydney)
TTY	02 8281 5773
FACSIMILE	02 9264 5364
EMAIL	icac@icac.nsw.gov.au
OFFICE HOURS	9.00am to 5.00pm, Monday to Friday

I·C·A·C

Independent Commission Against Corruption

The Hon Dr Meredith Burgmann MLC
President
Legislative Council
Parliament House
Sydney NSW 2000

The Hon John Aquilina MP
Speaker
Legislative Assembly
Parliament House
Sydney NSW 2000

Madam President
Mr Speaker

In accordance with section 74 of the *Independent Commission Against Corruption Act 1988*, I am pleased to present the Independent Commission Against Corruption's second report of an investigation into alleged misconduct associated with the former South Western Sydney Area Health Service. The Commission's first report, presented in April 2005, dealt with the alleged mistreatment of nurses who complained to the Hon Craig Knowles MP, the former NSW Minister for Health. This report deals with a wide range of additional allegations made by numerous persons, most of whom were nurses employed by the SWSAHS.

The Commission found that none of the allegations were substantiated. Consequently, the Commission did not make any finding that any person engaged in corrupt conduct or any recommendation that consideration be given to taking criminal or disciplinary action against any person.

I draw your attention to the recommendation that the report be made public forthwith pursuant to section 78(2) of the *Independent Commission Against Corruption Act 1988*.

Yours sincerely

The Hon Jerrold Cripps QC
Commissioner

Abbreviations used in this report

CMO	Chief Medical Officer
CNS	Clinical Nurse Specialist
FHS	Fairfield Health Service
HCCC	Health Care Complaints Commission
LHS	Liverpool Health Service
MHS	Macarthur Health Service
NSWNA	New South Wales Nurses' Association
O&G	Obstetrics and Gynaecology
SCI	Special Commission of Inquiry into Campbelltown and Camden Hospitals
SWSAHS	South Western Sydney Area Health Service

Major publications referred to in this report

Health Care Complaints Commission, *Investigation report: Campbelltown and Camden Hospitals, Macarthur Health Service*, December 2003.

Independent Commission Against Corruption, *Report on investigation into the alleged mistreatment of nurses*, April 2005.

New South Wales Parliament, Legislative Council, General Purpose Standing Committee No.2, *Complaints handling within NSW Health*, Report No.17, June 2004.

Special Commission of Inquiry into Campbelltown and Camden Hospitals, *Final Report*, 30 July 2004.

Contents

Executive summary

This is the second report by the Independent Commission Against Corruption ("the Commission") arising from its investigation into alleged misconduct associated with the former South Western Sydney Area Health Service (SWSAHS). The first report, released in April 2005, dealt with the alleged mistreatment of three nurses (Nola Fraser, Sheree Martin and Giselle Simmons) who complained in November 2002 to the then Minister for Health, the Hon. Craig Knowles MP, about perceived maladministration and misconduct at SWSAHS hospitals. This report deals with a large number of separate allegations made by the same three nurses and a number of additional persons, most of whom were employees of the SWSAHS.

In accordance with its jurisdiction under the *Independent Commission Against Corruption Act 1988* (NSW) ("the ICAC Act"), the Commission's investigation was limited to those allegations which reasonably implied that "corrupt conduct" may have occurred.

As part of its investigation the Commission interviewed or obtained written statements from over 200 witnesses and examined over 100,000 documents and electronic records. The Commission also co-operated and exchanged information with many other bodies that conducted relevant parallel inquiries, including the Special Commission of Inquiry into Campbelltown and Camden Hospitals ("the SCI"), Health Care Complaints Commission (HCCC), NSW Police, State Coroner and NSW Ombudsman.

The Commission's investigation proved to be extremely time-consuming and resource-intensive. This was due to the large number and diversity of the allegations that were made, the vague and generalised nature of many of the allegations, the lengthy period over which the allegations were made (some were made years after the alleged event), the large number of potential witnesses and the large volume of potentially relevant documents and electronic records. The Commission also considered it necessary to postpone some of its proposed activities in order to avoid possible interference with parallel inquiries being conducted by other bodies, including the SCI, HCCC, NSW Police and State Coroner.

The Commission did not hold any public hearings or public inquiries in relation to the specific allegations addressed in this report.

The allegations investigated by the Commission and its ultimate findings are as follows:

Alleged "cover-up" involving the destruction and concealment of evidence

Nola Fraser, who worked as an After Hours Nurse Manager at Campbelltown and Camden Hospitals until she took extended leave from March 2002, and Sheree Martin, who worked as an enrolled nurse at those hospitals until she took extended leave from August 2002, made a series of highly publicised allegations to the effect that senior officers from within the SWSAHS deliberately covered-up improper practices and adverse incidents at SWSAHS hospitals by destroying or concealing relevant evidence after they complained about such practices and incidents to Minister Knowles on 5 November 2002.

The Commission found that there is no evidence to support these allegations. Not only were they denied by the alleged wrongdoers and not supported by any documentary or electronic evidence obtained by the Commission, but none of the more than 100 persons interviewed by the Commission in relation to these particular allegations (including Ms Fraser, Ms Martin and every other person identified as a potential witness by either of them or any other person) claimed to have any first-hand knowledge of the alleged wrongdoing. While the Commission accepts that Ms Fraser and Ms Martin are likely to have personally believed that their allegations were true, it has concluded that the allegations were founded on nothing more than gossip, speculation and hearsay.

Alleged "political cover-up" by Minister Knowles

Ms Fraser alleged that after she and other nurses complained to Minister Knowles on 5 November 2002 about perceived maladministration and misconduct within the SWSAHS he failed to take adequate action and engaged in a "political cover-up".

The Commission found that there is no evidence to support this allegation. Minister Knowles' overall handling of the nurses' complaints was entirely responsible and commendable.

Alleged falsification and alteration of records

Ms Fraser alleged that after she and other nurses complained to Minister Knowles a manager at Campbelltown Hospital improperly altered incident forms and patient notes and a senior officer from the Macarthur Health Service (MHS), which was part of the SWSAHS, inappropriately asked a doctor at that hospital to alter patient notes. The Commission found that there is no evidence to support these allegations. Ms Fraser had no direct knowledge of the relevant facts. Her allegations were based on nothing more than hearsay and speculation.

Giselle Simmons, formerly an Acting Nurse Unit Manager at Fairfield Hospital, alleged that comments she made about perceived dangerous care at that hospital at a SWSAHS meeting were improperly "struck from the minutes" of the meeting. The Commission found that there is no evidence to support this allegation.

Julie Quinn, a Nurse Unit Manager at Liverpool Hospital, alleged that minutes from a Liverpool Health Service meeting were improperly altered to remove references to concerns that had been raised at the meeting about a perceived "dangerous" situation at Liverpool Hospital. The Commission established that amendments were made to a draft set of minutes but did not find any evidence of impropriety.

A number of nurses, including Ms Fraser, alleged that a doctor at Camden Hospital and a doctor at Campbelltown Hospital falsified patient notes by recording that they had examined patients when they had not. The Commission investigated each allegation and, after consultation, formally referred both matters (and the evidence it had obtained) to the SCI. The SCI undertook inquiries and concluded that the allegation against the doctor from Camden Hospital warranted "investigation with a view to disciplinary action being considered" and referred the matter to the HCCC, which is the body responsible for taking such action. The Commission also provided the HCCC with all of the evidence it obtained in relation to this matter and the HCCC has recently advised the Commission that it proposes to take disciplinary action against the doctor (who denies the allegation against him). The SCI concluded that the allegation against the doctor from Campbelltown Hospital, which was that he "was well known" for completing records for examinations he had not done because "he was too lazy", was too vague to warrant further action and did not refer it to the HCCC. In light of the involvement of the SCI and the HCCC, the Commission has not made any findings or expressed any conclusions in relation to these allegations.

Alleged criminal offences and suspicious deaths at Liverpool Hospital

Ms Fraser alleged that a patient was raped and a nurse was drugged at Liverpool Hospital and senior officers from within the Liverpool Health Service (LHS), which was part of the SWSAHS, mishandled and/or tried to cover up the offences. The Commission found that there is no evidence to support the specific allegations made by Ms Fraser, who had no direct knowledge of the relevant facts. The Commission agrees with the assessment of the NSW Police, which investigated each incident and decided not to lay any charges, that there is insufficient evidence to substantiate either of the alleged offences. In addition, the Commission did not find any evidence of corrupt conduct on the part of any person in relation to the events following the two alleged offences.

Kathrine Grover, who was a Senior Nurse Manager at Liverpool Hospital until she resigned in 2001, alleged that management mishandled the suspicious death of a young female patient in the Mental Health Unit at that hospital. The Commission found that there is no convincing evidence to support this allegation.

Julie Quinn alleged that senior officers from within the LHS mishandled the death of an elderly male patient at the hospital arising from suspected neglect at a nursing home. The Commission found that while Ms Quinn showed admirable concern for patient welfare in relation to this matter her specific allegations were excessive. The Commission is not satisfied that any neglect occurred at the nursing home and did not find any evidence of corrupt conduct on the part of any officer from within the LHS in relation to this matter.

The Commission also received a complaint and referral in relation to alleged euthanasia by a doctor at Liverpool Hospital. The Commission is continuing to investigate this matter in conjunction with the NSW Police, State Coroner and HCCC. At this stage, no findings of fact have been made and no decision has been made about the future conduct of this matter. The doctor in question has denied the allegations against him.

Alleged reprisals against whistleblowers

Twelve nurses, two doctors and a security guard/wardsman alleged that they were bullied, harassed or disciplined by superiors and/or co-workers as a reprisal for making legitimate complaints about perceived inadequate practices or adverse incidents within the SWSAHS. For preliminary purposes it was accepted, without it ultimately being necessary to decide, that such actions, if proven, could constitute corrupt conduct.

The Commission did not find sufficient evidence to substantiate any of these allegations.

Three of the nurses (Yvonne Quinn, Valerie Owen and Sandra Solarz) were subjected to disciplinary action by the Macarthur Health Service (MHS) that was so flawed and unfair that they were entirely justified in suspecting that they were being "victimised" for something. However, the Commission did not find sufficient evidence to be satisfied that the persons responsible for taking the disciplinary action acted either maliciously or in deliberate disregard of the legal requirements of procedural fairness.

Alleged improper attempts to silence nurses through "hush money" and deeds of release

Yvonne Quinn and Valerie Owen alleged that after they gave notice of their intention to resign from the MHS, and indicated that they intended to complain about the unfair disciplinary action taken against them, improper attempts were made by senior MHS and SWSAHS officers to "buy their silence" by offering them "hush money" and proposing that they sign deeds of release containing confidentiality and non-disparagement clauses.

The Commission found that the only payments offered or proposed to be offered to the nurses were relatively small amounts which they had requested (and were arguably entitled to) in relation to shift penalties they were not paid during a period of suspension. In addition, there was nothing unusual or improper about the deeds of release that were offered to the nurses. The deeds were first proposed by the nurses' union representative, not an officer from the MHS or SWSAHS, and only one deed was ever prepared (for Ms Quinn). That deed was drafted by the union representative and it was never executed. No pressure was placed on either nurse to enter into a deed and when they decided not to do so their decisions were fully respected.

It is understandable that Ms Quinn and Ms Owen, after having been subjected to seriously flawed and unfair disciplinary action, were suspicious about the proposed payments and deeds of release. However, the Commission did not find any evidence of impropriety on the part of any person.

Kathrine Grover also alleged that after she complained about patient care issues at Liverpool Hospital the SWSAHS attempted "to get rid of" her and "silence" her by paying $15,000 and requesting that she sign a deed of release. The Commission found that the payment and deed were merely part of an ordinary settlement of a workers' compensation claim. Ms Grover had resigned from the hospital over eight months before the payment was first offered or made and the deed did not prohibit her from speaking about any issue. The Commission did not find any evidence of impropriety on the part of any person.

Allegations regarding the HCCC's investigation of the Macarthur Health Service

A number of the complainant nurses and other persons alleged that the investigation conducted by the HCCC into the nurses' complaints about maladministration and misconduct within the MHS was "a whitewash", "a cover-up", "corrupt" and/or "criminal". The Commission investigated this matter in conjunction with the SCI and, like the SCI, the Commission did not find any evidence of corrupt conduct on the part of any officer of the HCCC, including former HCCC Commissioner Amanda Adrian.

Formal findings and recommendations

In light of the fact that none of the allegations investigated by the Commission were ultimately substantiated, the Commission has not made any finding that any person engaged in "corrupt conduct" or made any recommendation that consideration be given to taking criminal or disciplinary action against any person.

Having regard to the Commission's findings of fact, coupled with the consideration that over 100 relevant reforms have already been recommended as a result of relatively recent inquiries conducted by other bodies (including, but not limited to, the SCI, a NSW Parliamentary Committee and the HCCC), the Commission has not seen fit to make any recommendations for the reform of any laws or the revision of any practices or procedures of any public authority or public official.

Chapter 1: Introduction

This report presents the results of a wide-ranging investigation by the Independent Commission Against Corruption ("the Commission") into alleged misconduct associated with the former South Western Sydney Area Health Service (SWSAHS).

At the relevant times the SWSAHS was an area health service established under the *Health Services Act 1997* (NSW) and one of its primary functions was to manage public hospitals in South-Western Sydney. It performed this function through a number of separate sector health services, including (but not limited to):

- the Macarthur Health Service (MHS), which encompassed Campbelltown and Camden Hospitals;
- the Liverpool Health Service (LHS), which encompassed Liverpool Hospital; and
- the Fairfield Health Service (FHS), which encompassed Fairfield Hospital.

On 1 January 2005 the SWSAHS was amalgamated with the Central Sydney Area Health Service to become the Sydney South West Area Health Service.

Since November 2002 a number of current and former SWSAHS employees have made highly-publicised allegations about perceived improper practices or adverse incidents at the above SWSAHS health services and hospitals. Many of these allegations have been the subject of separate, yet overlapping, inquiries by a range of different bodies, including the NSW Department of Health ("NSW Health"), Health Care Complaints Commission (HCCC), Special Commission of Inquiry into Campbelltown and Camden Hospitals ("the SCI"), NSW Ombudsman, NSW Parliament, NSW Police, State Coroner and the Commission.

In accordance with its jurisdiction under the *Independent Commission Against Corruption Act 1988* (NSW) ("the ICAC Act"), the Commission's investigation was limited to those allegations which reasonably implied that "corrupt conduct", as defined in sections 7 to 9, may have occurred. Explanations of the Commission's jurisdiction, relevant legal principles and the Commission's role are contained in Appendices 1 and 2 of this report.

Background and parallel inquiries by other bodies

On 5 November 2002 four current or former nurses from Campbelltown and Camden Hospitals (Nola Fraser, Sheree Martin, Yvonne Quinn and Valerie Owen), accompanied by a solicitor (John Chalhoub) who is Ms Fraser's brother, met with the Hon. Craig Knowles MP, the then NSW Minister for Health, and made numerous allegations relating to perceived maladministration and misconduct within the SWSAHS, particularly within the MHS and at Campbelltown and Camden Hospitals. Immediately after the meeting, Minister Knowles prepared a memorandum and arranged for it to be sent to Robyn Kruk, Director-General of NSW Health. The memorandum contained a brief summary of the meeting and concluded with the following words:

> *Mr Chalhoub and the nurses advised that they had documentation to substantiate their allegations. Mr Chalhoub undertook to compile a composite document to assist in any enquiries.*
>
> *I advised* [Mr Chalhoub and the nurses] *that the matters raised were serious and would need to be investigated. I undertook to forward their names, addresses and contact details to you as Director General for immediate investigation.*
>
> *Naturally, I expect that the individuals will be interviewed as a matter of urgency to test the veracity of their claims.*

On 5 or 6 November 2002 Minister Knowles' memorandum was received by Ms Kruk. On 6 November 2002 Ms Kruk provided it to Victoria Walker, Director of Audit of NSW Health, with the following written instruction:

> *Please make contact today and commence investigation immediately. I would like an interim report asap.*

Between 6 and 19 November 2002 Ms Walker and a member of her staff interviewed and/or obtained written statements and documents from Mr Chalhoub, the four nurses who met with Minister Knowles and three other nurses from SWSAHS hospitals who made complaints. On or about 18 November 2002 Ms Walker provided a memorandum to Ms Kruk, which included the following interim assessment:

> *In my view the complainants have provided cogent and persuasive reports of what appear to be long standing clinical and management and performance problems, poor processes, and of specific adverse incidents that reflect badly on both the hospital and the clinical governance of SWSAHS and its Board.*

On 18 November 2002 Ms Kruk referred the nurses' allegations, along with a copy of Ms Walker's

memorandum, to the HCCC for investigation and also notified the State Coroner, the NSW Police and the Commission. Her letter to the HCCC included the following passages:

> *These allegations have been made by a number of staff and concern both management and clinical practices at the hospitals. Staff link these practices to a number of deaths.*
> …
> *Given the seriousness of the allegations I would anticipate your liaising with other relevant agencies including the State Coroner's Office and the NSW Police as necessary and as the course of your investigation dictates.*

On 21 November 2002 Ms Walker provided the HCCC with transcripts of interviews she had conducted with the complainant nurses and 18 folders of documents the nurses had produced. Shortly afterwards the HCCC commenced an investigation into the complaint, which involved conducting interviews with, and collecting large volumes of documents from, the complainant nurses and many other officers from within the SWSAHS.

On 28 August 2003, prior to completion of the HCCC's investigation, Ms Kruk appointed an Expert Clinical Review Team headed by Professor Bruce Barraclough, AO, to review clinical and administrative practices within the MHS and at Campbelltown and Camden Hospitals. On 15 October 2003 the Team produced a report which identified many workplace deficiencies, including the lack of an open and fair culture, and contained a number of recommendations for reform. On 19 October 2003 the Hon. Morris Iemma MP, the then NSW Minister for Health, announced a series of changes aimed at achieving these reforms.

On 9 December 2003 the HCCC produced a final report, entitled *Investigation Report, Campbelltown and Camden Hospitals, Macarthur Health Service* ("the HCCC report"), which contained findings to the effect that many of the complainant nurses' allegations had been substantiated. In particular, the HCCC concluded that:

- the level of care provided to many patients at Campbelltown and Camden Hospitals was poor;
- safety and quality systems within the MHS were inadequate and required immediate attention; and
- disciplinary action taken by the MHS against some of the complainant nurses, particularly Ms Quinn and Ms Owen, was heavy-handed and unfair.

The HCCC report contained 70 recommendations for the implementation of reforms to address the above issues, but it did not recommend that any action be taken against any individuals.

On 11 December 2003 Minister Iemma held a press conference and declared that the HCCC report did not "go far enough" because it failed "to hold a single person accountable". He stated that he had "lost confidence in the HCCC" and announced that:

- Amanda Adrian had been removed from her position as HCCC Commissioner;
- the SWSAHS Board had been dissolved;
- 19 deaths examined by the HCCC had been referred to the State Coroner; and
- a Special Commission of Inquiry headed by Bret Walker SC ("the SCI") had been established to inquire into the complainant nurses' allegations and the HCCC's investigation of those allegations.

The SCI conducted a thorough inquiry which involved analysing tens of thousands of documents, interviewing 18 individuals, holding public and private hearings, liaising with the Commission and considering over 100 written submissions from members of the public. It released interim reports on 31 March 2004 and 1 June 2004 and a final report on 30 July 2004. The SCI concluded that the HCCC's investigation was flawed because it did not investigate the professional conduct of individual practitioners implicated in the complainant nurses' allegations. Consequently, it referred a number of the matters back to the HCCC for investigation, with recommendations that it consider taking disciplinary action against 15 doctors and 11 nurses and consider referring seven doctors to the NSW Medical Board to have their performance assessed. The SCI also made 22 recommendations for the implementation of statutory and administrative reforms to improve the patient care complaints system in NSW.

At the same time as the SCI inquiry was taking place, the NSW Legislative Council General Purpose Standing Committee No. 2 considered a number of allegations made by the complainant nurses as part of its inquiry into complaints handling within NSW Health. On 17 June 2004 the Committee released its Report No. 17, *Complaints handling within NSW Health*, which identified problems relating to the management of complaints at Campbelltown and Camden Hospitals and contained 19 recommendations for reforms across the NSW health system.

Various allegations relating to perceived maladministration or misconduct within the SWSAHS have also been the subject of relatively recent investigations or inquiries by other agencies, including the NSW Police, the State Coroner and the NSW Ombudsman.

Why the Commission investigated

Since November 2002 the Commission has received a series of referrals and complaints relating to a wide range of alleged misconduct associated with the SWSAHS. Some of the matters had been, were being or were proposed to be investigated by the other agencies referred to in the preceding section of this report. When each matter was received by the Commission it was assessed in order to determine whether it fell within the terms of the ICAC Act. Those which did were either investigated by the Commission or referred to another agency for investigation, depending on the particular circumstances. In addition, some matters were investigated by the Commission in conjunction with other agencies.

The allegations addressed in this report were investigated by the Commission for a variety of reasons, including the following:

- the matters alleged, if proven to be true, could constitute "corrupt conduct";
- some of the main complainants had made other allegations (not involving corrupt conduct) that were found to be substantiated by other agencies;
- the allegations were relatively serious and had received substantial publicity, which may have created an impression that the allegations were true and which contributed to an apparent crisis in public confidence in some SWSAHS hospitals;
- most of the allegations (or particular aspects of them) had not been fully investigated by any other agency;
- some of the allegations had been investigated, in whole or in part, by other agencies but there had been public criticism of those investigations; and
- it was considered to be in the public interest to establish whether the outstanding allegations were substantiated and, if so, initiate appropriate remedial action.

The Commission's investigation

The Commission's investigation proved to be extremely time-consuming and resource intensive. This was due to the large number and diversity of the allegations that were made, the vague and generalised nature of many of the allegations, the lengthy period over which the allegations were made (some were made years after the alleged event), the large number of potential witnesses and the large volume of potentially relevant documents and electronic records. The Commission also considered it necessary to postpone some of its proposed activities in order to avoid possible interference with relevant parallel inquiries being conducted by other agencies, such as the HCCC, SCI, NSW Police and State Coroner.

During the course of its investigation the Commission exercised its coercive information-gathering powers under sections 21, 22 and 23 of the ICAC Act on a large number of occasions and:

- interviewed and/or obtained written statements from over 200 persons, including every complainant, every person identified as a potential witness to corrupt conduct and every person alleged to have engaged in corrupt conduct;
- requested the complainants, and compelled public officials, to produce large volumes of potentially relevant documents;
- entered SWSAHS premises to obtain potentially relevant documents;
- copied potentially relevant electronic records (including email records) from the NSW Health and SWSAHS computer servers, from back-up tapes containing records previously held on those servers and from around 100 individual computer hard disk drives used by NSW Health, SWSAHS and MHS officers;
- co-operated and exchanged information with other agencies that were conducting relevant parallel inquires; and
- carefully examined the more than 100,000 potentially relevant documents and electronic records that were ultimately obtained.

Public hearings and the Commission's first report

Prior to 1 July 2005 the ICAC Act provided that for the purpose of an investigation the Commission may hold a hearing, either in public or in private. In deciding whether to do so the Commission was obliged to have regard to any matters which it considered to be related to the public interest. Following recent amendments, the ICAC Act now provides for "compulsory examinations", which are held in private, and "public inquiries". The Commission may only hold a compulsory examination or public inquiry if it is satisfied that it is in the public interest to do so and in deciding whether this is the case in relation a public inquiry it must consider the following:

(a) the benefit of exposing to the public, and making it aware, of corrupt conduct,
(b) the seriousness of the allegation or complaint being investigated,
(c) any risk of undue prejudice to a person's reputation (including prejudice that might arise from not holding an inquiry),
(d) whether the public interest in exposing the matter is outweighed by the public interest in preserving the privacy of the persons concerned.

The Commission decided that it was in the public interest to hold public hearings in relation to some of the allegations it was investigating, namely, the alleged mistreatment of three nurses (Nola Fraser, Sheree Martin and Giselle Simmons) who complained to Minister Knowles about perceived maladministration and misconduct within the SWSAHS. The details of those allegations, the reasons for the decision to hold public hearings and the Commission's ultimate findings are contained in the report released by the Commission in April 2005 entitled *Report on investigation into the alleged mistreatment of nurses* ("the Commission's first report"). In summary, the Commission concluded that the allegations made by those three nurses, which were contradicted by many eyewitnesses, were either false or unsubstantiated, but had been made in good faith.

The Commission considered whether to hold public hearings or public inquiries in relation to the allegations addressed in this report but concluded that it would not be in the public interest to do so, primarily because the relevant facts were able to be ascertained without the need to resort to such compulsory procedures and the allegations were found to be lacking in substance.

Section 78(2) recommendation

Pursuant to section 78(2) of the ICAC Act, the Commission recommends that this report be made public forthwith. This recommendation allows either presiding officer of the Houses of Parliament to make the report public, whether or not Parliament is in session.

Chapter 2: Alleged cover-up by senior MHS and SWAHS officers

Nola Fraser, who worked as an After Hours Nurse Manager at Campbelltown and Camden Hospitals until she took extended leave from March 2002, and Sheree Martin, who worked as an enrolled nurse at those hospitals until she took extended leave from August 2002, made a number of highly publicised allegations to the effect that senior officers from within the SWSAHS deliberately covered-up improper practices and adverse incidents at SWSAHS hospitals by destroying or concealing relevant evidence after they complained about such practices and incidents to Minister Knowles on 5 November 2002. In particular, one or both of them alleged that:

- senior MHS and SWSAHS officers attended Campbelltown Hospital on a weekend in mid-to-late November 2002 and shredded documents, deleted records from their computers and hid cabinets full of patient files;
- senior MHS officers instructed Dr David Hugelmeyer (the Director of Emergency Medicine, MHS) to go to another doctor's office at Camden Hospital in late November 2002 and "get rid of anything that would incriminate the hospital"; and
- Dr Helen Parsons (the Medical Director, MHS) removed patient file notes from MHS premises in mid November 2002.

Alleged shredding, concealment and deletion of documents or computer records

The allegations

On 15 November 2002, during an interview with NSW Health officers, Ms Fraser expressed fears that unnamed persons would attempt to destroy documents and emails supporting her allegations of mismanagement and misconduct at Campbelltown and Camden Hospitals. For example, she stated:

> *I know they will go in and they will destroy the evidence … the only advantage in all of this is because the depth of the problem is so great they will not be able to cover their tracks in every respect … What I'm concerned about is … they know the emails are on the system and they will … destroy them.*

On 21 November 2002 Ms Fraser and Ms Martin met with Victoria Walker, Director of Audit of NSW Health, at her office. On 22 November 2002 they met with the Hon. Jillian Skinner MP, the then Shadow Minister for Health, and later that day Ms Skinner issued a media release which included the following passage:

> *Nurses have today told me that [NSW Health] … has told the nurses that secondary sources have confirmed their fears that:*
>
> - *the shredders at Campbelltown & Camden Hospitals have been running hot, and*
> - *a filing cabinet full of documents has been removed and 'hidden' in an empty part of the hospital.*

On 22 November 2002 NSW Health responded by issuing a media release which stated:

> *Robyn Kruk today rejected suggestions that [NSW Health] had confirmed the substance of any claims made by nurses in relation to Campbelltown and Camden Hospitals.*

On 25 November 2002 Ms Fraser sent an email to Minister Knowles in which she alleged that MHS and SWSAHS "management", including Jennifer Collins (the then General Manager, MHS) had engaged in a "cover-up". Her email included the following passage:

> *During the last two weeks there have been numerous reports that management are tampering with records, misplacing and fabricating evidence and "shredding" away patients notes as they did their lives … These sick innocent people … were not only robbed of their lives but the management of Macarthur Health Service has now attempted to eradicate any evidence that they once existed.*

On 24 February 2003 Ms Fraser and Ms Martin, using the pseudonyms "Mary" and "Jane", participated in an interview with Alan Jones that was broadcast by Sydney radio station 2GB. The interview included the following exchange:

Jones: *Have senior management destroyed documents?*

Jane: *Yes.*

Mary: *Yes.*

Jones: *They've shredded documents?*

Jane: *And altered.*

Mary: *To our knowledge an email … a few emails were sent to the initial investigators about the shredding, about the deleting of information off their hard drives, about moving patients' notes in big*

filing cabinets and hidden [sic] *them. This was officially put on email.*

On 25 February 2003 Ms Fraser and Ms Martin, using the pseudonyms "Jane" and "Mary", participated in another interview with Alan Jones that was broadcast by Sydney radio station 2GB. The interview included the following exchange:

Jane: *… there is an administration of corruption, there's an administration of cover up and when deaths occur … those deaths are covered up …*

Jones: *And you're saying evidence was destroyed and —*

Jane: *Absolutely.*

Jones: *— shredded?*

On 5 March 2003 Ms Fraser, along with Ms Martin and other complainant nurses, participated in an interview with officers of the HCCC and made the following assertion:

… you also have to understand that there has been information that was given to the audit section of [NSW Health] *… that they were tampering with notes. There was evidence. People had seen them deleting stuff from their hard drive. People had heard the shredders going all weekend. This is hard facts. This is not gossip.*

On 14 March 2003 Ms Fraser and Ms Martin participated in another interview with officers of the HCCC and the following exchanges occurred:

HCCC: *Nola, one of the issues you have raised is concerns about the integrity of the documentation at Macarthur Health Service since the report of the allegations. Can you give us more information around that?*

Fraser: *Since the report of the allegations, that weekend – I've got the date but I can't remember it offhand – but the Area people came in. One was Greg Driver and Ian Southwell because people recognised who they were. They all had suits on and everybody walked in on Saturday morning and said in these like suits saying, "Where's the meeting?" There was this big meeting and there were lots of people at this meeting – over 50 people in suits. This was the Area people met at Campbelltown Hospital and I believe that was the weekend that they maybe put this plan together because the following Monday they started this strategic planning of trying to divide and conquer …*

They called a number of meetings but that weekend, and I think it was the weekend of 17 and 18 November from memory, there were reports that administration had been in all weekend; that they were deleting – there were witnesses that they were deleting stuff from their hard drive

Martin: *This was emailed to Victoria Walker, the head of the audit section [of NSW Health]. She read the email to us. One girl emailed her. She said, "I don't know if this interests you but the shredders have been going all weekend since the investigation"*

Fraser: *She says in the email basically she heard that there was an investigation into Campbelltown and Camden Hospital on the news and she could not help but put two and two together with the activities that she saw happening over the weekend. That's the gist of the email and it was that the shredders were going – …*

And also that they were moving cabinets with patients' notes stuffed in them and it would be interesting — "You may be interested to know that these cabinets, two huge brown cabinets, who Security helped move, are in the new building locked away in the safe in Pharmacy."

On 14 November 2003 Ms Fraser participated in an interview with Quentin Dempster that was broadcast by the ABC on the television program *Stateline*. The interview included the following exchange:

Dempster: *What's worse, though, is the claim that, in recent years, documents were destroyed at Macarthur Area Health to hide the evidentiary trail.*

Fraser: *What I'm saying is that I had a lot of emails and messages from people at the hospital on a particular weekend that there were shredders going and that the administrators were seen deleting things from their hard drive and that Area was involved, Area had been called in.*

On 18 November 2003 Ms Fraser telephoned the Commission and stated that around one year earlier Victoria Walker "had received information from a 'Vicki Pratt', an employee at Campbelltown Hospital, concerning the destruction of evidence she had witnessed".

On 3 December 2003 Ms Martin participated in an interview with Commission officers and the following exchanges occurred:

Martin: *[W]hat happened was we went to see Victoria Walker in her office … and she said "You have a guardian angel" you know 'cause we said "Look we've heard from staff — "*

ICAC: *We — we said?*

Martin: *Nola and I were there. Nola and I had heard from the few people in hospital saying "oh they're all up there and all these notes have been moved" and blah, blah, but we had no evidence and she logged on to her computer and she read us an email. She said it was from a girl called Vicky and she didn't identify herself, this girl Vicky but in the email to Victoria Walker it said "I don't know if this is – if this is relevant or if you can use this information but I work at the hospital and I saw the following things" and the things she said in the email were she saw brown cabinets of patient notes being wheeled to the new section of Pharmacy. She saw the – she heard the shredders going all weekend in the operating suite where they have the shredders and that she saw some man up in Greer Jones' office and they were doing something to the computer.*

On 5 December 2003 Ms Fraser participated in an interview with Commission officers and the following exchanges occurred:

Fraser: *… the hospital obviously knew they were going to be under investigation, because there was a lot of activities happening in the hospital that didn't normally happen.*

ICAC: *And what do you mean by activities that "normally wouldn't happen"?*

Fraser: *Oh, such as files — like cabinets full of files being moved and hidden, Area people being called in over two weekends, you know, they were all hovering over Administration's hard drives and appeared to be deleting things.*

ICAC: *You know this yourself directly – how do you know this?*

Fraser: *Well, this is the email from this girl, but also on that particular weekend, the people who were on duty were texting me saying "you should see them, they're all up in their offices. They're hovering around" –*

ICAC: *Who were these people?*

Fraser: *Oh, there was Colleen Thomas, there was wardsmen –*

ICAC: *And Colleen texted you on your mobile phone?*

Fraser: *Yes, on my mobile phone.*

ICAC: *Right, and she said what?*

Fraser: *She said, "Oh, you know something's happening. Administration in all over the weekend* [including] *Ian Southwell* [and] *Greg Driver …*

ICAC: *So you received a text message on your mobile phone from one person. Who else contacted you about the destruction —*

Fraser: *Theatre staff.*

ICAC: *Can you name names?*

Fraser: *Yeah, Lyn Chalker. Lyn Chalker said that a nurse — a nurse — what was her name? She'd know — told her that the wardsman had heard the shredders going all weekend …*

ICAC: *Can you nominate anyone else who we may be able to speak to who may have some further knowledge of destruction of evidence?*

Fraser: *Oh, I would suggest that you start with the wardsmen that were on duty that weekend, and Security. Apparently Security were involved …*

ICAC: *And basically did you have a conversation with Victoria Walker from the NSW Health in relation to this information about documents being destroyed?*

Fraser: *Yes.*

ICAC: *And can you tell me the content of that conversation that you had with her, or she had with you?*

Fraser: *Yeah, Sheree and I went in there one day … and she says – her exact words were – I don't know if Sheree remembers …, but it was "Don't worry, you have a guardian*

angel, you two". I've had an email received from somebody that was on, and she read the email to us, and I said, "Who was that?" and she said, "A girl called Vicki Pratt". I said, "I don't know a Vicki Pratt", and of course, you know, I wrote the name down and I thought "I'll never forget this name Vicki Pratt. I must ring her and thank her". But it was a girl who gave intricate details of security, wardsmen brown cabinets, patient files being shoved in brown cabinets and that they were taken to the new hospital in the pharmacist section in like a secret wall, or a door that they'd be pleased to know that's where it is. About Area people, it appears to be men in suits and Area people have been in all weekend that they're hovering around their hard drives and computers appearing to be deleting things of cleaning up their files, you know, and she mentioned a few more unusual activities …

ICAC: *Did* [Victoria Walker] *appear to read* [the email] *verbatim? Word for word?*

Fraser: Yes.

ICAC: *Did it appear as though the author of the email was speaking first hand about something they saw –*

Fraser: Yes, yes she witnessed. That's what she said, "I have witnessed activities over the weekend that are very concerning, and you may be interested to know".

On 11 December 2003 Ms Fraser and Ms Martin participated in a widely reported press conference and repeatedly alleged that administrators and managers from the MHS and SWSAHS had engaged in a "cover-up". Ms Fraser said the cover-up had been "systemic" and "deliberate", while Ms Martin said there was "an overall culture of cover up". They made similar allegations in public forums on subsequent occasions.

On 17 December 2004 Ms Martin provided the Commission with a written response to a request for information in which she stated that, to the best of her recollection, the person named "Vicki" who sent an email to Victoria Walker in mid-to-late November 2002 wrote in her email "that there was unusual activity [at Campbelltown Hospital] that weekend, with filing cabinets being moved, someone doing something to Greer Jones [sic] computer [and] shredders going on the weekend".

Having regard to the fact that the wider allegations made by the complainant nurses were first publicised on Friday, 15 November 2002, when NSW Health issued a media release stating that it was investigating "allegations relating to management practices at Campbelltown and Camden Hospitals … raised by hospital staff members", the "cover-up" allegations made by Ms Fraser and/or Ms Martin may be particularised and summarised as follows:

- A girl named Vicky/Vicki sent an email to Victoria Walker, Director of Audit of NSW Health, in which she stated that a large number of administrators from the MHS and SWSAHS had attended Campbelltown Hospital "all weekend" on 16 and 17 November 2002 and held a "big meeting", shredded large volumes of documents (the shredders were "going all weekend" and "running hot"), deleted information from their computers, moved filing cabinets full of "patients' notes" and "hid" them in a "safe" or "secret wall" in the new pharmacy section.
- In her email, Vicky/Vicki stated that she had "witnessed" the abovementioned activities "first hand" and provided "intricate details" about them.
- There were "a lot" of other emails, reports and messages from people who were "on duty" at Campbelltown Hospital "that particular weekend" and had "seen" the abovementioned activities.

Ms Fraser specifically described her allegations as "hard facts ... not gossip".

The facts

After an extensive search, the Commission found the email from "Vicki" referred to by Ms Fraser and Ms Martin. It was sent on Wednesday, 20 November 2002, from Vicki Watt (not "Pratt", as suggested by Ms Fraser), a scientific officer at Campbelltown Hospital, to Tom Breen, Director of Internal Audit Services at SWSAHS. This original email was not sent to Victoria Walker, but Mr Breen's reply on 21 November 2002 (which included the text of the original email from Ms Watt) was copied to Ms Walker. The only relevant parts of Ms Watt's original email read as follows:

Since reports in the newspapers last weekend and prior to those reports, some information has been circulating the hospital …

> *Last week just prior to the newspaper reports, even though I have no proof, I had also heard that some of the supervisors within* [Campbelltown] *hospital, including Greer Jones, were wiping information off their computers because allegations had been made. As to what I have no idea.*
>
> *I was also working yesterday evening and was told that three large filing cabinets were taken upstairs to Greer Jones' office and filled with paperwork. These were then taken to the security office in the new building and then transported down to the new pharmacy department, which has yet to be opened, and locked in the safe. If this was the case, it appears that someone is trying to hide something …*

Ms Walker initially told the Commission that she had no recollection of either receiving this email or reading it out to Ms Fraser or Ms Martin. However, after she was shown copies of pertinent records from her electronic mailbox, she agreed that she had received the email, opened it and read it on 21 November 2002. She further agreed that Ms Fraser and Ms Martin had attended her office on that day and she eventually conceded that it was "possible" that she had read the email out to them on that occasion. The Commission is satisfied that she did, in fact, do so.

There are a number of noteworthy points about Ms Watt's email:

- It does not contain any reference to administrators, or any other persons, attending Campbelltown Hospital on any weekend or having a meeting at any time.
- It does not contain any reference to the alleged shredding of documents.
- While it refers to the alleged wiping of information from computers and movement of filing cabinets, it does not suggest that those activities occurred on a weekend. Indeed, it clearly implies that the former activity occurred sometime during the period from Monday, 11 November 2002, to Friday, 15 November 2002, and that the latter activity occurred on Tuesday, 19 November 2002.
- It does not contain "intricate details" about the alleged activities. In particular, it does not mention the name of any person allegedly involved in the activities apart from Greer Jones (the then MHS Director of Maternal and Child Health, who, at the time, was acting as the MHS Director of Nursing and Acute Services) and it does not mention what type of information was allegedly wiped from computers or what type of "paperwork" was in the filing cabinets.
- Ms Watt did not state or suggest that she witnessed any of the alleged activities herself. Indeed, she specifically remarked that she had "no proof" and made it plain that she was merely recounting what she had heard from another person or other persons. She did not even state or suggest that the other person or persons had actually witnessed any of the activities.

Records obtained by the Commission show that Mr Breen and Ms Walker liaised about the matters raised in Ms Watt's email and decided that Ian Southwell, the CEO of the SWSAHS, should determine what action should be taken in relation to them.

It appears that Mr Southwell and Mr Breen concluded that the relocation of the documents in the filing cabinets was merely a "common sense" security measure and did not involve anything suspicious. However, they decided that they should investigate the allegation that supervisors "were wiping information off their computers because allegations had been made". In relation to this allegation, records show that on 21 and 22 November 2002 Mr Southwell instructed Mr Breen to get more information from Ms Watt and then "do whatever was necessary".

Records show that Mr Breen made some preliminary arrangements for relevant computers to be seized and examined (at considerable cost) by an external forensic auditor, but when he spoke to Ms Watt she said that her information "was all hearsay", that she "did not know the names" of any witnesses and "had no further specifics". Following these responses, on 27 November 2002 Mr Breen prepared a written report which contained the conclusion that "no further action is needed". On 28 November 2002 Owen Thomas (the then Acting Director of Operations, SWSAHS) wrote the following comment on the report:

> *CEO, In the absence of any specifics from V Watt (earlier information being hearsay) I support* [Mr Breen's] *conclusion. No further action recommended at this stage.*

On 4 December 2002 Mr Southwell wrote "Agreed" on the report. Thereafter, no further action was taken by the SWSAHS in relation to the matters raised by Ms Watt.

The Commission did not find any evidence to suggest that the handling of this matter by Mr Breen, Mr Thomas or Mr Southwell was anything other than appropriate.

The Commission interviewed Ms Watt. She stated that she had no direct knowledge of the matters referred to in her email and was merely repeating what had been told to her by Mark Stanley, a security officer and wardsman at Campbelltown Hospital, who said that he had been informed of the matters by Keith Hurney, another security officer and wardsman. At the relevant time, Greer Jones had recently taken disciplinary action against Mr Stanley and Mr Hurney (for unrelated incidents) and both felt that she had treated them unfairly in upholding allegations against them which they denied.

The Commission interviewed Mr Stanley and he stated that he had no direct knowledge of the matters referred to in Ms Watt's email and was informed of them by Mr Hurney.

The Commission interviewed Mr Hurney. His recollection of the relevant events was poor. He stated that he had been directed to move two filing cabinets to the new pharmacy section of Campbelltown Hospital and that he had done so, but that he was not sure who had given the direction, when the person had given it or when he had carried it out. In particular, he was not sure whether any of the relevant events occurred on a weekend or not. In addition, he said that he did not know what was in the filing cabinets because they were locked. When asked whether he had any knowledge of Greer Jones or anyone else improperly wiping information off their computers, he said that he did and explained that he believed that Ms Jones had "ignored" information he submitted in relation to the disciplinary proceedings against him. He said "she basically wiped all of my information and accepted the [complainant's] word against mine". He said that he had no knowledge of Ms Jones or anyone else improperly wiping information off their computers. When asked whether he had ever told any other person that Ms Jones or anyone else had improperly wiped information off their computers, he said that he could not remember.

The Commission examined relevant computer data (including data relating to deleted files and emails) from the SWSAHS server, from back-up tapes of the server and from individual hard disk drives relating to Ms Jones and every other person directly or indirectly implicated in the alleged wrongdoing and did not find any evidence to support the allegation that administrators from the MHS or SWSAHS improperly deleted information from their computers in November 2002. In addition, none of the persons interviewed by the Commission claimed to have any direct knowledge of this alleged wrongdoing, none of the documents obtained by the Commission supported this allegation and every person directly or indirectly implicated in this alleged wrongdoing denied it.

The Commission confirmed that filing cabinets with documents in them were moved to the new pharmacy section of Campbelltown Hospital in November 2002, but did not find any evidence of impropriety on the part of any person. The Commission located the cabinets and found that they contained confidential medico-legal files which included only copies (not originals) of patient records. The Commission interviewed the persons who physically moved the files and none of them had any information to support the allegation that they were moved in order to conceal or destroy evidence. The Commission also interviewed the persons responsible for the decision to relocate the files, Dr Helen Parsons (the then MHS Medical Director of the MHS) and Jennifer Collins (the then General Manager of the MHS), and they explained that they were simply moved to a more secure section of the hospital because there had been a number of break-ins where the files were previously kept and there was further evidence indicating that staff may have improperly accessed the files. These explanations were supported by various records and evidence from numerous witnesses, including Andrew Drake (the then MHS Manager of Security and Patient Services) who liaised with NSW Police in relation to the break-ins. He confirmed that after the break-ins there was a reorganisation of security and storage arrangements for the medico-legal files which involved transporting them in filing cabinets to a new part of Campbelltown Hospital. He said:

> *…no files were destroyed during this process and it was not part of any cover-up … it was simply to safeguard the records.*

The Commission reviewed the thousands of documents contained in the relocated filing cabinets and found only one (a copy of a report containing a review of an adverse incident) that ought to have been, but was not, provided to the HCCC in relation to its investigation of the complainant nurses' allegations. However, the MHS officers who were responsible for providing relevant documents to the HCCC – and did provide it with many thousands of documents (including many relating to the adverse incident in question) – have denied that this document was deliberately withheld and the HCCC

has informed the Commission that its investigation and overall findings were unaffected by the fact that it did not receive the document. Indeed, in one respect, the document actually favoured the MHS. In its final report the HCCC criticised the MHS for not carrying out a review of the relevant adverse incident and this criticism would not have been made if the document in question had been provided to the HCCC.

Greer Jones told the Commission that she "had nothing to do with" the movement of the filing cabinets to the new pharmacy section of the Hospital and her denials were supported by Dr Parsons and Ms Collins. The medico-legal files in those cabinets came from the Acute Services section of the Hospital, which was located next to Ms Jones' office. In an unrelated incident, Ms Jones had empty filing cabinets delivered to an office she was occupying for the purpose of storing existing documents in that office because she suspected that someone had improperly entered the office and accessed confidential records. It appears to the Commission that the statements in Vicki Watt's email reflect confusion between the movements of the two different sets of filing cabinets.

The Commission interviewed numerous administrators and managers from the MHS and SWSAHS and did not find any evidence of a "big meeting" occurring at Campbelltown Hospital on the weekend of 16 and 17 November 2002. Ms Collins and Dr Parsons stated that they separately attended the Hospital on 16 November and Ms Jones stated that she probably attended on 17 November, but all three said that their attendance had not been pre-planned with each other or anyone else and they denied attending any meeting. Greg Driver, the SWSAHS Human Resources Manager, denied attending Campbelltown Hospital on that weekend and Ian Southwell, the then CEO of the SWSAHS, said that he often attended on weekends and thought he might have done so on 16 or 17 November. All five persons denied any knowledge of, or involvement in, the destruction or concealment of evidence and the Commission has not found any evidence to contradict those denials.

During the course of its investigation the Commission interviewed over 100 persons in relation to the alleged destruction or concealment of relevant evidence (including Ms Fraser, Ms Martin, all of the persons directly or indirectly implicated in the allegations and every person identified as a potential witness by Ms Fraser, Ms Martin or anyone else) and none of them claimed to have any direct knowledge of the alleged wrongdoing, including the alleged shredding of documentary evidence.

Ms Fraser informed the Commission that her knowledge of the alleged shredding of documents came from two sources: the Vicki Watt email and Lyn Chalker (a nurse from Campbelltown Hospital). As previously discussed, the Vicki Watt email contained no reference to shredding.

The Commission interviewed Ms Chalker and she stated that on or about the weekend of 16 and 17 November 2002 she called into Campbelltown Hospital and spoke to a female nurse (whose name she could not remember) who told her that "the shredders are going overtime". Ms Chalker said that the unnamed nurse did not say anything else about this alleged activity and did not explain how she knew about it. Ms Chalker said that she subsequently spoke to Ms Fraser and recounted what she had been told by the unnamed nurse. Ms Fraser told the Commission that Ms Chalker also told her that the unnamed nurse said that a "wardsman had heard the shredders going all weekend".

The Commission interviewed Valerie Owen (who formerly worked as a nurse at Campbelltown Hospital) and she stated that Ms Chalker told her that the information about the alleged shredding came from a wardsman named "Ray" and a woman named "Daisy" who worked as a telephonist and receptionist at Campbelltown Hospital.

The Commission identified six wardsmen and security officers (staff hold both positions) who may have worked at Campbelltown Hospital on the weekend of 16 and 17 November 2002, including one named "Ray", and interviewed all of them. They all stated that they had heard rumours to the effect that managers had shredded documents at around that time, but none of them claimed to have any direct knowledge of any such activity. Ray said that "the rumours could be nothing more than a myth", but indicated that his partner "Daisy" might know something more.

The Commission interviewed Daisy and she confirmed that she worked at Campbelltown Hospital in November 2002. She said that on a weekend at around that time she had a brief conversation with a cleaner who had started work at 6am that morning. She could not remember whether the cleaner was a man or woman, but she recalled that the cleaner told her that "Jennifer Collins was in her office shredding documents" and had been doing so "all night". She

said that the cleaner did not clarify whether he/she had actually "seen" Ms Collins shredding documents and did not explain how he/she knew that she had been doing so "all night". Daisy said that she could not remember anything else about the cleaner or the conversation. She said that she could not remember if she had recounted her conversation with the cleaner to any other person or persons.

The Commission interviewed 24 cleaners who, according to MHS records, worked at Campbelltown Hospital on the weekend of 16 and 17 November 2002. Most of them said that they had heard rumours about the alleged shredding of documents, but only one claimed to have anything remotely resembling direct knowledge. That person (whose name is known to the Commission) said that, while he had not actually seen any person shredding documents, on a day in November 2002 he noticed that there was "a lot of shredded material in bags" in the general vicinity of Ms Collins' office. He explained that usually only about one bag per week of shredding was produced in that area but that on this occasion there was "a bit more" than one bag. He said that other "unusual" activities occurred at around this time, explaining that filing cabinets were moved and people (including Ms Collins and Ms Jones) were seen working "late". He said that he spoke to "a few friends" (who he declined to name) about the unusual activities that were occurring and said that he knew Daisy but was not sure whether he spoke to her about them. He said that "the rumour mill" started and people began speculating that documents were being destroyed or discarded but "he had no idea" if they actually were.

Ms Collins denied that she had ever shredded any documents at Campbelltown Hospital or at any other place while she was the General Manager of the MHS and denied that she had ever seen any other member of MHS management shred any documents. She also denied that she had ever worked at the Hospital "all night". The Commission did not find any evidence to contradict Ms Collins' denials.

On many occasions the Commission requested Ms Fraser and Ms Martin to produce copies of any documents they might have to support their allegations about the alleged destruction or concealment of evidence, but none were produced. The only allegedly relevant document identified by Ms Fraser was "an email from Dr Eddy Lim". She did not provide the Commission with a copy of the email and the Commission was unable to either verify its existence or obtain a copy of it by other means. However, the Commission asked Dr Lim if he was aware of the destruction of any documents by persons within the MHS and he said "I have heard rumours to that effect but I have no knowledge of that actually happening".

Alleged disposal of incriminating material at Camden Hospital

The allegation

On a number of occasions Ms Fraser, in the course of alleging that senior MHS and SWSAHS officers engaged in a deliberate cover-up involving the destruction and concealment of evidence relevant to matters investigated by the HCCC, alleged that Dr David Hugelmeyer (Director of Emergency Medicine, MHS) was instructed to go to Camden Hospital in late November 2002 and get rid of material that could incriminate the Hospital. The particular content of the allegation varied on each occasion she made it.

On 5 March 2003, during an interview with HCCC officers, Ms Fraser alleged that "David Hugelmeyer was instructed to go to Camden Hospital and get rid of all the incident forms". Incident forms (also known as "incident reports") are pre-printed paper forms filled out by staff to report adverse incidents and/or make complaints.

On 5 December 2003, during an interview with Commission officers, Ms Fraser alleged that "They actually asked David Hugelmeyer to go to Camden Hospital to get rid of anything that would incriminate the hospital".

By letter dated 23 March 2004 the SCI requested further information from Ms Fraser in relation to this allegation. By letter dated 2 April 2004 her solicitors responded as follows:

> *David Hugelmeyer informed Nola Fraser in late November 2002, that he had been instructed by Helen Parsons whom had in turn been instructed by Lisa Kremmer to 'spring clean'. When he attended the Department to 'spring clean' he found documents that he was concerned about destroying and contacted Helen Parsons by telephone. Ms Fraser recalls David Hugelmeyer saying that he explained to Helen Parsons that some of the documentation to be destroyed was patient information such as medical notes as well as Incident Reports. Helen Parsons responded by saying that it was okay and provided 2 waste disposal bins asking him to sort documents to "keep" in one bin and documents to "destroy" in another. David Hugelmeyer advised Ms*

Fraser that he complied with this request and sorted the documents into two "bins" and then left these for collection by Helen Parsons.

The facts

Dr Hugelmeyer was interviewed by both the Commission and the SCI in relation to Ms Fraser's allegation. During these interviews he provided the following information:

- In November 2002 Dr Parsons asked him to "clean out" a very messy office in the Emergency Department at Camden Hospital which had been used by a Career Medical Officer ("the CMO") who had left months earlier. He regarded this task as part of his "normal role" because he was responsible for the Emergency Department. He believed that Dr Parsons had been told that the office needed to be cleaned out by Lisa Kremmer, Nursing Unit Manager of the Emergency Department.
- When he inspected the CMO's office he discovered that it was full of paperwork, including "patient sensitive information" (information referring to the identity of patients) that should not be put "in the regular rubbish" because of "patient confidentiality", so he telephoned Dr Parsons and said "Look, there's a lot of kind of sensitive stuff over here … we need some sort of sensitive document disposal … I don't feel comfortable just throwing this out in the regular rubbish".
- He was provided with a "secure bin" with a lock on it and he cleaned out the office, putting any patient sensitive material in that bin and other material in a "general rubbish bin". When he finished he said to Dr Parsons "it's done" and told her that he had dealt with sensitive material "in the appropriate fashion". He does not know what happened to the material he put in the secure bin, but when he put it in the bin it was his understanding that it would be "destroyed".
- When he was cleaning out the office he did not see anything that appeared to be "a permanent record". There were copies of incident reports, but no originals. There were no original "patient records". He did not discard anything he considered to be "the one and only copy of something that the hospital might want". He does not know whether any of the documents he disposed of related to matters being investigated by the HCCC.
- The only instruction he was given by Dr Parsons was to "clean out" the office. He was not instructed by her or anyone else to "get rid of" any particular type of documents or material. He accepted that it would be "reasonable to assume" that she had chosen him to clean out the office because he held "a responsible position" and had a "professional ethical understanding of the sensitivity of [medical] documents".
- At the time, he did not think that the request to clean out the office "was particularly nefarious" and he did not believe that he "was participating in anything that was overt cover-up". However, he subsequently reflected on the matter and thought that it had not been "particularly appropriate" to clean out the office at that particular time (which was at around the same time as the complainant nurses' allegations had become public). He said that he was "not impugning anybody's motives", but he thought that it was "poor timing".

Email and personnel records obtained by the Commission show that the last rostered clinical shift for the CMO was on 31 July 2001 and since then he had either been on leave or absent without leave. They also show that in May 2002 he visited Camden Hospital "to clear out his office" and that in late July 2002 it was considered that he had "abandoned his position".

Enquiries conducted by the Commission have established that the Emergency Department at Camden Hospital was relocated in mid-to-late 2002. In November 2002 the Department was in the process of moving, or had just completed its move, from an old section of the Hospital to a new section. The old section was scheduled to be demolished so there was a need to "decommission" all of the offices in that section. The office of the CMO was located in the old section of the Hospital.

In an email to Greer Jones, and a number of other persons, sent on 20 November 2002, Dr Parsons wrote "Greer will arrange to have [the CMO's] office at Camden which is full of paperwork, to be cleared. Lisa feels that there are probably no medical records in there".

The Commission interviewed Greer Jones and she said that she had heard that Dr Hugelmeyer cleaned out the CMO's office, but she did not know what documents had been in the office or what he had done with them.

Dr Parsons was interviewed by both the Commission and the SCI in relation to Ms Fraser's allegation. During

these interviews she said that she had had discussions with Lisa Kremmer about the need to clean out the CMO's office because it was in the old section of the Hospital that was about to be demolished. She said that she might have also spoken to Dr Hugelmeyer about it and told him that the office "had to be cleaned up", but she had no recollection of any specific conversation with him in relation to this matter. She said that she "certainly did not order anyone to destroy anything" and had "no direct involvement" in the actual cleaning up of the office.

The Commission interviewed Ms Kremmer and she said that she spoke to both Dr Parsons and Dr Hugelmeyer about the need to decommission the CMO's office because "we had a deadline for when the builders were going to be coming in to demolish the place". She said that she gave Dr Hugelmeyer access to the office for the purpose of cleaning it out, arranged for him to have a "locked security bin" for the disposal of any sensitive material and actually saw him going through the office but did not know exactly what material was in there at that time. She said that the CMO and another person had previously gone through the office on separate occasions and she thought that any medical records had already been returned to the Clinical Information Department. She said that she had no knowledge of any person improperly destroying documents or records within the MHS.

The Commission has not found any evidence to support Ms Fraser's allegation that Dr Hugelmeyer was instructed to get rid of incident forms or incriminating material, or carry out a "spring clean", at Camden Hospital. Indeed, Dr Hugelmeyer and the other relevant witnesses squarely contradicted this allegation. The available evidence does not suggest that there was anything suspicious about the request made to Dr Hugelmeyer to clean out another doctor's office, in circumstances where the doctor had left the hospital long before and his office was about to be demolished, and it does not suggest that any of the material actually disposed of by Dr Hugelmeyer either consisted of original records or related to matters that were being investigated by the HCCC.

Alleged removal of patient file notes from Campbelltown Hospital by Dr Parsons

The allegation

On 16 December 2003 Ms Fraser was interviewed by the Commission and was asked to elaborate on her allegation that senior MHS and SWSAHS officers engaged in a deliberate cover-up involving the destruction and concealment of evidence relevant to matters investigated by the HCCC. The following exchange occurred:

Fraser: *I think you know about Sheree Martin's mother-in-law. She's a volunteer worker and she saw Helen Parsons putting in patient notes, patient file notes in a big wheelie bag and wheeling them out of* [Campbelltown] *hospital to return two hours later with nothing.*

ICAC: *That's over the weekend on the* [16th and 17th] *November 2002?*

Fraser: *Yeah …*

By letter dated 23 January 2004 Ms Fraser repeated her allegation to the SCI in the following terms:

Dr Parsons was reportedly noted on one occasion to place patient records in a large case and return several hours later with an empty case.

The facts

Sheree Martin's mother-in-law, Dorothy Kwasniak, worked as a volunteer at Campbelltown Hospital in 2002. She was interviewed by the Commission and the following exchange occurred:

ICAC: *Can you tell me anything about removal of patient files by Dr Helen Parsons?*

Kwasniak: *Well, I don't know if she removed any. I can only tell you something that I saw one Sunday.*

ICAC: *Yep. Do you know when that was roughly?*

Kwasniak: *It was, oh, might've been October/ November. It was before — you know the day that they televised it …*

ICAC: *When the allegations first became public?*

Kwasniak: *Yeah — And I saw Jennifer Collins and Greer Jones walk out of the hospital.*

They'd been there all day but I couldn't tell you what they were doing. Then later in the after — no, later that morning I saw Dr Parsons wheel — you know those cases with the wheels on it?

ICAC: *Yep.*

Kwasniak: She wheeled it out, and there was — a little car, a little van, she put in that and went away. And I just thought she was going on holidays, which she could've been.

ICAC: *It looked like a wheelie suitcase, did it?*

Kwasniak: Yeah, like you have on a holiday to put it in.

ICAC: *Yeah.*

Kwasniak: And a couple of hours later she came back, and — but I never thought much about it, was just you know I thought, what are they doing here? That's what crossed my mind. What are they doing here on a Sunday? …

ICAC: *Okay and what was in the suitcase, do you know?*

Kwasniak: I've got no idea. That's what I say. She could've been getting ready to go for a holiday. I can't say she had files or anything, because I don't know what was in the suitcase, or — because I was in the foyer. Where she came from I don't know but I just thought it was odd the three of them in there on a Sunday.

ICAC: *And she came back later that afternoon, did you say?*

Kwasniak: She came back an hour or so later without the case.

It is evident from the above exchange that, contrary to Ms Fraser's allegation, Ms Kwasniak did not know what (if anything) was in Dr Parson's suitcase and she certainly did not see her put "patient file notes" or "patient records" in there. In addition, Ms Kwasniak was unable to specifically identify the date upon which she recalled seeing Dr Parsons with the suitcase, apart from remembering that it was a Sunday in or around October or November and it was "before" the complainant nurses' allegations first became public. The allegations first became public on 15 November 2002, so it appears to be unlikely that the incident occurred on the weekend of 16 and 17 November 2002, as suggested by Ms Fraser.

Dr Parsons was interviewed by both the Commission and the SCI in relation to Ms Fraser's allegation. During these interviews she stated that she had a suitcase with wheels which she often wheeled around Campbelltown hospital, including on weekends, but it never contained "medical records". She said that she could not recall having ever taken a medical record off the hospital premises and she denied ever having destroyed or hidden a medical record. Dr Parsons' statements were entirely plausible and the Commission did not find any evidence to contradict them.

Relevant findings by other agencies

The Commission notes that the results of its investigation into the aforementioned allegations are consistent with the outcomes of partially overlapping inquiries conducted by a number of other bodies.

On 6 March 2003 – shortly after Ms Fraser and Ms Martin publicly alleged that MHS administrators had engaged in a cover-up involving the destruction and concealment of evidence – Ian Southwell, at the request of Robyn Kruk, directed Tom Breen to investigate "whether there might have been an element of fraud or cover-up" in relation to the events leading up to the HCCC's investigation of the complainant nurses' allegations. After interviewing a number of witnesses and examining relevant records, Mr Breen prepared a report dated 12 March 2003 in which he informed Mr Southwell that he had found "no evidence" of "any element or any suspicion of fraud or corruption".

During its investigation the HCCC examined allegations to the effect that MHS officers had deliberately destroyed relevant documentary evidence. In its report (at page 243) the HCCC addressed this allegation as follows:

> *One allegation* [made by some of the complainant nurses] *concerned the shredding of documents by MHS managers and administrators that were important to our investigation. This is a very serious allegation as it calls into question the integrity of these managers and administrators. We were generally impressed by the efforts made by MHS to provide us with the documents we needed and there is no evidence to suggest key documents were missing or that there were noteworthy gaps in any of the records or other documents reviewed or obtained by the Commission … We found no evidence during our investigation to support the allegations.*

In addition to the aforementioned cover-up allegations, Ms Fraser alleged that incident reports submitted by her to MHS administrators were deliberately destroyed or discarded in order to hinder investigations into her complaints. The Commission referred this matter to the SCI for investigation, as it was alleged that the reports related to matters falling within its terms of reference. The Special Commissioner, Bret Walker SC, concluded that Ms Fraser's recollection was "inaccurate" and made the following finding:

> *The administrators at Campbelltown and Camden Hospitals and at Macarthur Health Service did not deliberately set out to cover up these adverse events or clinical incidents, or to stifle investigation of allegations about them. There was no cover up … I expressly reject any allegation, hint or suggestion that has been made that Macarthur Health Service attempted to cover up any incidences of allegedly unsafe patient care or treatment by the removal or destruction of incident reports.*

The Commission's findings

The Commission finds that there is no evidence to support the allegations made by Ms Fraser and/or Ms Martin that have been considered in this chapter. Not only were they denied by the alleged wrongdoers and not supported by any documentary or electronic evidence obtained by the Commission, but none of the more than 100 persons interviewed by the Commission in relation to the allegations (including Ms Fraser, Ms Martin and every other person identified as a potential witness by either of them or any other person) claimed to have any first-hand knowledge of the alleged wrongdoing. While the Commission accepts that Ms Fraser and Ms Martin are likely to have personally believed that their allegations were true, it finds that they were based on nothing more than gossip, speculation and hearsay.

Statement under section 74A(2) of the ICAC Act

Under section 74A(2) of the ICAC Act, the Commission is required to include in its reports, in respect of each "affected" person, a statement as to whether or not in all the circumstances the Commission is of the opinion that consideration should be given to the following:

(a) obtaining the advice of the Director of Public Prosecutions with respect to the prosecution of the person for a specified offence,

(b) the taking of action against the person for a specified disciplinary offence,

(c) the taking of action against the person as a public official on specified grounds, with a view to dismissing, dispensing with the services of or otherwise terminating the services of the public official.

An "affected" person is defined, in section 74A(3) of the ICAC Act, as including a person "against whom in the Commission's opinion, substantial allegations have been made in the course of or in connection with the investigation concerned".

To the extent that any person is an "affected person" in relation to the allegations considered in this chapter of the report, the Commission is not of the opinion that consideration should be given to any of the matters listed in section 74A(2) in respect of that person.

Chapter 3: Alleged "political cover-up" by Minister Knowles

Nola Fraser alleged that after she and three other nurses complained to Minister Knowles on 5 November 2002 about perceived maladministration and misconduct within the SWSAHS he failed to take adequate action and engaged in a "political cover-up".

The allegations

During public hearings held by the Commission in August 2004 Ms Fraser alleged that at the meeting she had with Minister Knowles on 5 November 2002, which was also attended by three other nurses (Sheree Martin, Yvonne Quinn and Valerie Owen) and her brother (John Chalhoub), Minister Knowles reacted to complaints she made about Jennifer Collins by becoming "very, very defensive" and saying "Jennifer Collins is a friend of mine". She further alleged that he then behaved towards her in a threatening and intimidating manner.

After the meeting, at around the same time as she formed the suspicion that senior MHS officers (including Jennifer Collins) were engaging in a cover-up involving the destruction and concealment of evidence relating to matters she had complained about, Ms Fraser was told that Ms Collins was a member of the same political party as Minister Knowles, the Australian Labor Party (ALP). Shortly thereafter, on 25 November 2002, she sent an email to Minister Knowles which included the following text:

> *We are writing to express our concerns in relation to the inadequate actions you have elected to take with regard to the outcome of this inquiry …*
>
> *During the last two weeks there have been numerous reports that management are tampering with records, misplacing and fabricating evidence and "shredding" away patients notes as they did their lives … These sick innocent people … were not only robbed of their lives but the management of Macarthur Health Service has now attempted to eradicate any evidence that they once existed …*
>
> *Your decision not to stand down those named in the inquiry has conveniently given them time to "cover up" … Actions speak louder than words and your apathetic action, which is apparent in your failure to stand down those named,* [sic] *as responsible only serves to condone this inexcusable behaviour.*
>
> *It has been brought to our attention that the General Manager Jennifer Collins maybe* [sic] *a member of the labour* [sic] *party … If this is the case this may explain your reluctance to address these critical matters …*
>
> *Perhaps the shredding, fabricate* [sic] *and hiding of evidence is sadly taking longer than originally anticipated and I hope that this has not been a factor in you avoiding the only correct decision as the Minister of Health and that is IMMEDIATELY stand down all those named in the inquiry.*
>
> *We call upon you as the Minister of Health to stand down staff who have been named in these allegations and stop this cover up once and for all … If you fail to make these people accountable, then you, yourself must be held accountable.*

On 25 February 2003 Ms Fraser, using the pseudonym "Jane", participated in an interview with Alan Jones that was broadcast by Sydney radio station 2GB and she stated:

> *I've even asked the Minister … to clarify a political alliance between people that work … high up in Campbelltown Hospital and his political party and he refuses to confirm whether in fact that's true and to me it's just a big political cover-up.*

On a number of subsequent occasions Ms Fraser publicly repeated her allegations about Minister Knowles' reaction to her complaints about Ms Collins and asserted that the two of them had a "political alliance". She further alleged that the NSW Government had failed to conduct "an independent, objective investigation" into her complaints, that Minister Knowles was part of the "cover-up" and that he should be dismissed.

By letter dated 3 December 2003 the Hon. Barry O'Farrell MP, Deputy Leader of the NSW Opposition and Shadow Minister for Health, requested that the Commission investigate Ms Fraser's allegations.

The facts

The behaviour of Minister Knowles at the meeting on 5 November 2002 was examined at public hearings held by the Commission in August 2004 and is specifically addressed in the Commission's first report, which was released in April 2005. At those public hearings all of the persons who attended the meeting were asked whether Minister Knowles had said that Ms Collins was "a friend" of his, as alleged by Ms Fraser. Minister Knowles denied that he said this and none of the other attendees could recall him having said it. Minister Knowles said that at the meeting he merely said that he "knew" Ms Collins. All of the other attendees recalled him saying this.

In its first report the Commission concluded (at page 6) that at the meeting on 5 November 2002 Minister Knowles "did not threaten, intimidate or attempt to intimidate any person, or engage in any other conduct that could reasonably be regarded as improper". The Commission found (at pages 21-22) that Minister Knowles considered the allegations made by Ms Fraser at the meeting "to be very serious", he responded to her in an "appropriate" and "responsible" manner and he "said that he would order an investigation".

There is no doubt that immediately after the meeting on 5 November 2002 Minister Knowles did order an investigation into the nurses' allegations and he specifically identified Ms Collins as the main focus of their complaints. The memorandum he wrote to Robyn Kruk, Director General of NSW Health, straight after the meeting included the following passages:

> *Further to our telephone conversation, I would like to advise you of discussions held in my electorate office today with five people …*
>
> *The five people made a range of allegations about senior members of staff at Campbelltown Hospital, in particular Jennifer Collins …*
>
> *The allegations relate to allegations of mismanagement, negligence, patient neglect, and a failure by the "Critical Care Committee" to properly oversee the clinical performance of the hospital over a period of some years.*
>
> *The main focus of attention was on the hospital CEO, Jennifer Collins. It was asserted that the hospital's performance had declined under her leadership and that the culture of the organization made it difficult to have their concerns investigated …*
>
> *I advised that the matters raised were serious and would need to be investigated. I undertook to forward their names, addresses and contact details to you as Director General for immediate investigation.*
>
> *Naturally, I expect that the individuals will be interviewed as a matter of urgency to test the veracity of their claims.*

In its first report the Commission concluded (at page 21) that:

> *Mr Knowles' swift action after the meeting with the nurses, in directing NSW Health to conduct an "immediate investigation" and interview the nurses "as a matter of urgency", was commendable.*

As detailed in Chapter One of this report, Ms Kruk, after receiving Minister Knowles' memorandum of 5 November 2002, ordered an immediate preliminary investigation into the complainant nurses' allegations and within a fortnight she formally referred the matter to the HCCC for full investigation.

In her email to Minister Knowles of 25 November 2002, Ms Fraser alleged that MHS management were engaging in a "cover-up" involving the destruction and concealment of evidence and she called on him to "stand down those named in the inquiry" in order to stop the "cover-up". As concluded in the previous chapter of this report, Ms Fraser's allegations were based on nothing more than gossip, speculation and hearsay. They did not provide reasonable grounds for standing down any person.

Upon receiving Ms Fraser's email Minister Knowles promptly provided a copy of it to Ms Kruk "for transmission to the HCCC" and asked her to respond to Ms Fraser. On 27 November 2002 Ms Kruk provided a copy of the email to the HCCC and wrote to Ms Fraser informing her that it would be considered "as part of the HCCC's investigation".

The HCCC is an "independent" body: section 3 of the *Health Care Complaints Act 1993*. Section 81 of that Act specifically provides that the HCCC is not "subject to the control and direction of the Minister" in respect of the "assessment" or "investigation" of a complaint.

The Commission has not found any evidence to suggest that Minister Knowles sought to improperly influence the HCCC, or any other body or person, in relation to the investigation of the complainant nurses' allegations. Indeed, Amanda Adrian, the then Commissioner of the HCCC, has expressly denied that Minister Knowles or any other public official sought to improperly influence her in relation to the HCCC's investigation.

Ms Collins has publicly stated that she was a member of the ALP for a period of around 18 months in the mid 1990s and has not been a member since. At a public hearing held by the Commission on 22 September 2004 Minister Knowles stated that in November 2002 he did not know that Ms Collins had been a member of the ALP and he indicated that it was only in late 2003 that he was first informed that she had been a member of the ALP.

During separate interviews with Commission officers Minister Knowles and Ms Collins both denied that

they were friends. They maintained that they had only met each other on a few occasions, which were all work-related, and that their relationship was nothing more than an ordinary "professional association". The Commission did not find any evidence to contradict their statements. In addition, the Commission did not find any evidence to suggest that Minister Knowles acted in a partial manner towards Ms Collins in his handling of the complainant nurses' allegations. Indeed, the terms of his memorandum of 5 November 2002 to Ms Kruk and the fact that he forwarded Ms Fraser's email of 25 November 2002 to Ms Kruk for onward transmission to the HCCC, clearly show that he did not.

The Commission's finding

Minister Knowles handled the complainant nurses' allegations in an entirely responsible and commendable manner. He immediately ordered an investigation, he promptly provided relevant information to the bodies conducting the investigation and there is no evidence that he sought to improperly influence any body or person in relation to the investigation. The allegations made by Ms Fraser are not supported by any evidence.

Statement under section 74A(2) of the ICAC Act

To the extent that any person is an "affected person", within the meaning of section 74A(3) of the ICAC Act, in relation to the allegations considered in this chapter of the report, the Commission is not of the opinion that consideration should be given to any of the matters listed in section 74A(2) of the ICAC Act in respect of that person.

Chapter 4: Alleged falsification and alteration of records

On numerous occasions Nola Fraser made general allegations to the effect that MHS management, in addition to destroying and concealing evidence, falsified or improperly altered medical records in order to conceal improper practices or adverse incidents.

The Commission sought further information from Ms Fraser, and from other persons who made similar complaints, and ultimately identified the following specific allegations:

- Ms Fraser alleged that Catherine O'Connor, Nursing Unit Manager of the Intensive Care Unit (ICU) at Campbelltown Hospital, was taken off the ward for weeks to go through and improperly alter incident forms and patient notes.
- Ms Fraser alleged that Dr Helen Parsons inappropriately asked Dr Mary Prendergast, a Visiting Medical Officer at Campbelltown Hospital, to alter patient notes.
- Giselle Simmons, formerly an Acting Nurse Unit Manager at Fairfield Hospital, alleged that comments she made about perceived dangerous care at that hospital at a SWSAHS meeting were improperly "struck from the minutes" of the meeting.
- Julie Quinn, a Nurse Unit Manager at Liverpool Hospital, alleged that minutes from a Liverpool Health Service meeting were improperly altered to remove references to concerns that had been raised at the meeting about a perceived "dangerous" situation at Liverpool Hospital.
- A number of nurses, including Ms Fraser, alleged that a locum doctor at Camden Hospital and a doctor at Campbelltown Hospital falsified patient notes by recording that they had examined patients when they had not.

Alleged alteration of incident reports and patient notes by Catherine O'Connor

The allegation

On 5 March 2003 Ms Fraser, along with other complainant nurses, participated in an interview with officers of the HCCC and the following exchange occurred:

HCCC: I invite anyone who wants to speak to me separately about concerns with tampering with documentation – and I need good clear information about what sorts of documents, when —

Fraser: Managers were taken off the ward, especially in intensive care, for four weeks, replaced with another manager so she could go through all the notes …

On 14 March 2003 Ms Fraser along with other complainant nurses, participated in an interview with officers of the HCCC and, after she alleged that MHS managers had destroyed and concealed relevant evidence, the following exchanges occurred:

Fraser: There were also reports from doctors and nurse that admin and managers, especially [the] *intensive care manager, was taken off the ward, off her ward for a month to go through all the incident forms, all the intensive care notes. She just didn't exist. She was just doing everything to make sure they dotted their i's, crossed their t's and if they didn't, well, that now was the opportunity to dot their i's and cross their t's and that administration were working day and night behind closed doors, nobody saw them in that building, in their little office, but there was a lot of activity happening. This was a number of weeks.*

HCCC: [D]*id anyone witness changes to medical records being made?*

Fraser: Look, not to my knowledge … [But] *why would you go through notes unless you had a motive?*

When Ms Fraser was interviewed by the Commission on 5 December 2003 she was asked whether she had "further knowledge of the destruction of evidence" and she alleged that "Cathy O'Connor was pulled off her ward for weeks and weeks" to "go through intensive care patient notes" and "fix it up". She identified Vanessa Bragg, a nurse from the Intensive Care Unit (ICU) at Campbelltown Hospital, as "the best person to speak to".

On each occasion that Ms Fraser made her allegation she clearly implied that Ms O'Conner went through the incident forms and/or patient notes for the purpose of making improper alterations to them.

The facts

The Commission interviewed Ms Bragg in relation to this allegation and the following exchange occurred:

Bragg: *I know that* [Catherine O'Connor] *was taken off the floor for three weeks and replaced … so that she could go through all the notes because they were trying to, they were trying to think what notes I, what patients I would complain about and go through those notes. Now I don't know why. I don't know whether it was to, you know, change them or what. I don't know why.*

ICAC: *Have you had any knowledge that any patients' notes that you had dealt with had been altered or changed at all?*

Bragg: *I haven't seen patient's notes, yeah, since, so I can't say …*

It is clear that Ms Bragg, who was the source of Ms Fraser's information, did not know or claim to know whether Ms O'Connor actually changed any incident forms or patient notes.

The Commission interviewed Ms O'Connor in relation to this allegation and she explained that when the HCCC released its first draft report in relation to its investigation of the complainant nurses' allegations (which was on 29 January 2003) she was reassigned from her normal duties on the ICU ward for many weeks to assist in the preparation of a MHS response to the HCCC (that response was provided to the HCCC on 4 March 2003). She denied having ever falsified or improperly altered any incident report or patient record and denied that she had any knowledge of any other person having done so. Ms O'Connor's explanation and denials are entirely plausible and the Commission did not find any evidence to contradict them.

The Commission's finding

Ms Fraser had no direct knowledge of the relevant facts. Her allegation was founded on nothing more than hearsay and speculation. There is no evidence to support the allegation.

Alleged request to Dr Prendergast to alter patient notes

The allegation

Nola Fraser was interviewed by the Commission on 16 December 2003 and she said:

> *I wanted to tell you about, you know, Mary Prendergast and Helen Parsons asking her to go and change obstetric notes … She refused to do so and Helen Parsons told her she was not a team player.*

By letter dated 23 January 2004 Ms Fraser repeated the allegation to the SCI under the heading "Alteration of patient documents and inappropriate requests for doctors to remove documents" in the following terms:

> *Dr Mary Prendergast, O&G was asked by Dr Helen Parsons to alter the notes of a patient. Dr Prendergast refused whereupon Dr Parsons said "You are not a team player".*

By letter dated 12 May 2004 the Hon. Barry O'Farrell MP, Deputy Leader of the NSW Opposition and Shadow Minister for Health, requested that the Commission investigate the allegations against Dr Parsons.

The facts

Dr Prendergast, who was a Visiting Medical Officer in the Obstetrics and Gynaecology (O&G) Department at Campbelltown Hospital, was interviewed by both the Commission and the SCI in relation to Mr Fraser's allegation. During these interviews she provided the following information:

- In September 2003 the HCCC produced a preliminary report containing adverse findings in relation to a case in which Dr Prendergast was involved and Dr Parsons asked her to prepare a written response.
- The case involved a seriously ill pregnant patient who attended the Emergency Department at Campbelltown Hospital at 11:59am on 26 September 2001 but was not seen by any doctor from the O&G Department until 3:00pm.
- On 22 September 2003 Dr Prendergast prepared a report which included the sentence "There was a delay of over 3 hours before the O&G Department Staff were notified re this patient". She sent the report to Dr Parsons.

- On 17 November 2003 Dr Parsons telephoned Dr Prendergast and said the hospital's lawyers had reviewed her report and "suggested" she remove the abovementioned sentence because it "reflected badly" on the Emergency Department. Dr Parsons "asked" Dr Prendergast if she would remove the sentence and she said she had "no intention of changing the report". Dr Parsons said "I take it, then, you won't do it" and she said "No, I won't". Dr Parsons said words to the effect of "Well, I wouldn't have thought so given that you've always been very difficult and won't work as a member of the team". There was no further discussion and Dr Prendergast heard nothing further about the report.

There are two particularly noteworthy points in relation to the information provided by Dr Prendergast. Firstly, she claimed that she was asked to change her own report, not alter patient notes (as alleged by Ms Fraser). Secondly, she specifically stated that Dr Parsons merely "requested", rather than "directed", her to change the report.

Dr Parsons was interviewed by both the Commission and the SCI in relation to this allegation. During these interviews she provided the following information:

- Michael Woodhouse, the then Acting General Manager of the MHS, co-ordinated the responses from doctors to the preliminary HCCC report. A number of the doctors were concerned that there could be adverse consequences for them as a result of the HCCC's findings and those with personal medical defence coverage arranged for their own lawyers to look at their responses before they were sent to the HCCC. The SWSAHS engaged lawyers to look over the reports of doctors who did not have such coverage. Dr Parsons understood that the lawyers were hired "to help them" and "make sure … they didn't put their foot in it".
- Dr Parsons recalled that she was asked by Mr Woodhouse to telephone Dr Prendergast and request that she "perhaps look at changing the wording" of her response. She could not recall exactly what Mr Woodhouse asked her to say, or why he asked her to say it, but whatever it was she subsequently telephoned Dr Prendergast and said it to her.
- The only thing that Dr Parsons could recall about her conversation with Dr Prendergast was that it was a short conversation, Dr Prendergast was "not happy" and refused to change her report and she (Dr Parsons) "immediately desisted". Dr Parsons denied that she or the MHS attempted to hide the fact that there had been a three-hour delay before the O&G Department had been notified of the patient in question, she denied saying to Dr Prendergast that she wanted the sentence removed from her report because it reflected badly on the Emergency Department and she denied saying to Dr Prendergast that she was not a team player.

Mr Woodhouse confirmed that the SWSAHS engaged lawyers to review the reports prepared by doctors in response to the preliminary HCCC report and provide advice. He had some memory of asking Dr Parsons to ensure that Dr Prendergast understood the advice which had been given in relation to her report, but he did not recall directing her to ask Dr Prendergast to amend her report.

The Commission identified Tim Smyth, a partner of the law firm Phillips Fox, as the lawyer who had been hired by the SWSAHS to provide advice in relation to the reports prepared by doctors responding to adverse findings in the preliminary HCCC report. After obtaining a waiver of legal professional privilege from his client, Mr Smyth provided the Commission with the following information:

- On 31 October 2003 Mr Smyth was faxed a copy of Dr Prendergast's report and asked to review it before it was sent to the HCCC. He was asked to contact Catherine O'Connor, who reported to Mr Woodhouse.
- Mr Smyth reviewed the report and the only concern he had was with the sentence "There was a delay of over 3 hours before the O&G Department Staff were notified re this patient". He "felt that that sentence may be misinterpreted by the HCCC as Dr Prendergast asserting [that] no-one saw [the patient] for the first three hours after she arrived in the Emergency Department".
- On 31 October 2003 Mr Smyth telephoned Ms O'Connor and had a conversation which is recorded in a contemporaneous file note (provided to the Commission) as follows: "discussed asking Dr Prendergast to amend [the sentence] – either delete or add 'while receiving medical and nursing care', … there was a delay in calling …".

- Mr Smyth said that he merely wanted it brought to Dr Prendergast's attention that the sentence could be misinterpreted and there was never any instruction that she must alter the report. He noted that after Dr Prendergast refused to change the report it was provided to the HCCC without any amendment.

Mr Symth's professed concerns about the possible misinterpretation of the sentence in Dr Prendergast's report are supported by the fact that the patient's medical records show that she was attended to by a doctor and nurses on many occasions during the three-hour period when she was in the Emergency Department.

In addition, Mr Symth's and Dr Parsons' explanations and denials are strongly supported by the fact that the three-hour delay before the O&G Department was notified of the patient in question is clearly evident from both the patient's medical records, copies of which were held by the HCCC, and from other passages of Dr Prendergast's report. Indeed, the first page of her report specifically identifies when the patient presented to the Emergency Department ("at 11:59am") and when the O&G Department was initially notified of the patient ("at approximately 1500 hours"). Accordingly, even if the sentence in question (which was on the second page of the report) had been completely removed it would not have concealed the three-hour delay or any other relevant information. This fact, in itself, is sufficient to dispel any suspicion of a sinister motive in relation to the suggested amendment to Dr Prendergast's report.

The Commission's finding

Ms Fraser had no direct knowledge of the relevant facts. Her allegation that Dr Parsons inappropriately asked Dr Prendergast to "change obstetric notes" or "alter the notes of a patient" was founded on nothing more than hearsay and speculation. There is no evidence to support the allegation.

The Commission is satisfied that Mr Symth's advice in relation to the sentence in Dr Prendergast's report was legitimate and was given in good faith. It appears that there was simply an unfortunate misunderstanding between Dr Prendergast and Dr Parsons in relation to the ultimate delivery of that advice. The Commission can appreciate how Dr Prendergast may have interpreted the message she received as an attempt to silence her or conceal relevant information, but the Commission is satisfied that neither Dr Parsons nor any other person had such an intention.

Alleged improper alteration of minutes of a SWSAHS meeting

The allegation

In a statutory declaration sworn on 19 November 2003, Giselle Simmons, who was an Acting Nurse Unit Manager of the Intensive Care Unit (ICU) at Fairfield Hospital from 4 November 2002 to 28 February 2003, alleged that she complained about "dangerous care" in the ICU at a SWSAHS meeting and a SWSAHS doctor (whose name is known to the Commission) "had struck from the minutes what [she] had said about dangerous care".

During an interview with the Commission on 30 December 2003 Ms Simmons further alleged that at the meeting in question the SWSAHS doctor said "you're wasting our time … nothing [will] change" and "told the girl that was taking the minutes to strike ["everything" Ms Simmons had said] from the minutes". Ms Simmons said other things about the doctor and clearly implied that his actions in relation to the minutes were improper and were undertaken in order to remove any record of her complaint or prevent action being taken in relation to her complaint, or both.

The facts

The Commission identified the meeting in question as the SWSAHS Intensive Care Clinical Advisory Committee meeting held on 12 February 2003 and obtained the minutes for that meeting, which contain the following passage (on page 2):

> ***Patient Care and Service***
>
> *There were concerns raised about quality patient care, high number of patients referred to Fairfield ICU – inability to cope with the demand and availability of staff.*
>
> *Committee felt that any issues and concerns regarding patient care of individual patients should first be referred to Fairfield Health Services Review Committee or the review committee in the relevant Health Sector. Review Committees across Area, include Dr Gillian Bishop Area Advisor ICU. Any decisions and outcomes can be raised and followed up by this committee if need be. Nurses can also directly access the review process.*

> *Dr Pain advised that it is appropriate for members to raise concerns about quality at this committee although it is preferable that such concerns be raised in the relevant Sectors prior to raising these with this Committee.*

The Commission obtained the minutes from the next meeting of the Committee, which recorded that the minutes from the previous meeting were "accepted".

The Commission also obtained a copy of an email sent on 13 February 2003 from Ms Simmons to Dr Charles Pain, who chaired the meeting held the previous day, and a copy of a reply sent by Dr Pain on 14 February 2003. In her email, Ms Simmons referred to the meeting held the previous day, and the issues she raised at the meeting, in positive terms and did not make any reference to her comments being struck from the minutes or the SWSAHS doctor saying that she was wasting the committee's time. In his reply, Dr Pain wrote "Thank you very much for raising your issues at the meeting" and identified a number of practical steps Ms Simmons could take to have her concerns addressed. Referring to the committee in question, he ended his email with the following words:

> *You should feel free to brief the* [committee] *on how these matters are being progressed in Fairfield. I note your willingness to seek constructive solutions to these problems and was pleased that the [committee] responded with some helpful advice and offers of support. We should continue to keep this issue on the agenda of the* [committee].

The Commission interviewed four people who attended the committee meeting in question (including the chairperson, the minute-taker and a doctor who sat next to Ms Simmons at the meeting) and they provided the following information:

- None of them supported Ms Simmons' claim that her comments were struck from the minutes or that the SWSAHS doctor, or any other person, directed that they be struck from the minutes.
- The minutes of meetings of the committee usually take the form of brief points and are not intended to be a verbatim record of what was said at the meeting.
- The passage in the minutes under the heading "Patient Care and Service" (quoted above) related to the comments made by Ms Simmons at the meeting and they all believed that it was an accurate summary.
- The SWSAHS doctor had no role in drafting or amending minutes of the meeting.

On 19 August 2004 the Commission showed Ms Simmons a copy of the minutes of the meeting in question and she conceded that she had never actually seen the minutes before and had simply assumed that her comments had been struck out. She agreed that the passage in the minutes quoted above related to the comments she made about the level of patient care in the ICU at Fairfield Hospital, but she maintained that the passage was not accurate because it "glossed over" much of what she had said at the meeting.

The Commission's finding

The Commission finds that there is no evidence to support Ms Simmons' allegation.

Alleged improper alteration of minutes of a Liverpool Health Service meeting

The allegation

On 22 January 2004 Julie Quinn, a Nurse Unit Manager at Liverpool Hospital, participated in an interview with Commission officers and alleged that:

- She attended a Liverpool Health Service Patient Flow Management (LHS PFM) meeting on 12 June 2002 and at that meeting either she or a medical officer, whose name she could not remember, expressed concern about a perceived "dangerous" situation at Liverpool Hospital.
- A set of minutes for the meeting was subsequently emailed to all of the attendees and it included a reference to the perceived dangerous situation. Five or ten minutes later "an email [came] through saying they wanted to recall those minutes" and a "revised" set of minutes was sent through which did not contain any reference to the perceived dangerous situation.
- At the next LHS PFM meeting on 10 July 2002 someone, whom she thought was Leanne Mills (Director of Nursing and Clinical Services, LHS), said "there was a bit of a mistake, we sent out one lot of minutes and then we recalled them". The person asked if anyone had opened the first set of minutes and most of the attendees said they had "so

they [the first set] were the ones that were confirmed".

- A week or two later she checked where the minutes for LHS PFM meetings were stored on a common computer drive and discovered that the revised set of minutes had been saved instead of the first set. She believed that there had been an improper attempt to conceal what had been said at the meeting. She did not nominate any particular individual as having deliberately been a party to the impropriety.

The facts

The Commission obtained copies of the first set and revised set of minutes for the meeting in question. The first set included the following paragraph under the heading "Winter Strategy Update":

> *The target for winter beds was 30. Out of these 19 have opened to date. The hospital has recorded 65 LTO hours and the Emergency staff feel that the situation is becoming dangerous. Incident reports will be presented to Raad Richards.*

These comments relate to the fact that the demand for hospital beds in the Emergency Department (ED) peaks during winter and one of the strategies employed to cope with this is to make additional beds ("winter beds") available. "65 LTO hours" means that for 65 hours of the preceding month the ED was on Life Threatening Only status, which means that it was so full that only patients with life-threatening conditions could be admitted.

In the revised set of minutes the abovementioned paragraph had been replaced with the following: "The target for winter beds was 42. Out of these 19 have opened to date". There were also changes to many other sections of the minutes, including the addition of three extra action items.

The Commission obtained a copy of the minutes from the next LHS PFM meeting on 10 July 2002, which included the following sentence "Minutes of the previous meeting held on 12 June 2002 were confirmed and accepted". There was no mention of two different sets of minutes for that meeting having been distributed or of any discussion about the accuracy of the minutes for that meeting having taken place.

The Commission interviewed a number of persons who attended the LHS PFM meetings on 12 June 2002 and 10 July 2002, including Leanne Mills, and also examined a number of minutes from other LHS PFM meetings, and the following information emerged:

- The LHS PFM meetings were usually chaired by Raad Richards (the then General Manager, LHS). When he attended his secretary would take the minutes and then send them out to the other attendees by email. The minutes were not intended to be a verbatim record of everything that was said at the meeting.
- Mr Richards did not attend the LHS PFM meetings on 12 June 2002 or 10 July 2002. In his absence, Leanne Mills chaired both of the meetings. Ms Mills stated that she did not take the minutes at these meetings and neither she nor anyone else interviewed by the Commission could recall who did.
- Minutes are regarded as "drafts" unless and until they are accepted at the following meeting. It is not unusual for an "amended" set of draft minutes to be sent out to attendees if inaccuracies or omissions had been identified in a previous draft set, in which case the amended set would effectively supersede the previous set.
- The first item on the agenda of each meeting was the minutes from the previous meeting. If any person had concerns about the draft minutes from the previous meeting an opportunity was given for the person to raise those concerns and propose an amendment to the draft minutes before they were confirmed and accepted. Any such concerns or proposed amendments were recorded in the minutes of the meeting at which they were raised. Many of the minutes examined by the Commission recorded that such concerns or proposed amendments had been raised. Indeed, the minutes of the meeting held on 12 June 2002 recorded two amendments (which were accepted) to the minutes of the previous meeting held on 8 May 2002.
- None of the persons interviewed by the Commission could recall: (i) any reference being made at the meeting on 12 June 2002 to any perceived "dangerous" situation in the ED; (ii) having received two sets of draft minutes for that meeting; or (iii) there having been any discussion at the subsequent meeting on 10 July 2002 about there having been two sets of draft minutes. However, they said that if they had been sent one set of draft minutes, followed by an amended set, they would have

discarded the first set and treated the amended set as the current draft version.

- Ms Mills said that she had no reason to believe that the amendments to the minutes of the meeting held on 12 June 2002 were made to "cover up" patient care issues at Liverpool Hospital.

The Commission's finding

The Commission is satisfied that there were two sets of draft minutes for the LHS PFM meeting held on 12 June 2002. The first set included the passage "The hospital has recorded 65 LTO hours and the Emergency staff feel that the situation is becoming dangerous. Incident reports will be presented to Raad Richards". The second set had a number of amendments, including (but not limited to) the deletion of this passage. While this deletion raises a suspicion that the minutes were altered for an improper, or at least undesirable, purpose, there is nothing suspicious about the other amendments that were made. In accordance with what appears to be the ordinary (and, in the Commission's opinion, logical) practice relating to LHS PFM meetings, the Commission is satisfied that the amended set of draft minutes effectively superseded the previous draft set.

The Commission believes that it is inherently unlikely that the first draft set of minutes, rather than the subsequent amended set, would have been confirmed and accepted at the next meeting (on 10 July 2002) merely because most of the attendees said that they had "opened" the first set, as alleged by Ms Quinn. If such an unusual event had occurred it is likely that the minutes of the meeting on 10 July 2002 would have contained a reference to it. It is more likely that the amended set of minutes was confirmed and accepted and it appears that no person raised any concerns about the accuracy of those minutes.

In all of the circumstances, the Commission is not satisfied that there was any impropriety in relation to the amendment of the minutes.

Alleged falsification of patient notes by two doctors

A number of nurses, including Ms Fraser, alleged that a locum doctor at Camden Hospital and a doctor at Campbelltown Hospital falsified patient notes by recording that they had examined patients when they had not.

The Commission investigated each allegation and, after consultation, formally referred both matters (along with the evidence it had obtained) to the SCI, as they fell within its terms of reference.

The SCI undertook various inquiries and concluded that the allegation against the locum doctor from Camden Hospital warranted "investigation with a view to disciplinary action being considered". Accordingly, it formally referred the matter to the HCCC, which is the body responsible for taking such action. The Commission also provided the HCCC with all of the evidence it obtained in relation to this matter and the HCCC has recently advised the Commission that it proposes to take disciplinary action against the doctor (who denies the allegation against him).

The SCI concluded that the allegation against the doctor from Campbelltown Hospital, which was that he "was well known" for completing records for examinations he never undertook because "he was too lazy", was too vague to warrant further action and did not refer it to the HCCC.

In light of the involvement of the SCI and the HCCC, the Commission has not made any findings or expressed any conclusions in relation to these allegations.

Statement under section 74A(2) of the ICAC Act

To the extent that any person is an "affected person", within the meaning of section 74A(3) of the ICAC Act, in relation to the allegations considered in this chapter of the report, the Commission is not of the opinion that consideration should be given to any of the matters listed in section 74A(2) of the ICAC Act in respect of that person.

Chapter 5: Alleged criminal offences and suspicious deaths at Liverpool Hospital

A number of nurses have alleged that criminal offences and suspicious deaths occurred at Liverpool Hospital and that officers from within the Liverpool Health Service (LHS), including at the hospital, mishandled them and/or tried to cover them up. In particular:

- Nola Fraser alleged that a female patient was raped by a male doctor at the hospital and that officers from the hospital mistreated the victim and threatened a witness;
- Nola Fraser alleged that a nurse at the hospital spiked another nurse's drink with a potentially deadly drug and that administrators from the LHS did not conduct a proper, full or honest investigation;
- Kathrine Grover alleged that "management" mishandled the suspicious death of a young female patient in the Mental Health Unit at the hospital;
- Julie Quinn alleged that senior officers mishandled the death of an elderly male patient arising from suspected neglect at a nursing home; and
- two nurses alleged that a doctor euthanased one or more patients at the hospital.

Alleged rape of a patient

The allegations

On 24 January 2003 Ms Fraser made an allegation to an HCCC officer which was recorded in a file note by the officer as follows:

> *Told me* [a patient] *… was raped by a consultant at Liverpool hospital in the last few months and a new grad nurse who witnessed it was told if she came forward she would never work again.*

On 14 March 2003 Ms Fraser participated in an interview with HCCC officers and she repeated her allegation, stating that after the alleged rape:

> *They discharged her* [the alleged victim] *home immediately and told her she was never to come back to Liverpool Hospital again.*

Ms Fraser further stated that:

> *It went to the DPP* [Director of Public Prosecutions] *and then the nurse – she was a new grad on the ward – the nurse was threatened with her job; that she would never work again in Australia if she testified over this. So her only witness wouldn't testify.*

The facts

The Commission identified the relevant incident as having occurred in May 2000. The Commission interviewed or obtained written statements from numerous persons, including Ms Fraser, the alleged victim ("the patient"), the alleged offender ("the doctor") and the graduate nurse who witnessed the incident ("the nurse"). The Commission also obtained a large volume of documents, including copies of the patient's file from Liverpool Hospital ("the patient's file") and the NSW Police Brief of Evidence in relation to the alleged offence. The information obtained by the Commission may be summarised as follows:

- Ms Fraser has no direct knowledge of the relevant facts.
- The 29 year-old patient was admitted to Liverpool Hospital in late April 2000 suffering from a undiagnosed illness. She underwent many tests and on 1 May 2000 further tests were planned, including a pap smear and a vaginal examination. On that day a doctor explained the tests to her. The patient had never had these types of tests before and had never engaged in penetrative sexual intercourse. She was very reluctant to have the tests but eventually agreed because she was told that they were necessary. Records in the patient's file show that there were sound medical reasons for requiring the tests.
- On 3 May 2000 the doctor was assigned the task of performing the pap smear and vaginal examination. He had previously had no contact with the patient and no role in deciding that the tests should be conducted. In the late afternoon the doctor saw the patient and explained the tests to her. She reluctantly agreed to them. At around 6pm he began the tests with a female nurse present. The pap smear was performed without incident. However, the patient experienced pain during the vaginal examination and it was not completed. The patient alleges that she screamed out "stop" a number of times but the doctor continued with the examination for what she thought was "a few minutes" and the nurse "had to pull him off" to get him to stop. The doctor alleges that she never said "stop" and that he immediately ceased the procedure when he realised that she was in pain.
- Very shortly after the incident the nurse wrote the following note in the patient's file:

[Doctor] *performed a pap smear, and a vaginal examination. During the pap smear there was nil complaints voiced by* [patient] *… During the vaginal examination* [patient] *was in pain, grimacing and moaning loudly and* [patient] *cried out in discomfort.* [Doctor] *stopped vaginal examination and attempted to comfort patient. This was unsuccessful and patient was in tears. I then attempted to comfort* [patient]*, sat and talked with her, she was distant and upset. I offered her the phone to call family or friend. She refused and said she would wait for her friend to arrive.*

- Shortly after the incident the patient was visited by her friend, who was a nurse at Liverpool Hospital, and seen by many other nurses, a different doctor from the Obstetrics and Gynaecology Department, and more than one social worker from the hospital. The friend and one or more of the social workers stayed with the patient for "a few hours" until after midnight.
- At the patient's request, a hospital staff member contacted a NSW Police Gay and Lesbian Liaison Officer. The patient spoke to that officer over the telephone during the morning on 4 May 2000 and the officer made arrangements for the alleged sexual assault to be investigated by detectives at Liverpool Police Station.
- On 4 May 2000 the patient was visited at the hospital by her friend and her mother and she was seen by doctors (other than the alleged offender), nurses, social workers and the hospital's patient liaison officer on many occasions.
- On 5 May 2000 detectives from Liverpool Police Station visited the patient at the hospital and arranged for her to subsequently attend the station and provide a statement. On that day the patient was also seen by doctors (other than the alleged offender), nurses, social workers and the patient liaison officer on many occasions.
- In the late afternoon on 5 May 2000 the patient was discharged from the hospital.
- The NSW Police conducted a thorough investigation into the alleged sexual assault. As part of this investigation, the doctor voluntarily participated in a tape-recorded interview and the nurse voluntarily provided a statement. The doctor denied any wrongdoing and his version of events was fully supported by the nurse. The police concluded that there was insufficient evidence to prove the alleged offence and decided not to lay any charges. The matter was not referred to the DPP.
- The detective in charge of the police investigation informed the Commission that Liverpool Hospital was fully co-operative in relation to this matter and that no person hindered or obstructed the investigation. He stated that he had no knowledge of any threats or intimidation towards the nurse.
- The nurse informed the Commission that she was never threatened or intimidated in relation to this incident. She said that she had "nothing but praise for the support [she] received from hospital management and the union in relation to this matter" and was not aware of any attempts by the hospital to cover up the incident.
- The patient told the Commission that she believed that she was discharged from Liverpool Hospital sooner than she expected because of the alleged sexual assault. However, she also stated that she actually asked to "go home" shortly after that incident. She did not allege to either the Commission or NSW Police that she was told "never to come back to Liverpool Hospital again". After she was discharged on 5 May 2000 she continued to be an outpatient at Liverpool Hospital for several years.

The Commission's findings

The Commission is satisfied that there is no evidence to support the specific allegations made by Ms Fraser. The Commission agrees with the assessment of the NSW Police that there is insufficient evidence to substantiate the alleged offence. The Commission did not find any evidence of corrupt conduct on the part of any person in relation to the events following the alleged sexual assault.

Alleged drink-spiking incident

The allegation

During an interview with Commission officers Ms Fraser alleged that at Liverpool Hospital a nurse spiked another nurse's drink with a potentially deadly drug and that administrators from the LHS did not conduct a proper, full or honest investigation.

The facts

The Commission interviewed 17 persons in relation to this matter. Nine of these persons, including Ms Fraser, had no direct knowledge of the relevant facts, but had heard and spread rumours about the alleged drink-spiking incident. The eight remaining persons consisted of the alleged victim, two alleged offenders, one person to whom one of the alleged offenders had reportedly made an admission and four administrators who had a role in relation to the investigation of the alleged offence. The Commission also obtained a large volume of documents, including records from the LHS and copies of the NSW Police Brief of Evidence in relation to the alleged offence. The information obtained by the Commission may be summarised as follows:

- In late October 2003 a rumour circulated in Liverpool Hospital that on an unknown date in the past a female nurse ("the alleged female offender") spiked another female nurse's drink with a diuretic called Lasix, which causes increased urine output and can be dangerous in large doses. On 28 October 2003 the alleged victim was informed of the rumour and she said that a few weeks earlier, during a night shift, she had become ill and experienced symptoms consistent with having consumed Lasix and was forced to take sick leave for her rostered shift the next night (on 8 October 2003). Based on this information the rumour became that the drink-spiking incident had occurred during the night shift on 7 October 2003, when the two nurses had worked together. The two nurses had a history of conflict and, according to various witnesses, staff at the hospital often played "practical jokes" on each other, such as misusing laxatives and putting KY jelly on telephone mouth pieces. At some point the rumour grew to include the allegation that a male nurse ("the alleged male offender") had also been involved in the drink-spiking incident.
- On 25 October 2003 a nurse informed Julie Quinn, the relevant Nurse Unit Manager, of the rumour and on 28 October 2003 Ms Quinn informed various senior officers. On 31 October 2003 Teresa Anderson, Acting General Manager of the LHS, was informed of the rumour and she referred it to Leanne Mills, the Director of Nursing & Clinical Services of the LHS, for investigation. On 1 November 2003 the alleged victim wrote a letter in which she referred to the drink-spiking allegation and her illness in early October 2003 and requested that the matter be investigated.
- Ms Mills and Gina Finocchiaro, Employee Services Manager of the LHS, conducted an investigation into the alleged incident. On 6 November 2003 Ms Mills spoke to the alleged victim, who could not substantiate the allegation other than to say that she and the alleged female offender had a hostile relationship and that around one month earlier she had experienced symptoms consistent with having consumed Lasix. On 18 November 2003 Ms Mills and Ms Finocchiaro formally interviewed Ms Quinn, who had no direct knowledge in relation to the alleged incident but had heard rumours from many sources. On 20 November 2003 and 4 December 2003 they interviewed the alleged offenders and each denied any knowledge of, or involvement in, the alleged incident other than having heard rumours. On 15 December 2003 they met with the alleged victim and informed her that they had not found sufficient evidence to substantiate the allegation, but that they would consider speaking to other witnesses. At this point they doubted that they had jurisdiction to interview persons external to the LHS. Shortly afterwards they were informed by more senior officers that they could seek to interview external persons but because of the Christmas break no external persons were spoken to over the next few weeks.
- On 6, 8 and 12 January 2004 Ms Mills and/or Ms Finocchiaro conducted interviews over the telephone with three external persons. None of these persons claimed to have any direct knowledge of the alleged incident. One of them claimed that she had heard that the alleged male offender admitted to a third person that he had spiked the alleged victim's drink, but when the third person was subsequently spoken to on 27 January 2004 he denied this. The external person interviewed on 6 January 2004 claimed that the alleged female offender told her that the male offender had spiked the alleged victim's drink and that she (the alleged female offender) thought it was funny. The external persons requested that their identities not be disclosed to the alleged offenders and their request was granted.
- On 14 January 2004 Ms Mills and Ms Finocchiaro formally interviewed the alleged offenders a second time and the allegations made by the external

persons were put to them without revealing their identities or other specific details. Both continued to deny any knowledge of, or involvement in, the alleged incident other than having heard rumours. In particular, the alleged female offender denied that she had any knowledge of the alleged male offender having spiked the drink and rejected the allegation that she told an external person that he had spiked the drink.

- Ms Mills and Ms Finocchiaro reviewed the alleged victim's leave record and found that she had taken sick leave on 8 October 2003 and found no other occasion of sick leave that was consistent with the alleged drink-spiking offence. They also reviewed the attendance records of the alleged victim and the alleged offenders. Those showed that the alleged female offender and alleged victim both worked on the night shift on 7 October 2003, but the alleged male offender did not. They also searched for relevant surveillance footage for the night of 7 October 2003, but there was none.
- On 27 January 2004 Ms Mills and Ms Finocchiaro provided a report to Ms Anderson which contained the conclusion that there was "no clear evidence to substantiate" that either of the alleged offenders placed any substance into the alleged victim's drink. The report also noted that the alleged victim had stated that she had reported the matter to the police and concluded with the following recommendations:

  Even though there is no substantive evidence to indicate that the alleged incident occurred, given the seriousness of the allegation and the inconsistencies in the evidence, this matter should be referred to the Nurses Registration Board for further review and investigation.

  In summary, the following recommendations are provided:

  1. *That* [the alleged victim] *be advised of the outcome of the investigation.*
  2. *That* [the alleged offenders and Ms Quinn] *be advised of the outcome of the investigation.*
  3. *That* [the alleged victim] *be provided with alternate casual shifts to those worked by* [the alleged offenders] *wherever possible.*
  4. *That* [the LHS] *actively pursue assisting NSW Police in their investigation into the alleged incident.*
  5. *That the alleged incident and investigation be referred to the Nurses Registration Board for further review.*
- These recommendations were subsequently accepted by the LHS and SWSAHS and were fully acted upon.
- On 9 February 2004 Ms Finocchiaro accompanied the alleged victim to Liverpool Police Station and they both provided formal statements. In her statement the alleged victim referred to the drink-spiking rumour, her hostile relationship with the alleged female offender and the symptoms she had experienced during the night shift on 7 October 2003. She concluded her statement with the following paragraph:

  I did not give anyone permission to add diuretic substances to my drink. I believe that it was too coincidental that I had the symptoms and they matched the stories I have heard about [the alleged female offender] *placing a diuretic in my drink. I believe that she would have done this because I have seen her repercussions on other people that have been on her bad side.*
- The NSW Police investigated the matter, obtaining statements from many persons, and concluded that there was insufficient evidence to substantiate the alleged drink-spiking offence or charge any person.
- On 17 March 2004 Ms Anderson wrote letters to the alleged offenders which included the following passage:

  I confirm my verbal advice that there is no clear evidence to substantiate that either you and/or a colleague placed any substance into [the alleged victim's] *drink. Even though there is no substantive evidence to indicate that the alleged incident occurred, given the seriousness of the allegation and the inconsistencies in the evidence, this matter should be referred to the Nurses Registration Board for further review and investigation.*
- By letters dated 2 April 2004 the SWSAHS referred the two alleged offenders to the Nurses Registration Board (NRB). The letter included the following passages:

  The [alleged victim] *alleges that* [the alleged offender] *in collaboration with another nurse placed a substantial dose of the diuretic Lasix in her (the registered nurse's) drink. On investigation the most likely date the incident*

occurred was the 7 October 2003 as the registered nurse making the complaint had an occurrence of sick leave following the shift.

While there is no substantive evidence to indicate that the alleged incident occurred, given the seriousness of the allegations and inconsistencies in the information found during the investigation the matter warrants notification.

- The NRB subsequently referred the matter to the HCCC for investigation.
- The Commission, in consultation with the HCCC, investigated this matter and ascertained that the ultimate source of the rumours at the hospital was the external person interviewed by Ms Mills and/or Ms Finocchiaro on 6 January 2004 (hereafter "the external source"). During an interview with the Commission the external source stated that the alleged female offender told her that the alleged male offender had told her (the alleged female offender) that he spiked the alleged victim's drink and that they both thought it was a funny "practical joke". However, after careful consideration, the external source stated that she was "sure" that the alleged female offender told her this in "July of 2003" (i.e. around three months before the alleged victim's illness) and that "a few months later" she repeated it to "a friend" who then told "another girl" who worked at Liverpool Hospital. The Commission interviewed both the "friend" and other "girl" and they confirmed that they had heard the rumour according to this sequence of events. The "girl" further stated that she passed on the rumour to a nurse who then passed it on to Ms Quinn. The Commission interviewed the nurse in question and Ms Quinn and they too confirmed that they had heard the rumour according to this sequence of events. As previously stated, Ms Quinn heard the rumour on 25 October 2003 and reported it to senior officers three days later.
- The Commission interviewed the alleged offenders and they continued to deny any knowledge of, or involvement in, the alleged drink-spiking incident other than having heard rumours. In addition, the alleged female offender provided information which, if true, could be construed as a possible motive on the part of the external source for creating a false rumour about the alleged female offender.
- Ultimately, in the absence of a confession, there are only two slender shreds of 'evidence' supporting the alleged offence. The first is the illness of the alleged victim on 7 October 2003. The second is the claim by the external source that the alleged female offender made certain statements to her in July 2003 (around three months before the alleged victim's illness). Putting to one side the likelihood that evidence from the external source about the making of those statements would not be admissible in any court (because it would be regarded as hearsay in respect of the alleged male offender and it would probably not be regarded as an "admission" in respect of the alleged female offender), the two shreds of evidence are completely contradictory in terms of substantiating the alleged offence. The acceptance of one of those slender shreds effectively nullifies the relevance of the other.
- After investigations by the LHS, the NSW Police and the Commission, coupled with referrals to the NRB and HCCC, no evidence has emerged that can reasonably elevate the alleged drink-spiking offence beyond the status of a mere rumour.

The Commission's findings

The Commission is satisfied that there is no evidence to support the specific allegation made by Ms Fraser. It is clear that the drink-spiking rumour was more than adequately investigated by the LHS and there is no evidence of impropriety on the part of any person who was involved in that investigation. In addition, the Commission fully agrees with the assessment of the NSW Police that there is insufficient evidence to substantiate the alleged drink-spiking offence.

Alleged suspicious death in the Mental Health Unit

The allegation

During an interview with Commission officers on 21 January 2004 Kathrine Grover, who was a Senior Nurse Manager at Liverpool Hospital for a number of years until she resigned in 2001, alleged that the Mental Health Unit at Liverpool Hospital was "unsafe" and she referred to a 22 year-old Aboriginal woman who died when she was a patient in the unit. She alleged that the woman should have been under constant supervision but was "found dead in her bed and like dead cold, rigor mortis dead, she'd been dead for hours". She stated that "22 year-old women just don't turn up dead in bed" and

suggested that "management" may not have reported the death to the police or the Coroner.

On 2 February 2004 Sydney radio station 2GB broadcast comments from one of its presenters, Alan Jones, in relation to Ms Grover's allegations. After referring to a "crisis" in NSW hospitals he stated:

> *And just on mental health, the family of a girl who died in the Mental Health Unit of Liverpool Hospital on April 17, 2000 … can't thank Kathrine Grover enough. She is the one who spoke about the treatment. She said* [name of patient stated] *should have been under constant supervision. She died from toxic poisoning but the time of death was never questioned. It was given as five past seven on April 17, 2000 but now documents reveal that medical officials examining the body had found it at that hour to be already cold … It's appalling stuff.*

The facts

In relation to this matter the Commission obtained records from Ms Grover, the LHS, the SWSAHS, the NSW Police and Westmead Coroners Court. The information from those records may be summarised as follows:

- Ms Grover has no direct knowledge of the relevant facts.
- The patient had a long history of psychiatric illness and had been diagnosed with attention hyperactive disorder, Tourette's syndrome, chronic schizophrenia and borderline personality disorder. On 27 March 2000 she was admitted to the Macquarie Clinic, an inpatient psychiatric unit at Liverpool Hospital after a self-harm incident. During the first two weeks of her admission she repeatedly harmed herself and threatened to harm herself. She was given an anti-psychotic drug called Thioridazine and her condition improved.
- On the morning of 17 April 2000 the patient was attended to by a nurse and seen to be alive at 4:15am, 5:10am, 5:50am and 6:00am. At 6:35am the nurse went to attend to the patient and found her "unresponsive and with no pulse". CPR was commenced, the medical emergency team (MET) was called and she was subsequently pronounced dead.
- The death was immediately reported to the NSW Police, in accordance with the obligation under subsection 12A(1) of the *Coroners Act 1980* (NSW), and police officers attended the hospital shortly after the death and viewed the body. The death was also reported to the Coroner.
- According to her own email record, Ms Grover was notified of the death at 7:05am on the day that it occurred and was "advised that the police had already been contacted by the [Mental Health Unit] staff".
- An autopsy was performed by Dr Neil Langlois, Forensic Pathologist at Westmead Hospital, who certified the cause of death as "toxic effects of Thioridazine". In his post-mortem report he made the following observation:

  > *… it is possible that patients who are treated with Thioridazine may die suddenly and unexpectedly at any time even with a normal therapeutic range of drugs. The mechanism for this is unclear, it may be due to the effects of the drug on the heart. Studies on this matter have revealed no clear causal relationship and such events appear to be unpredictable.*
- After the death the deceased's family made a number of representations concerning the deceased's care, treatment and medication at the Macquarie Clinic. The matter was referred to the NSW Police Service Coroner's Support Unit for investigation. As part of that investigation Professor Graeme Starmer prepared an expert report in relation to the care, treatment and subsequent death of the deceased. Professor Starmer recorded that the level of Thioridazine in the deceased's blood at the time of death was within the therapeutic range.
- At the request of the deceased's family, an inquest was held at the Westmead Coroners Court on 2 and 3 February 2003. The family were represented at the inquest by a barrister who made a number of submissions on their behalf. He did not challenge the fact (ultimately found by the Coroner) that the patient was found with no pulse at 6:35am and that a nurse had previously seen the patient alive at 4:15am, 5:10am, 5:50am and 6:00am.
- The Coroner found that the deceased received "good care and treatment" at the Macquarie Clinic and, in response to a submission from the family's barrister, stated "I do not believe that there is any evidence to suggest to me that there has been a major failure, that current checks and balances insofar as how they relate to this matter are unsatisfactory". The Coroner found that the

level of Thioridazine in the deceased's blood at the time of death was within the therapeutic range and that the death was "unexpected". The Coroner concluded that the cause of death was "toxic effects of Thioridazine" and specifically noted that this conclusion "is not suggestive that the dose was inappropriate or excessive in regard to what was known of the drug at the time".

- After the circumstances surrounding the patient's death were publicly aired by Mr Jones on 2GB last year the NSW Police revisited certain aspects of its investigation of her death. On 4 February 2004 homicide squad investigators obtained a statement from Ms Grover in which she alleged that a particular nurse at the Macquarie Clinic (whose name is known to the Commission) informed her of the patient's death on 17 April 2000 and said that "they just found [the patient] dead in bed and that she was 'dead, cold dead' and that she had been dead for a long time". On 9 March 2004 a NSW Police Detective spoke with this nurse and he stated that he recalled the circumstances surrounding the patient's death. He stated that he arrived at work before 7am and "on his arrival" he realised there was a problem with a patient and stayed at his station to provide directions to the MET. He said that he only became aware that the patient had died after the MET finished working on the patient. He said that he believed that he only saw the body when the police subsequently arrived and he showed them into her room. He stated that he did not touch or examine the deceased in any way, nor did he have or raise any concerns about the death. He denied making the statement attributed to him by Ms Grover.
- The NSW Police subsequently concluded that the statements made by Ms Grover in relation to this matter that were broadcast by Mr Jones on 2GB were "inaccurate" and that "no further action is required in the investigation into the circumstances surrounding the death of [the patient]".

The Commission's findings

The Commission is satisfied that there is no convincing evidence to support the allegations made by Ms Grover and broadcast by Mr Jones.

Alleged mishandling of a death arising from suspected neglect at a nursing home

The allegation

During an interview with Commission officers on 22 January 2004, and in a written statement dated 12 June 2004, Julie Quinn (a Nursing Unit Manager in the Emergency Department at Liverpool Hospital) alleged that senior LHS officers mishandled the death at Liverpool Hospital of an elderly male patient. She asserted that the patient arrived at the hospital in "a state of neglect", after having been "just left to die" at the nursing home, and later died because of "neglect in that nursing home". She alleged that the matter should have been referred to NSW Health, the HCCC and/or the Coroner for an investigation "as to why there is such neglect in that nursing home" but that "it wasn't taken seriously" by senior LHS officers.

The facts

The Commission interviewed many persons in relation to this matter and examined a large volume of relevant documents, including patient files from Liverpool and Fairfield Hospitals. The information obtained by the Commission may be summarised as follows:

- Shortly before 1am on 31 August 2003 a 76 year-old male patient was transferred from a nursing home to the Emergency Department at Liverpool Hospital. He was suffering from dementia, sepsis (severe infection of the bloodstream by toxin-producing bacteria), hyperglycaemia (high blood glucose levels), conjunctivitis (eye infections), multiple infected ulcers, a swollen scrotum and a gangrenous foot. Later that day the patient's wife and daughter attended the hospital, were advised by a doctor that "active treatment" would be "futile and likely to cause discomfort" and agreed that attempts should not be made to resuscitate him in the event of a cardiorespiratory arrest or medical emergency. On 2 September 2003 the patient died at the hospital. The death certificate identified the cause of death and factors contributing to it as sepsis, dementia, heart disease and diabetes.
- When the patient first arrived at the Emergency Department a nurse thought that his body was in such a poor state that she filled out an

incident form in which she wrote "On changing patient – unbelievable neglect of patient became evident … Dressings inappropriate and hadn't been changed for a long time". On the form she also identified "possible contributory factors" as "Failure of nursing home to provide adequate care … Diabetes not controlled. Hospitalisation should have been requested a long time before this presentation".

- The incident form was completed by the nurse on 31 August 2003. It was subsequently provided to Ms Quinn, who signed it and forwarded it to Associate Professor Kathy Daffurn (Co-Director, Critical Care Division, LHS) on or around 1 September 2003. On or around 2 September 2003 A/Professor Daffurn instructed Leanne Mills (Director of Nursing and Clinical Services, LHS) to ensure that the allegations of neglect at the nursing home were investigated. Ms Mills then instructed Cathy Crowe (Clinical Nurse Consultant for Ambulatory/Continuum Care at Liverpool Hospital), who had previously worked in an Aged Care Assessment Team, to undertake various enquiries.
- Ms Crowe briefly saw the patient before he died and examined his patient file from Liverpool Hospital. The Commission also examined the file and it showed that: the patient was allergic to penicillin and vitamin E; since around 1955 he had been an insulin-dependent diabetic; since 1981 he had suffered from cellulitis (inflammation of cellular tissue) and recurring multiple chronic diabetic ulcers on his legs and feet which frequently became infected, were very slow to heal and were difficult to dress; since 1981 he had suffered a range of eye complications arising from his diabetes; since 1991 he had suffered from recurring cellulitis and ulcers around his scrotum; in 1998 he had triple bypass heart surgery; and in 2002 he was diagnosed with dementia, hearing loss and poor vision.
- Ms Crowe spoke to the Quality Manager of the organisation which ran the nursing home and she stated that: the patient had been transferred to the nursing home from Fairfield Hospital and stayed there for only a relatively short period of time; he had longstanding serious illnesses arising from his diabetes, including multiple leg ulcers, and was receiving "palliative care" (care offered to improve the comfort of a dying patient, as opposed to active treatment aimed at curing the patient's illness) at the nursing home; his condition deteriorated very rapidly on 30 August 2003 and the nurse on duty that night called an ambulance which took him to Liverpool Hospital.
- The Commission also spoke to the Quality Manager. She confirmed the matters referred to above and stated that she also spoke to Ms Mills some time after speaking to Ms Crowe and informed Ms Mills that: the apparent inappropriate dressing on the patient when he arrived at Liverpool Hospital had not been applied by nursing home staff; she suspected that it had been applied by the ambulance officers, but they refused to discuss the issue with her because of patient confidentiality; the patient's family did not raise any concerns or make any complaints about the quality of care provided by the nursing home; she did not believe that there had been neglect at the nursing home; she believed that staff from Liverpool Hospital who suspected that neglect had occurred were probably unaware of the patient's full medical history and she offered to talk to them and address their concerns, but her offer was not taken up.
- The Commission spoke to the person who was the Director of Nursing at the nursing home in 2003. She stated that she had been directed by the Quality Manager to investigate the allegation that the patient was neglected at the nursing home and did not find any evidence to support the allegation. She provided a range of additional specific information which accorded with that provided by the Quality Manager.
- The Commission examined the patient's file from Fairfield Hospital. It showed that: the patient was taken by ambulance from his home to that hospital on 22 May 2003; he was diagnosed with dementia, poor mobility, virtual blindness, unstable diabetes, hypoglycaemia, cellulitis and skin discolouration on both legs, ulcers on both legs which had been "flared" for four to six weeks and scrotal swelling; he was considered too ill to return to his home and was transferred to the nursing home on 28 May 2003.
- Ms Crowe spoke to the patient's General Practitioner (GP), who regularly saw the patient at the nursing home, and he advised that the patient's family were happy with the care and treatment he received at the nursing home. The Commission also spoke to the GP and he stated

that: he had been the patient's GP for over 25 years; the patient had longstanding vascular disease, venous disease and complications arising from unstable diabetes (such as chronic ulcers) which caused him to have "horrendous looking" skin problems, particularly on his legs; when the patient was in the nursing home he visited him on an almost daily basis and saw his condition deteriorate as a natural consequence of his longstanding diseases until it eventually reached the stage where "active" treatment would have been futile; he discussed this deterioration with the patient's family; in light of his experience with the nursing home and the ambulance service he believes that any inappropriate dressings found on the patient when he was admitted to Liverpool Hospital were likely to have been applied by ambulance officers, rather than nursing home staff; he has no concerns about the quality of care provided to the patient at the nursing home; he has had extensive dealings with the nurses and managers at the nursing home over a long period of time and in his opinion they are "above reproach".

- The Commission spoke to the patient's daughter and she stated that: her father had been suffering from serious illnesses, including chronic infected ulcers which were slow to heal and difficult to dress, for a long time before he was transferred to the nursing home from Fairfield Hospital; his GP regularly saw him at the nursing home; his condition deteriorated and the GP informed the family that the main priority was to make him as comfortable as possible during the remainder of his life, rather than attempt to actively cure his illnesses; neither she nor any other family member had any concerns or made any complaints about the quality of care provided to him at the nursing home; she found all of the nursing home staff, including the nurse who was on duty the night when he was transferred to Liverpool Hospital, to be "very caring"; neither she nor any other family member had any concerns or made any complaints about the care and treatment provided to him at Liverpool Hospital; she was "very happy" with the care and treatment provided at that hospital.
- Ms Crowe consulted Professor Hugh Dickson (Professor of Rehabilitation, Director of Ambulatory Care and Director of Clinical Governance, LHS) and he, after reviewing records relating to the patient, advised her that the patient's condition upon arrival at Liverpool Hospital could have been caused by his longstanding illnesses and did not necessarily imply neglect on the part of the nursing home.
- Ms Crowe advised Ms Mills of the outcomes of her enquiries and informed her that she was of the opinion that there had not been any neglect at the nursing home.
- Ms Mills spoke to the Quality Manager, as mentioned above, and also consulted Professor Dickson. The Commission spoke to Professor Dickson and he confirmed that he reviewed records relating to the patient and advised Ms Mills that: the patient's condition on arrival at Liverpool Hospital did not necessarily imply neglect; the state of the patient's legs and scrotum may have been the natural result of the various longstanding diseases he had; those diseases were such that they may have caused the patient's condition to rapidly deteriorate over a very short period of time (possibly as short as a few hours) to such an extent that the state of his body could be regarded as "alarming" by nursing staff in the Emergency Department.
- No complaints were raised at Liverpool Hospital about the patient's actual death, which occurred after the incident form was completed by the nurse from the Emergency Department. The doctor who was responsible for the medical care of the patient immediately prior to his death, and who completed the death certificate, did not regard the circumstances of his death as warranting notification to the Coroner.
- As a result of the enquiries she undertook and the advice she received, particularly from Ms Crowe and Professor Dickson who had relevant expertise, Ms Mills formed the view that it was "highly unlikely" that neglect had occurred at the nursing home. She reported her view and the outcomes of the relevant inquiries to A/ Professor Daffurn.
- Ms Mills claims that, in response to persistent complaints from Ms Quinn, she reported the alleged neglect at the nursing home to the "Commonwealth Department of Aging and Disabilities" (presumably the Department of Health and Ageing), which is responsible for ensuring that approved providers of aged care meet all of their obligations under the *Aged Care Act 1997* (including obligations relating to quality of care) and for taking action

against approved providers who breach their responsibilities. The Commission could not verify Ms Mills' claim.

- On 20 November 2003, Ms Quinn sent an email to Ms Mills in which she wrote "Leanne i [sic] was wondering what the outcome was re the incident form sent re [the patient]. I informed the staff that reported it i [sic] would give them some feedback". On 10 December 2003 Ms Mills replied to Ms Quinn with an email in which she wrote "I am trying to contact the Quality Manager form [sic] the Nursing Home Group to arrange for her to come and speak to your staff". On 19 December 2003 Ms Quinn replied to Ms Mills with an email in which she wrote "Leanne I [sic] do not think that a chat with the staff is what is required. It concerns me greatly that this incident has not been given a priority, in fact is obviously of little concern to the organisation … I would expect that a case such as this would be notified to [NSW Health] so that the practices at the [nursing home] could be investigated". She also asserted in her email that "no action has been taken regarding concerns expressed in the incident form". On 21 January 2004 Ms Mills replied to Ms Quinn with an email in which she wrote "I am unable to identify how you have come to your conclusions from my email dated December 10 2003. There was an investigation, it was taken seriously and [your staff's] concerns were notified to the Commonwealth Department of Aging and Disabilities … The action taken is what I hoped the quality manager and myself could discuss with staff". It appears that no further action was taken by anyone from within the LHS in relation to this matter.
- At the relevant time, the policy relating to reporting incidents to NSW Health was contained in NSW Health Circular No. 97/58, entitled Incidents Reportable to the Department, which has since been superseded by Circular No 2003/88. The relevant part of Circular 97/58 is as follows:

> ***1.1 Scope of Reportable Incidents***
>
> *The aim of this circular is to ensure that the Department is advised in a timely and effective manner of any incidents that satisfy one or more of the following criteria:*
>
> - *affect public health or safety;*
> - *suggest a system or process problem affecting patient care that may require attention by the Department centrally or advice to other parts of the health system;*
> - *have the potential to be of concern to the community or media;*
> - *require a co-ordinated response by the Department.*
>
> *It is neither possible, nor appropriate, to rigidly define categories of such incidents as the need to report an incident depends on the nature of the incident and an assessment against the above five criteria … As a guide only, the following types of incidents would generally warrant prompt advice to the Department:*
>
> - *suicides or serious attempted suicides by a patient/client or staff member;*
> - *complication or adverse outcome in clinical care suggesting an unexpected risk to patients or clients in similar settings in the health system;*
> - *deaths in custody;*
> - *major disruption or threat to health service provision (eg fire, damage, bomb or other threat requiring action/evacuation);*
> - *incident likely to be the subject of media interest/attention or to generate representations by relatives.*

- Ms Mills stated to the Commission that she believed that the allegations of neglect at the nursing home were properly handled by the LHS, notwithstanding that the investigation took months to complete and the incident was not ultimately reported to NSW Health, the HCCC or the Coroner. She also suggested that one of the reasons for undertaking such a time-consuming investigation, and not immediately reporting it to one of those other agencies, was the seriousness of the allegations.

The Commission's findings

Ms Quinn and other relevant staff from the Emergency Department at Liverpool Hospital showed admirable concern for patient welfare in relation to this matter by promptly submitting the incident report, but Ms Quinn also hastily concluded that there was actual neglect at the nursing home without full knowledge of the relevant facts.

Ms Mills took longer than she herself would have liked to deal with this matter, but it appears that she treated the matter seriously and the delay was primarily due to her belief that she should not report serious allegations with potentially severe repercussions without first taking reasonable steps to satisfy herself that the facts warranted making such a report.

Having regard to all of the relevant evidence, the Commission is not satisfied that there was any neglect at the nursing home or that the overall circumstances of this matter necessitated a report to NSW Health, the HCCC or the Coroner. The Commission is satisfied that Ms Mills and other LHS officers acted in good faith in investigating the matter and deciding not to report it to any of these agencies.

In all of the circumstances the Commission believes that Ms Quinn's specific allegations are excessive. The Commission did not find any evidence of corrupt conduct on the part of any officer from within the LHS in relation to this matter.

Alleged euthanasia at Liverpool Hospital

The Commission also received a complaint and referral in relation to alleged euthanasia by a doctor at Liverpool Hospital. The Commission is continuing to investigate this matter in conjunction with the NSW Police, State Coroner and HCCC. At this stage, no findings of fact have been made and no decision has been made about the future conduct of this matter. The doctor in question has denied the allegations against him.

Statement under section 74A(2) of the ICAC Act

To the extent that any person is an "affected person", within the meaning of section 74A(3) of the ICAC Act, in relation to the allegations considered in this chapter of the report, the Commission is not of the opinion that consideration should be given to any of the matters listed in section 74A(2) of the ICAC Act in respect of that person.

Chapter 6: Alleged reprisals against whistleblowers

Twelve nurses, two doctors and a security guard/ wardsman alleged that they were bullied, harassed or disciplined by superiors and/or co-workers as a reprisal for making legitimate complaints about perceived inadequate practices or adverse incidents within the SWSAHS. For preliminary purposes it was accepted, without it ultimately being necessary to decide, that such actions, if proven, could constitute "corrupt conduct", as defined in the ICAC Act, at least under certain circumstances.

The Commission conducted an extensive investigation into these allegations, which involved interviewing or obtaining written statements from around 100 witnesses (including the 15 complainants) and examining tens of thousands of documentary and electronic records. The Commission also worked in conjunction with the HCCC and the SCI, which examined a number of the same complaints that were made to the Commission. It is convenient to initially have regard to the outcomes of the inquiries conducted by those two agencies.

The HCCC inquiry

Thirteen of the 15 complaints in relation to the allegations presently under consideration worked at MHS hospitals. The HCCC investigated whether those hospitals have "a management that minimises incident reporting by bullying, intimidating and disciplining nurses who do report adverse events" (HCCC report, p. 28).

The HCCC focussed on disciplinary action that was taken against the following four MHS nurses (each of whom also complained to the Commission about that disciplinary action): Sheree Martin, Valerie Owen, Yvonne Quinn and Sandra Solarz (respectively referred to in the HCCC report as N3, N2, N4 and N6). The circumstances which gave rise to the disciplinary action, and the details of that action, are detailed at pages 144-163 of the HCCC report and it is not necessary to repeat them.

Ms Martin, who was employed as a nurse at Camden Hospital, was disciplined by the MHS in mid 2002 for allegedly exceeding the scope of her clinical practice on two occasions. Ms Quinn, Ms Owen and Ms Solarz, who were senior nurses employed in the operating theatres at Campbelltown Hospital, were disciplined by the MHS in mid-2002 after a number of co-workers alleged that they had been bullied and harassed by them.

The HCCC concluded that the disciplinary action taken against all four nurses was "heavy handed and confrontational" and did not involve a consideration of "all the relevant factors including subjective mitigating factors" (HCCC report, p.178). It further concluded (pp. 164-169) that the MHS:

- failed "to undertake a fair, impartial and complete investigation" into the allegations made by co-workers against Ms Owen, Ms Quinn and Ms Solarz;
- improperly suspended Ms Owen and Ms Quinn; and
- failed to comply with fundamental requirements of procedural fairness in relation to its disciplinary action against Ms Owen, Ms Quinn and Ms Solarz.

Ms Martin alleged that the disciplinary action was taken against her because she lodged a series of incident reports relating to patient care issues, but the HCCC concluded that there was no evidence to support this allegation and found that she only lodged the reports after the disciplinary action was taken against the four nurses (HCCC report, pp. 176-177).

Ms Quinn, Ms Owen and Ms Solarz alleged or implied that the disciplinary action was taken against them because they had complained about patient care issues and/or the conduct of a doctor, but the HCCC concluded that there was no evidence to support this allegation and remarked that the event which "appeared to trigger the action against them" was the making of allegations against them by a number of their co-workers.

The HCCC expressed its general conclusions in relation to these issues as follows (p. 176):

> *It was alleged that MHS management minimises incident reporting by bullying and intimidating nurses who report adverse events. We have not identified any direct or causal relationship between incident reporting by the four nurses and subsequent disciplining, intimidation or bullying by MHS management.*

While the HCCC was highly critical of many aspects of the disciplinary action taken against the four nurses, it did not conclude that the action was improperly motivated or that any of the flaws associated with the action taken against Ms Owen, Ms Quinn and Ms Solarz were deliberate. Indeed, it stated that (p.177):

> *The material suggests that* [the intention of MHS management] *was to deal with allegations of bullying and harassment* [made by co-workers against Ms Owen, Ms Quinn and Ms Solarz]. *The problem was that MHS management, in their response to the incidents reviewed, displayed a narrow focus on assigning blame and a lack of knowledge, skill and possibly experience in investigating and managing staff complaints.*

Under section 11 of the ICAC Act, the then Commissioner of the HCCC, Amanda Adrian, was under a duty to report "any matter" to the Commission that she suspected, on reasonable grounds, "may concern corrupt conduct". While Ms Adrian did report a matter to the Commission in relation to the HCCC's investigation of the complainant nurses' allegations, she did not report any matter relating to the disciplinary action taken against the four nurses.

The SCI inquiry

Nine of the 12 persons from MHS hospitals who complained to the Commission in relation to the allegations presently under consideration were also interviewed by the SCI. At least four of those persons (including Ms Fraser; Ms Martin and Vanessa Bragg, a nurse from Campbelltown Hospital) alleged to the SCI that they were bullied and harassed by co-workers and/or superiors for complaining about perceived inadequate practices or adverse incidents and they provided the SCI with a number of examples of alleged victimisation (some of which are referred to at pp.115-118 of the Final SCI Report).

The SCI Commissioner, Mr Bret Walker SC, observed that a number of the examples provided by the complainants highlighted that there appeared to be a high level of "interpersonal conflict" associated with "work-based interactions" involving them (Final SCI Report, p.116). He ultimately concluded that he "was not satisfied" that the material they submitted revealed "a deliberate and concerted attempt by managers in Macarthur Health Service to prevent issues being aired by the nurse informants" (p. 117). In particular, he stated that there was "no material which would justify a finding adverse to Dr Parsons", who was the primary focus of Ms Fraser's allegations.

In addition, Mr Walker considered a specific allegation made by Ms Owen and Ms Quinn that "a policy existed whereby the management of Macarthur Health Service implemented unfair disciplinary processes, which involved procedurally unfair investigations and the imposition of sanctions after nurses raised allegations involving unsafe or inadequate patient care or treatment" (Final SCI Report, p.135). While prevented by the SCI's limited terms of reference from exploring all aspects of this general allegation, Mr Walker specifically agreed with the conclusion of the HCCC that there was "no evidence linking" complaints about patient care issues made by Ms Quinn, Ms Owen or Ms Solarz to the disciplinary action that was taken against them by the MHS (pp.136-137). He further concurred with the finding of the HCCC that "the event which appeared to trigger" the disciplinary action against the three nurses was the making of allegations against them by their co-workers and also found that "the disciplinary action taken against Ms Martin was not in response to her raising concerns about patient care" (pp.136-137).

Mr Walker did not refer any matter to the Commission under section 11 of the ICAC Act.

The Commission's inquiry

The Commission carefully considered the allegations made by the 15 relevant complainants and the large volume of evidence it obtained in relation to those allegations. The general circumstances may be summarised as follows:

- most of the allegations were vague and dated back over a number of years;
- most of the complainants alleged that they had been mistreated by many persons;
- most of the complainants had no formal disciplinary action taken against them (Ms Quinn, Ms Owen, Ms Solarz and Ms Martin were notable exceptions);
- some of the alleged incidents of mistreatment were relatively minor and, even if they were proven to have occurred, they would not satisfy the definition of "corrupt conduct" in the ICAC Act;
- in relation to all of the alleged serious incidents of mistreatment there were witnesses who either directly contradicted the complainant's version of events or placed those events in a context different from that alleged by the complainant;
- most of the allegations were not supported, or were contradicted, by the available documentary and electronic evidence;
- many of the complainants appeared to concede

that they merely suspected, and had no actual proof, that the perceived mistreatment they had received was a form of reprisal against them for having complained about workplace practices or incidents;

- most of the complainants had themselves been accused of mistreating other persons, including (but not limited to) the persons they complained about;
- none of the persons complained about made any admission of deliberate wrongdoing (indeed, all of them denied such wrongdoing and many responded with counter allegations against the complainants); and
- many of the complainants had grievances relating to a host of issues, such as declined workers' compensation claims or unsuccessful job applications, and had clashed with a significant number of their co-workers or superiors.

The Commission paid particularly close attention to the circumstances surrounding the disciplinary action taken against Ms Quinn, Ms Owen and Ms Solarz. The Commission agrees that the action was flawed in the respects identified by the HCCC. Those flaws were so serious and unfair that the nurses were entirely justified in suspecting that they were being "victimised" for something. However, after examining numerous relevant documents and interviewing or obtaining written statements from 27 relevant witnesses (including the co-workers who alleged that they had been bullied and harassed by Ms Quinn, Ms Owen and Ms Solarz), the Commission was not able to be satisfied that the persons responsible for taking the disciplinary action acted either maliciously or in deliberate disregard of the legal requirements of procedural fairness.

The Commission ultimately found that the allegations made by all 15 complainants were highly subjective and they were either contradicted by the available evidence or there was conflicting evidence and the Commission was not able to resolve that conflict in favour of the complainants to the degree necessary to warrant finding that the allegations were substantiated.

The Commission's finding

The Commission did not find sufficient evidence to substantiate any of the allegations considered in this chapter of the report.

Statement under section 74A(2) of the ICAC Act

To the extent that any person is an "affected person", within the meaning of section 74A(3) of the ICAC Act, in relation to the allegations considered in this chapter of the report, the Commission is not of the opinion that consideration should be given to any of the matters listed in section 74A(2) of the ICAC Act in respect of that person.

Chapter 7: Alleged improper attempts to silence nurses through "hush money" and deeds of release

Three nurses alleged that improper attempts were made by senior MHS and/or SWSAHS officers to "silence" them by offering "hush money" and requesting that they sign restrictive deeds of release.

Yvonne Quinn and Valerie Owen

Ms Quinn and Ms Owen have alleged that after they gave notice of their intention to resign from the MHS, and indicated that they intended to complain about unfair disciplinary action that had been taken against them, improper attempts were made by senior MHS and SWSAHS officers, in collaboration with the NSW Nurses' Association (NSWNA), to "buy their silence" by offering them "hush money" and proposing that they sign deeds of release containing confidentiality and non-disparagement clauses.

In order to adequately assess this allegation it is necessary to consider the relevant facts in some detail.

Background & general circumstances

Ms Quinn and Ms Owen are highly experienced nurses, each of whom had worked as a clinical nurse specialist (CNS) in the operating theatres at Campbelltown Hospital for many years. On 19 April 2002 three of their co-workers met with Jennifer Collins, who was the then General Manager of the MHS and had previously been the President of the NSWNA for four years, and alleged that they had been bullied and harassed by Ms Quinn and Ms Owen. Later that day Ms Collins called Ms Quinn and Ms Owen into her office and suspended them (with pay) without informing them of the specific nature of the allegations that had been made or the identity of the persons who made them.

Ms Quinn and Ms Owen initially chose to retain a private solicitor, rather than use the services of the NSWNA, to formally represent them in relation to this disciplinary matter.

In early June 2002 Ms Collins provided Ms Quinn and Ms Owen with a statement which listed the allegations against them in vague and general terms. In addition to the allegation of bullying and harassment made against each of them by their co-workers, three other allegations were made against Ms Quinn and four others were made against Ms Owen.

On 5 July 2002 Ms Quinn and Ms Owen attended disciplinary interviews and were told by Greer Jones, the then Acting MHS Director of Nursing and Acute Services, that the allegation that each of them had bullied and harassed co-workers had been substantiated, but that none of the other allegations had. They were given a first and final warning and informed that their CNS status would be removed. They were also directed to return to work but informed that they could not return to their previous positions in operating theatres at Campbelltown Hospital.

After the interview on 5 July 2002 Ms Quinn and Ms Owen contacted the NSWNA and requested that it formally represent them. Over the preceding ten-week period they had been represented by their private solicitor, but they ultimately found this to be too costly. During this period they had also spoken to NSWNA officers on occasion and been provided with basic advice, but had been informed that the NSWNA could not formally represent them if they also had their own solicitor acting for them.

In mid-July 2002 the NSWNA decided to represent Ms Quinn and Ms Owen and they subsequently terminated the services of their solicitor. The NSWNA retained the law firm Whyburn & Associates to provide advice and assistance in relation to the matter and that firm subsequently wrote a number of letters to the MHS criticising the action taken against Ms Quinn and Ms Owen and requested that they be reinstated to their positions. The MHS declined to do so and Ms Quinn and Ms Owen took various forms of leave.

On 14 August 2002 two NSWNA officers, Jan Greig and Kathryn Sullivan, accompanied Ms Quinn and Ms Owen to separate meetings with Ms Collins, Ms Jones and Greg Driver (Human Resources Manager, SWSAHS). At the meetings Ms Sullivan submitted that the disciplinary action taken against Ms Quinn and Ms Owen was flawed and that they should be reinstated in their positions in the operating theatres at Campbelltown Hospital, but Ms Collins said that that was "untenable" because it would cause disharmony and she had a duty to protect staff who feared that they would be further bullied and harassed by Ms Quinn and Ms Owen. Ms Quinn was offered an alternative position at Camden Hospital and Ms Owen was offered an alternative position at Bankstown Hospital.

In late August and early September 2002 Ms Sullivan negotiated with Mr Driver for Ms Quinn and Ms Owen to return to work and retain their CNS status, but Mr Driver did not agree to any proposal that guaranteed a return to their previous positions.

By letter dated 9 September 2002 Ms Quinn informed Ms Jones of her intention to resign. At around this time Ms Sullivan informed Ms Quinn that Mr Driver had agreed to make a payment to her for shift penalties she had not been paid while she was suspended. Ms Sullivan also spoke to Ms Quinn about a proposed deed of release. On 16 September 2002 Ms Sullivan emailed Ms Quinn a copy of a draft deed, which was in the following terms:

DEED OF RELEASE

This DEED is made on the 11 September 2002 between Yvonne Quinn (referred to in this DEED as the Employee) of in the State of New South Wales;

AND Macarthur Health Service Therry Road PO Box 149 Campbelltown 2560 (referred to in this DEED as the Employer).

Part A. BACKGROUND

1. The Employee was employed by the Employer from 6 April 1993 to 20 September 2002.

2. That employment was terminated by the Employee's resignation in September 2002.

3. The parties agree to settle the Employee's dispute arising from the employment on the following terms.

Part B. OPERATIVE PART

1. The Employer shall pay to the Employee the sum of $3241.20 less the appropriate tax.

2. The Employee acknowledges that the receipt of the above payment is in full and final settlement of the dispute arising from the employment with the Employer. Outstanding award claims will be honoured where proven.

3. The Employer agrees not to hinder the future employment prospects of the Employee.

4. The parties agree not to disparage either party.

5. The parties will not disclose or discuss the terms of this DEED other than as required by law or to their advisers.

SIGNED SEALED AND DELIVERED

by Yvonne Quinn: ----------

in the presence of: ----------

by Macarthur Health Service: ----------

in the presence of: ----------

The email from Ms Sullivan to Ms Quinn of 16 September 2002 which had the deed attached to it was in the following terms:

Hi Yvonne

Herewith is the deed of release to which Greg Driver has agreed having made some changes of his own.

The confidentiality clause only extends to the deed itself – this means that you can't tell others that the [MHS] *is paying you $3200. However, you are at liberty to tell others that you chose to resign, and this is in your favour if you do.*

I took out point 4 from the standard deed and Greg put it back in. This means that the matter really ends when the agreement is signed and you have your money. Greg confirmed that any proven outstanding award entitlements would not be denied to you on the basis of this agreement and he will forward originals or at least copies of your payslips to you, including details of your severance pay.

If you want this finalised by 20 September, print off a copy and sign it with your witness, a family member/ friend will suffice but the original document has to be posted back to me at NSWNA 43 Australia Street, Camperdown 2050. Don't write anything else on the deed itself, but mark the envelope, Attn : K Sullivan. I'll then let Greg know that I am in receipt of it and he can authorise your payments.

I'm in the office tomorrow on 95503244 if you want to talk. It is a big meeting day [for Ms Sullivan the next day] *but don't let that put you off.*

Regards, Kathryn

On 17 September 2002 Ms Quinn replied to Ms Sullivan's email in the following terms:

Hi Kath,

After reading this document, and giving it a great deal of consideration my decision is that I have no interest in signing such a document. I expect my termination payment, with all my due entitlements, will be paid on Sept 26th, this being the next pay day following my last day of employment. Could you please establish precisely when I will be paid the back pay that I am owed by Campbelltown Hospital … thanks for your assistance, Yvonne.

On 23 September 2002 Ms Sullivan replied to Ms Quinn's email in the following terms:

Hi Yvonne,

I acknowledge your decision and have conveyed this to Greg Driver. He has put your termination pay arrangements in train for 26 September. Please e-mail me your resignation so that I can forward it onto him. I did remind him that you wanted copies of your payslips, too. Would you confirm payment when it has been made …

Regards, Kathryn

Ms Quinn did not sign the proposed deed and did not receive the proposed payment. On 25 September 2002 Ms Quinn wrote to Minister Knowles and complained about the way she had been treated by Ms Collins and Ms Jones in relation to the disciplinary action taken against her. In that letter she did not complain about, or mention, the proposed deed of release or proposed payment and she referred to her "union advocate" in positive terms.

In September 2002 Ms Sullivan informed Ms Owen that the MHS would agree to pay her for the shift penalties she did not receive while she was suspended and asked her if she would be willing to sign a deed of release. Ms Owen rejected the proposal. No proposed deed was ever drafted in relation to her and she did not receive any payment.

By letter dated 9 October 2002, Ms Owen informed Ms Jones of her intention to resign and included the following sentence "I look forward to an accurate and prompt assessment of *all* of my entitlements". In her letter she did not complain about, or mention, the proposed deed of release or proposed payment in relation to her forgone shift penalties.

The allegations

Ms Quinn and Ms Owen were interviewed by NSW Health, the HCCC and the Commission in relation to this matter (although only the Commission investigated it). The statements Ms Quinn and Ms Owen made during those interviews may be summarised as follows:

- They initially chose to retain a private lawyer, rather than use the NSWNA, to represent them because they distrusted the NSWNA and suspected that it would side with Ms Collins because she was a former President of the NSWNA.

- Over the period during which they were suspended they were financially disadvantaged because they were paid at their base rate and did not receive any of the additional payments they would have earned if they had worked their usual hours, such as shift penalties and "on-call", "in-charge" and "overtime" allowances.
- After the meeting on 14 August 2002 they told Ms Greig and Ms Sullivan that they wanted the NSWNA to take action in the Industrial Relations Commission (IRC) to get them reinstated in their previous positions. Ms Greig and Ms Sullivan said that they would consider this but Ms Sullivan later told them that the NSWNA would not support such action because it had been advised that it would be unlikely to succeed. Ms Sullivan advised them to take the alternative positions they had been offered and said that if they did not want to do so they should resign because otherwise they would be sacked. They eventually decided to resign because of this advice.
- Ms Owen telephoned Ms Sullivan "every week" requesting her to ask for payments she believed she was entitled to and Ms Sullivan became "irritated" with her.
- Ms Sullivan told them that she would try to negotiate a "financial settlement" for them, but all they wanted was to be reinstated in their previous positions.
- When Ms Quinn informed Ms Sullivan of her intention to resign she also told her that once she had done so she was "going to go public" about the unjust way she had been treated by the MHS. She did not ask Ms Sullivan to take any further steps on her behalf. Within the next few days Ms Sullivan telephoned her and said that Mr Driver wanted to make her "a financial offer". Ms Quinn said "A financial offer for what? What do they want to buy?" Ms Sullivan replied "No, no. No, it's not about buying something, they just feel that they owe you something ... they don't want to treat this just like an ordinary resignation". Ms Quinn said "How much are they going to pay me?" Ms Sullivan replied "They are offering $3,240.20 which represents the shift penalties that you weren't paid while you were [suspended] ... that's before tax". Ms Quinn said "I would probably feel better about it if it was more and if I got my in-charge allowance as well and my on-call allowance". Ms Sullivan replied "No, they can't do that because the auditors will pick it up but they can pay you your shift penalties because the auditors won't pick that up". Ms Quinn said "What do they want? People don't give you money for nothing". Ms Sullivan replied "They will want you to sign a deed of release". Ms Quinn said "What would the deed of release … say?". Ms Sullivan replied "I'll have to work that out with him … and I will email it to you". Ms Quinn said "Oh all right". A few days later Ms Sullivan emailed Ms Quinn a deed of release and she emailed a reply saying "I'm not interested in signing this deed of release because I'm not having my silence bought for $2,000". Ms Sullivan emailed a reply saying "I respect your decision".
- In September 2002 Ms Owen informed Ms Sullivan that she intended to resign and Ms Sullivan told her that "the hospital" offered to make a financial payment to Ms Quinn if she would sign a deed of release and that it would make the same offer to her. Ms Owen said "Well, what is that in fact?". Ms Sullivan replied "The hospital will pay you $3,200 if you sign a document stating that you will not say anything to disparage the hospital". Ms Owen said "What is this? Hush money?" Ms Sullivan replied "[I] wouldn't call it that … this is the money you would've got for your shift allowances and they want to make a gesture … because they know that this matter hasn't been dealt with as it should". Ms Quinn said "No, I think that that's hush money". Ms Sullivan replied "Well, you shouldn't look at it that way". Ms Owen said that she would not sign any deed because she did not want a "gag" put on her.
- Ms Quinn and Ms Owen both regarded the financial offer made to them as "hush money". They believe that Ms Collins and Ms Sullivan are "friends" and that the MHS, SWSAHS and NSWNA conspired to "buy their silence" so they would not speak publicly about the flawed and unfair disciplinary action taken against them.

Ms Fraser has also made allegations in relation to this matter. For example:

- in her email to Minister Knowles of 25 November 2002 she wrote "The public will judge the attempted pay-off of two dedicated experienced Theatre staff … [and] the collaboration of the Nurses' Association and Area Health human resource manager, as calculated and corrupt";

- on the ABC Stateline program broadcast on 14 November 2003 it was reported that Ms Fraser had alleged that nurses were paid "above-award hush money"; and
- on a number of occasions Ms Fraser told the Commission that the author of the proposed deed for Ms Quinn was Mr Driver.

Relevant NSW Health policies

There are two NSW Health policies which are relevant to the proposed payments and deeds for Ms Quinn and Ms Owen.

Clause 3.19 of the *Accounts and Audit Determination for Public Health Organisations* issued by NSW Health in October 1998 provides as follows (emphasis added):

> *Public Health Organisations* [the definition of which in clause 2.23 includes "an area health service"] *must not enter into any arrangements with individual employees (for example Deeds of Release, termination payments etc) in respect of the settlement of any employment or industrial dispute, or on the termination of employment, which involves the payment of money or benefits to the employee over and above award or statutory conditions and entitlements, without the prior written approval of the Deputy Director-General, Operations, or Director, Employee Relations.*

NSW Health Circular 96/48, which is entitled *Payment of Shift Penalties and Other Work Related Allowances Whilst Subject to Misconduct/Disciplinary Inquiries*, provides as follows (emphasis added):

> *Where an employee, who is engaged as a shift worker on a permanent or regular basis or has worked shift work regularly for the previous 3 months, is subject to a disciplinary inquiry or misconduct investigation and is:*
>
> 1. *allocated alternative duties pending the outcome of the disciplinary inquiry or the misconduct investigation;*
> 2. *placed on duties which result in a loss of shift penalties and other allowances; and*
> 3. *subsequently advised that there is no finding of guilt against them;*
>
> *then the employee is to be reimbursed for the loss of shift penalties and other allowances that relate to work or conditions. The reimbursement is to be based on the average of any shift penalties and other work related allowances for the preceding 6 months or if the period of shift work is less than 6 months, the average for the period worked.*

The proposed deed

At the outset, it is important to appreciate that, in the context of disputes resulting in the cessation of employment in the public or private sector, there is nothing inherently unusual or improper about a deed of release with confidentiality and non-disparagement clauses like those in clauses 4 and 5 of the proposed deed for Ms Quinn. Such deeds and clauses are common: see, e.g. *Crewdson v Department of Community Services* [2002] NSWIRComm 121 at [30]; *Diver v Object Pty Ltd* [2002] NSWIRComm 138 at [8]; *Dibb v Commissioner of Taxation* [2004] FCAFC 126 at [9]; *Dawson v Catholic Education Office* [2004] NSWIRComm 54 at [14]; *Donavan and Blade on Stage Pty Ltd* [2005] NSWIRComm 1056 at [91]; *K & S Freighters Pty Ltd v Shaw* [2005] QIRComm 38; Mark Paul "Don't Disparage Me" (2001) 39 (10) *Law Society Journal (NSW)* 4.

In addition, there are a number of significant points about the terms of the proposed deed for Ms Quinn. Firstly, the confidentiality provision in clause 5 only restricts disclosure of the terms of the deed. If the deed had been executed it would not have prohibited her from disclosing information relating to the circumstances surrounding the cessation of her employment or relating to any other workplace issue.

Secondly, unlike many non-disparagement clauses, the one in clause 4 of the proposed deed for Ms Quinn is *mutual*. If the deed had been executed, clause 4 would have prohibited her from disparaging the MHS, and possibly all of its employees, but it would have also had the desirable effect (from Ms Quinn's perspective) of prohibiting the MHS, and possibly all of its employees, from disparaging her.

Thirdly, no confidentiality or non-disparagement clause (irrespective of its wording) can lawfully prohibit a person from disclosing crimes or misconduct "of public concern" to an appropriate public authority (e.g. the police, Commission, HCCC or Ombudsman): *Kerridge v Simmonds* (1906) 4 CLR 253 at 258; *A v Hayden* (1984) 156 CLR 532 at 545, 553-61, 573 and 586-87; or possibly "even to the press" under certain circumstances: *Initial*

Services Ltd v Putterill [1968] 1 QB 396 at 405; *British Steel Corporation v Granada Television Ltd* [1981] AC 1096 at 1201; *Allied Mills Industries Pty Ltd v Trade Practices Commission (No 1)* (1981) 55 FLR 125. Any clause purporting to do so would be unenforceable on public policy grounds.

Fourthly, section 21 of the *Protected Disclosures Act 1994 (NSW)* affords substantial protection to public officials who make disclosures in accordance with Part 2 of that Act, including disclosures to the Commission concerning corrupt conduct (section 10), disclosures to the Ombudsman concerning maladministration (section 11) and disclosures to Members of Parliament or journalists under certain circumstances (section 19). That protection exempts public officials from "any liability" that would otherwise arise, for example, under the terms of a deed of release. The protection would have extended to disclosures made by Ms Quinn and Ms Owen before they resigned from the MHS and disclosures made afterwards if at the time of making those disclosures they were employed by some other public authority, such as Camden Hospital or Bankstown Hospital.

Fifthly, if the proposed deed for Ms Quinn had been executed, clause 3 in the operative part would have had the desirable effect from her perspective of preventing the MHS, and possibly all of its employees, from hindering her future employment prospects.

Evidence from other witnesses

The Commission interviewed Ms Collins in relation to this matter and she stated that the proposed payments and deeds in relation to Ms Quinn and Ms Owen were negotiated by the NSWNA and Mr Driver. She stated that she had no involvement other than being informed by him that the proposals fell within relevant policies and receiving a recommendation from him that she should approve them, which she did. She stated that she was not a friend of Ms Sullivan or Brett Holmes, who was the General Secretary of the NSWNA at the relevant time and is now the President of the NSWNA. Her statements were supported by documentary and electronic records obtained by the Commission and were not contradicted by any other witness.

The Commission interviewed Ms Jones and Mr Southwell, the then CEO of the SWSAHS, in relation to this matter and both stated that they had no involvement in the proposed deeds for Ms Quinn and Ms Owen. Mr Southwell said that they were negotiated by the NSWNA and Mr Driver. Their statements were supported by documentary and electronic records obtained by the Commission and were not contradicted by any other witness.

The Commission interviewed Mr Holmes in relation to this matter and he stated that the NSWNA had decided not to take action in the IRC on behalf of Ms Quinn and Ms Owen, based on legal advice it received to the effect that there was not a high likelihood of obtaining an order for them to be reinstated. He said that he had no role in relation to the proposed deeds for Ms Quinn and Ms Owen and had no discussions with Ms Collins in relation to Ms Quinn or Ms Owen. He said that he first saw the proposed deed for Ms Quinn in 2003 and considered it to be a "standard" document used "to protect the member from being locked out of future employment" when settling a dispute which involved cessation of the member's employment. His statements were supported by documents obtained by the Commission and were not contradicted by any other witness.

Pursuant to a notice issued under section 22 of the ICAC Act Mr Holmes also produced six examples of deeds of release entered into by NSWNA members in relation to the settlement of employment disputes and all of them, three of which predated the deed proposed for Ms Quinn, contained confidentiality and non-disparagement clauses which were either similar or more restrictive than those in the proposed deed for Ms Quinn.

The Commission interviewed Bob Whyburn, principal of the firm Whyburn & Associates at the relevant time. He confirmed that his firm provided advice to the NSWNA in relation to Ms Quinn and Ms Owen. He stated that, while he agreed that they had been treated unfairly by the MHS and "may have been able to succeed on this point in the IRC, … it would be unlikely that the IRC would direct that they could go back to their old positions because of the disharmony that had been caused". He also said that "deeds of release containing confidentiality clauses and non-disparagement clauses like those in the deed offered to Ms Quinn [are] very common because they … provide closure".

The Commission interviewed Ms Greig in relation to this matter. She stated that at the meetings on 14 August 2002 Ms Sullivan submitted that the action taken against Ms Quinn and Ms Owen was unreasonable and that they should be reinstated in their previous positions, but Ms Collins said they could not return because of the way some of their ex-colleagues felt about them. She said that she had no knowledge of anyone

from the NSWNA advising Ms Quinn or Ms Owen to resign and had no involvement in the proposed deeds of release. Her statements were supported by documents obtained by the Commission and were not contradicted by any other witness.

The Commission interviewed, and obtained a written statement from, Mr Driver in relation to this matter. The information he provided may be summarised as follows:

- Some time after the meetings on 14 August 2002 Mr Driver telephoned Ms Sullivan and sought to resolve "the industrial dispute that emerged following attempts by the [SWSAHS] to place [Ms Quinn and Ms Owen] back into the health system". During the discussions he had with her she indicated that it could assist in resolving the dispute if the nurses were paid for shift penalties and overtime allowances they would have earned if they had worked during the period they were suspended. He indicated that he was not prepared to consider the payment of overtime allowances but was prepared to consider the payment of shift penalties and he undertook to calculate what the appropriate amount would be. Some time later Ms Sullivan informed him that Ms Quinn intended to resign. Ms Sullivan also "raised the desirability of a Deed of Release", "to which [he] agreed".
- In early September 2002, Mr Driver obtained a printout of Ms Quinn's payroll details and calculated the amount of shift penalties she would have earned if she had worked during the period of her suspension. He based his calculation on averages in the period preceding her suspension and he ultimately arrived at the figure of $3,241.20. The Commission obtained copies of the printout, which is dated 6 September 2002, and handwritten notes from Mr Driver which detail how he arrived at this figure.
- At the time Mr Driver was considering the proposed payment for Ms Quinn he was unaware of clause 3.19 of the NSW Health Accounts and Audit Determination for Public Health Organisations. However, he has since examined it and he believes that the proposed payment "was not contrary to this provision" because the amount proposed to be paid was calculated "by reference to" shift penalty entitlements in the award and statutory conditions which governed Ms Quinn's employment.
- At the time Mr Driver was considering the proposed payment for Ms Quinn he was aware of NSW Health Circular 96/48 and he believed that the payment was "not inconsistent" with it because most of the allegations against Ms Quinn (3 out of 4) and Ms Owen (4 out of 5) were found to be not substantiated and the single substantiated allegation was "not regarded by Ms Collins as sufficiently serious to warrant dismissal". However, he did not believe that the nurses were "necessarily entitled" to the proposed payments. In all of the circumstances, he believed that it was "reasonable" to offer the payment for the purpose of settling the industrial dispute.
- Mr Driver spoke to Ms Sullivan and informed her that the relevant amount for Ms Quinn's foregone shift penalties was $3,241.20 less the appropriate tax.
- On 10 September 2002 Ms Sullivan emailed Mr Driver a draft version of the proposed deed for Ms Quinn. That version contained non-disparagement and confidentiality provisions in clauses 4 and 5 of the operative part of the deed. Mr Driver did not change the wording of those clauses and was never asked to delete them. On 11 September he emailed the draft deed to Ms Collins with the following message "Jennifer this seems OK to me do you agree, if you agree I will have it completed and sent back to the Nurses' Association". On 12 September Ms Collins replied with the single word "agreed". Later that day he emailed the draft deed back to Ms Sullivan with a message that he had made "minor changes" (which only related to dates). Around one week later Ms Sullivan informed him that Ms Quinn had decided not to sign the deed. The Commission obtained copies of relevant email records and file notes and they fully accord with Mr Driver's evidence in relation to this issue.
- It was Mr Driver's understanding that Ms Owen would be offered a payment for forgone shift penalties and a deed similar to the one offered to Ms Quinn, but in late September 2002 he was told that Ms Owen had decided not to sign any deed. He never saw a draft deed for Ms Owen and did not calculate the amount of her forgone penalties.
- The proposed payments were never made to Ms Quinn and Ms Owen for three reasons. Firstly, they were not "necessarily entitled" to them. Secondly, "they expressly rejected the settlement of the dispute on the terms proposed". Thirdly,

it was expected that they would take action in the IRC and "it would have been irresponsible to have paid the funds without an ultimate resolution to the dispute".

- Mr Driver submitted that "[i]n circumstances where the settlement of an industrial dispute involves the termination of the employment of the worker, it is common practice for parties to enter into a Deed of Release containing, inter alia, confidentiality and non-disparagement clauses, such as those contained in the draft Deed of Release provided … by Ms Sullivan". Mr Driver further submitted that it would have been "irresponsible" for him to recommend the settlement with Ms Quinn or Ms Owen, involving financial payments, without "protecting the Area Health Service" by way of a deed of release like the one proposed by Ms Sullivan.
- Mr Driver denied that the proposed payments for Ms Quinn and Ms Owen were "hush money" or that he ever said to anyone that they would have been greater but he could not "hide" greater amounts "from the auditors".

The Commission interviewed, and obtained documents from, Ms Sullivan in relation to this matter. The information she provided may be summarised as follows:

- The ability of the NSWNA to obtain a successful outcome for Ms Quinn and Ms Owen was significantly weakened by the fact that almost three months were lost when they chose to use a private solicitor to act for them instead of the NSWNA. By the time the NSWNA came to formally represent them, Ms Collins and Mr Driver had made up their minds that Ms Quinn and Ms Owen could not return to their previous positions and would not "budge".
- In August 2002 both Ms Quinn and Ms Owen informed Ms Sullivan that they had been financially disadvantaged during the period of their suspensions because they did not receive penalties or allowances they would have been paid if they had worked, so Ms Sullivan agreed to pursue this issue on their behalf. In file notes she prepared on 13 August 2002 (copies of which were obtained by the Commission) she outlined the issues she intended to discuss at the meetings on 14 August 2002 and she noted that Ms Quinn and Ms Owen had "been financially disadvantaged while being on suspension; being unable to earn penalties and allowances for nearly four months".
- At the meeting on 14 August 2002 Ms Collins and Mr Driver refused to reinstate Ms Quinn and Ms Owen in their previous positions and after the meeting the two nurses asked the NSWNA to take action on their behalf in the IRC. Ms Sullivan subsequently met with a lawyer from Whyburn & Associates and the NSWNA's Manager of Industrial Services and they advised against commencing an action in the IRC. This advice is recorded in a file note prepared by Ms Sullivan on 19 August 2002 (a copy of which was obtained by the Commission) which also includes the following note: "I conveyed the decision to both Val and Yvonne. Both were disappointed but asked that I continue to negotiate for their lost penalties and allowances".
- Ms Sullivan never advised either Ms Quinn or Ms Owen to resign. She merely outlined all of the options they had, one of which included resignation.
- After the meeting on 14 August 2002 Ms Sullivan spoke to Mr Driver over the telephone and negotiated options for Ms Quinn and Ms Owen to return to work and retain their CNS status. On 26 August 2002 Ms Quinn agreed to accept a position offered to her at Camden Hospital, but Ms Sullivan told the Commission that on 4 September 2002 Ms Quinn told her that "she doesn't now want to go to Camden and she … wants to resign with a settlement as compensation for the matter not being handled properly". These matters are recorded in an email and file note, copies of which have been obtained by the Commission.
- During her telephone negotiations with Mr Driver Ms Sullivan "made the case that the nurses had been [financially] disadvantaged" during their suspension and he said that he would consider this issue. Her task was difficult because Ms Quinn and/or Ms Owen continually identified new "entitlements" they wanted to be paid for, such as "overtime", "on-call" and "in-charge" allowances, so she repeatedly had to call Mr Driver and ask for additional payments. She said to Ms Quinn and/or Ms Owen "I'll do whatever I can to get you the best financial outcome … to remedy … the financial disadvantage you've had". She did not believe that they were "technically entitled" to be paid for all of the penalties and allowances they

might have earned if they had worked during the period of their suspension. She regarded them all as "negotiation items". She viewed her telephone discussions with Mr Driver as "an attempt to agree upon a compensation figure with the references to forgone penalties merely used as a means of arriving at a negotiated figure". Mr Driver ultimately agreed to make a payment for forgone shift penalties, but not allowances. He said "I can't pay those because they've been paid to other people and that would be a double payment and I have to answer to the auditors". She did not believe that Mr Driver was "implying that he would have offered some unauthorised payments if he thought that they would not have been detected by the auditors". Mr Driver ultimately provided her with a figure of $3,241.20 and said it was for shift penalties.

- Ms Sullivan raised the idea of having a deed of release during her negotiations with Mr Driver. She thought it would "benefit the nurses by offering them protection such as the clause to the effect that [the MHS] would not hinder their future employment prospects". Ms Sullivan is not a lawyer and did not have much experience in drafting deeds, but she thought that the confidentiality and non-disparagement clauses in the deed she prepared were "common" because she copied them from an existing "standard deed" or "template" (a copy of which she provided to the Commission). She also thought that the deed was desirable because the nurses continually asked her to request additional payments and she was "worried" that if they did not have a deed providing for "a full and final settlement for a set amount of money" the nurses "might come back to the [NSWNA] in a few months time and say 'you didn't negotiate enough for me'". She specifically added the second sentence in clause 3 of the operative part of the deed so the nurses would not be disadvantaged in relation to legitimate award entitlements. After she initially raised the idea of the deed Mr Driver agreed and treated it as a condition of the proposed payment of $3,241.20.
- When Ms Sullivan first informed Ms Quinn and/or Ms Owen of the proposed deed one or both of them indicated that they intended to complain to Minister Knowles about the unfair way they had been treated by the MHS, so she decided to take out clause 4 (the non-disparagement clause) from the draft deed she had prepared from the "standard deed". At the time, she thought that she had deleted this clause from the draft deed she emailed to Mr Driver. When he subsequently emailed it back with a message that he had made "minor changes" and she saw that the clause was in there she "assumed" that he had put it back in. That is why she wrote in her email to Ms Quinn of 16 September 2002 "I took out point 4 from the standard deed and Greg put it back in". She now accepts that the draft deed she sent to Mr Driver contained clause 4 and blames the error on her "poor computer skills". She did not have any specific discussions with Mr Driver about clause 4 of the proposed deed.
- When Ms Quinn and Ms Owen ultimately decided not to sign the proposed deeds Ms Sullivan fully respected their decisions and did not seek to change their minds.
- The only person Ms Sullivan dealt with from the MHS or SWSAHS in relation to the proposed deeds was Mr Driver. She did not have any dealing with Ms Collins, whom she "did not know very well at the time".
- The proposed payments to Ms Quinn and Ms Owen were not "hush money". It was the result of Ms Sullivan's efforts to obtain the best financial outcome for them. The deed was not intended to prevent them from complaining to Minister Knowles or the media.

The Commission's findings

Most of the circumstances relating to this matter are not in dispute and there is high degree of commonality amongst the oral accounts provided by the different witnesses. In the Commission's view, all of the witnesses were credible and honestly recounted the relevant events as they recalled them. Any differences lay in their subjective perceptions and, in the Commission's opinion, the perceptions of Ms Quinn and Ms Owen were coloured by the unfair disciplinary action that had been taken against them and their distrust of the NSWNA because of Ms Collins' previous position as President. Under the prevailing circumstances it is understandable that they were suspicious about the proposed payments and deeds of release which were presented to them.

The Commission is satisfied that the only payments offered or proposed to be offered to the nurses were relatively small amounts which they asked Ms Sullivan to request in relation to shift penalties they were not paid during the period of their suspension. They were

arguably entitled to those payments, although this point is not free from doubt. On the available evidence the Commission is satisfied that none of the persons involved in the negotiation or approval of the proposed payments acted improperly.

The Commission is satisfied that the deeds of release were first proposed by Ms Sullivan, not an officer from the MHS or SWSAHS, and that she proposed them in good faith. Only one deed was ever prepared (for Ms Quinn) and there was nothing unusual or improper about it. It was drafted by Ms Sullivan and it was never actually executed. No pressure was placed on either nurse to enter into a deed and when they decided not to do so their decisions were fully respected. On the available evidence the Commission is satisfied that none of the persons involved in the negotiation or approval of the deeds acted improperly.

Kathrine Grover

The allegation

During an interview with officers from the Commission on 21 January 2004 Kathrine Grover alleged that after she complained about patient care issues at Liverpool Hospital the SWSAHS attempted "to get rid of" her and "silence" her by paying $15,000 and requesting that she sign a deed of release.

The facts

The Commission interviewed a number of witnesses, and obtained numerous documents, in relation to this matter. The resulting information, all of which appears in formal records and has not been contradicted, may be summarised as follows:

- Ms Grover worked as a Nurse Manager at Liverpool Hospital for a number of years and was formally employed by the SWSAHS.
- On 15 March 2001 Ms Grover submitted a workers' compensation claim in respect of an injury allegedly sustained during her employment at Liverpool Hospital. The claim was declined by the SWSAHS's insurer, GIO, on 2 May 2001. She subsequently retained a private law firm which pursued conciliation and litigation on her behalf and sought an amount many times greater than $15,000.
- On 27 June 2001 Ms Grover submitted a letter of resignation to Liverpool Hospital.
- In March 2002 the lawyers acting for Ms Grover and lawyers acting for GIO agreed to settle the claim, with Ms Grover's consent, for $15,000.
- On 18 March 2002 Ms Grover signed a document prepared by her lawyers entitled "Authority to Settle Workers Compensation Claim", paragraph 8 of which provided that she agreed to sign a "common law release" if one was requested by GIO.
- On 18 March 2002 the matter was settled in the Compensation Court on the basis that Ms Grover would receive a payment of $15,000 and would "execute a common law release if called upon to do so". On that date she signed a deed of release prepared by the lawyers acting for GIO which did not contain a confidentiality clause, a non-disparagement clause or any other type of clause which prohibited her from speaking about any issue.

The Commission's finding

The $15,000 payment and deed of release were merely part of an ordinary settlement of a workers' compensation claim. Ms Grover resigned over eight months before the payment was either offered or made and the deed of release she was asked to sign did not prohibit her from speaking about any issue. The Commission did not find any evidence of impropriety on the part of any person.

Statement under section 74A(2) of the ICAC Act

To the extent that any person is an "affected person", within the meaning of section 74A(3) of the ICAC Act, in relation to the allegations considered in this chapter of the report, the Commission is not of the opinion that consideration should be given to any of the matters listed in section 74A(2) of the ICAC Act in respect of that person.

Chapter 8: The HCCC's investigation of the MHS

A number of the complainant nurses alleged, in both public and private forums, that the investigation conducted by the HCCC from November 2002 to December 2003 into their original complaints about maladministration and misconduct within the MHS was "a whitewash", "a cover-up", "corrupt" and/or "criminal". Similar complaints were made to the Commission by other persons, some of whom were anonymous. The allegations or complaints generally related to one or more of the following issues:

- an alleged conflict of interest between Amanda Adrian, the then Commissioner of the HCCC, and Jennifer Collins, the then General Manager of the MHS;
- an alleged reluctance on the part of HCCC officers to receive information from the complainant nurses; and
- the decision of the HCCC not to investigate individual medical practitioners.

The Commission investigated these matters prior to, and subsequently in conjunction with, the SCI. As part of its investigation the Commission interviewed or obtained written statements from 18 witnesses (including five HCCC officers), reviewed a large volume of documentation relating to the HCCC's investigation and examined relevant computer records (including email records from the HCCC). Evidence gathered by the Commission was subsequently shared with the SCI, which conducted its own investigation in relation to some (but not all) of the abovementioned issues and undertook to report any reasonably suspected corrupt conduct back to the Commission under section 11 of the ICAC Act. No such reports were made.

The Commission, like the SCI, did not find any evidence of corrupt conduct in relation to the HCCC's investigation. What follows is a brief summary of the Commission's investigation and its findings.

Alleged conflict of interest between Amanda Adrian and Jennifer Collins

On 29 November 2002, shortly after the HCCC commenced its investigation, Amanda Adrian addressed MHS staff and provided an overview of the HCCC's investigation into the complaints relating to the MHS. During that address it appears that she also volunteered that she "knew" Jennifer Collins from having worked at NSW Health at the same time as her a number of years earlier and she stated that in order to avoid any apprehension of bias she intended to "distance" herself from the running of the investigation.

Some of the complainant nurses, who were not present during Ms Adrian's address, were subsequently told about what she had said and formed the belief that she had declared that she was a "good friend" of Ms Collins and stated that she would "stand aside" from the investigation altogether because she had "a conflict of interest".

Ms Adrian did put in place mechanisms to distance herself from certain aspects of the investigation, but she did not "stand aside". When some of the nurses discovered this they alleged that Ms Adrian had a conflict of interest and was biased in favour of Ms Collins. Those allegations were referred to the Commission, including by Ms Adrian herself.

Ms Adrian and Ms Collins have both denied on numerous occasions that they are "friends". They have repeatedly maintained that their relationship is nothing more than an ordinary professional association. The Commission investigated this issue and found no evidence of any type of closer relationship that could give rise to a reasonable apprehension of bias or perception of a conflict of interest, applying the test of what a "hypothetical fair-minded" person, "properly informed" of the relevant facts, "might reasonably" apprehend or perceive: *Re Refugee Tribunal; Ex parte H* (2001) 75 ALJR 982 at 990 [28]; *Hot Holdings Pty Ltd v Creasy* [2002] HCA 51 at [68].

In addition, the Commission did not find any evidence to suggest that Ms Adrian acted in a partial manner towards Ms Collins in relation to the HCCC's investigation. Indeed, her decision (referred to below) to treat the nurses' allegations as a complaint against the MHS, of which Ms Collins was the General Manager, rather than against individual medical practitioners, had the very opposite effect to that of favouring Ms Collins. Furthermore, as mentioned in Chapter One of this report, the HCCC's investigation actually substantiated many, if not most, of the nurses' allegations.

The Commission did not find any evidence of corrupt conduct in respect of the relationship between Ms Adrian and Ms Collins.

Alleged reluctance of HCCC officers to receive information from the nurses

A number of the complainant nurses alleged that HCCC officers actively, and possibly corruptly, discouraged them from providing relevant information to support their complaints. They gave the following examples:

(i) they were advised that information they provided to the HCCC would not be classed as a protected disclosure within the meaning of the Protected Disclosures Act;

(ii) they were denied an indemnity from prosecution for any offences they may have committed in obtaining the information they had to support their complaints; and

(iii) they were initially required to be interviewed separately.

The Commission considered each of these complaints and concluded that:

- the advice referred to in paragraph (i) was perfectly correct because the HCCC is not one of the agencies nominated in Part 2 of the Protected Disclosures Act as being eligible to receive protected disclosures;
- the officer who declined the request for the indemnity referred to in paragraph (ii) had no choice but to do so because the HCCC has no power to issue indemnities; and
- the practice referred to in paragraph (iii) is a standard principle of investigation designed to preserve the integrity of evidence.

In addition, Ms Fraser, in both public and private forums, alleged that a female solicitor from the HCCC made various other comments to her that were designed to discourage her from raising complaints. The HCCC solicitor denied making most of the comments attributed to her by Ms Fraser or placed them in a context different from that alleged by Ms Fraser. The SCI Commissioner, Mr Walker SC, considered some aspects of this allegation and made the following finding (Final SCI report, p. 101):

> *In light of the records from the time in question and my impressions of the versions given by* [the HCCC solicitor] *and Ms Fraser, I am satisfied that* [the HCCC solicitor's] *version is more likely to approach more closely what actually happened.*

The Commission agrees with this finding and considers it to hold true in relation to all of the disputed comments in question. The Commission did not find any evidence of corrupt conduct in relation to the dealings of any HCCC officer with the complainant nurses.

Decision of the HCCC not to investigate individual medical practitioners

A major criticism levelled at the HCCC by a number of the complainant nurses, and others, was that Ms Adrian wrongly chose not to investigate the conduct of individual practitioners implicated in their original allegations. Mr Walker fully agreed with this criticism, concluding (Final SCI report, pp. 2 & 54) that:

> *The Health Care Complaints Commission wrongly did not investigate all these allegations in relation to the individual professional conduct of the relevant practitioners …*
>
> *At no stage did the Health Care Complaints Commission ever deal with the … complaint in accordance with the provisions of the Health Care Complaints Act governing complaints against or directly involving health practitioners being doctors or nurses.*

Some of the complainant nurses had alleged that this error was another corrupt aspect of the HCCC's investigation. However, Mr Walker effectively rejected this allegation with the following comments (pp. 56-57, emphasis added):

> *Errors of law are committed nearly every day by senior public administrators, ministers and judges. To detect legal error, or unlawful conduct in the case of administrators and ministers, is very far from something discreditable about the public officer in question. The most expert and conscientious public servants, the most public spirited and diligent ministers, and the wisest and fairest judges from time to time act inconsistently with the requirements of the law. Given that many legal standards involve the formation and application of assessments in the nature of intellectual judgements about composite facts and legal tests involving drawing a line, this is not surprising.*
>
> *…*
>
> *Elsewhere in this report there are conclusions about the role of Ms Adrian as the former Commissioner*

> *in charge of the overall work of the Health Care Complaints Commission, including its Macarthur Health Service investigation. I have not concluded that there were any deliberate choices to act contrary to the legal requirements as understood by Ms Adrian. I have not concluded that there was anything in the nature of bad faith in her administration of these matters. My conclusion goes no further than finding that she was, sincerely, wrong. That is not, at least in my opinion, to her personal discredit.*

Elsewhere in the SCI report (pp. 58, 67 & 70-71) Mr Walker referred to "the responsible staff of the Health Care Complaints Commission" and "the sincerity of those who worked on the Health Care Complaint Commission's Macarthur Health Service investigation", noting that even when they had failed to comply with statutory requirements they had not acted "with any bad faith".

Mr Walker's findings and observations fully accord with the evidence obtained by the Commission. The Commission did not find any evidence of corrupt conduct in relation to the erroneous decision of the HCCC to treat the nurses' allegations as a complaint against the MHS and not also as a complaint against the individual practitioners implicated in those allegations.

Statement under section 74A(2) of the ICAC Act

To the extent that any person is an "affected person", within the meaning of section 74A(3) of the ICAC Act, in relation to the allegations considered in this chapter of the report, the Commission is not of the opinion that consideration should be given to any of the matters listed in section 74A(2) of the ICAC Act in respect of that person.

Appendix 1: Corrupt conduct defined and the relevant standard of proof

Corrupt conduct is defined in section 7 of the *Independent Commission Against Corruption Act 1988* (the ICAC Act) as any conduct which falls within the description of corrupt conduct in either or both subsections (1) or (2) of section 8 and which is not excluded by section 9 of the ICAC Act. An examination of conduct to determine whether or not it is corrupt thus involves a consideration of two separate sections of the ICAC Act.

The first (section 8) defines the general nature of corrupt conduct. Section 8(1) provides that corrupt conduct is:

> *(a) any conduct of any person (whether or not a public official) that adversely affects, or that could adversely affect, either directly or indirectly, the honest or impartial exercise of official functions by any public official, any group or body of public officials or any public authority, or*
>
> *(b) any conduct of a public official that constitutes or involves the dishonest or partial exercise of any of his or her official functions, or*
>
> *(c) any conduct of a public official or former public official that constitutes or involves a breach of public trust, or*
>
> *(d) any conduct of a public official or former public official that involves the misuse of information or material that he or she has acquired in the course of his or her official functions, whether or not for his or her benefit or for the benefit of any other person.*

Section 8(2), specifies conduct, including the conduct of any person (whether or not a public official) that adversely affects, or that could adversely affect, either directly or indirectly, the exercise of official functions by any public official, any group or body of public officials or any public authority, and which, in addition, could involve a number of specific offences which are set out in that subsection. Such offences include: official misconduct (including breach of trust, extortion and imposition) (section 8(2)(a)); bribery (s.8(2)(b)); and obtaining or offering secret commissions (section 8(2)(d)).

Section 9(1) provides that, despite section 8, conduct does not amount to corrupt conduct unless it could constitute or involve:

> *(a) a criminal offence, or*
>
> *(b) a disciplinary offence, or*
>
> *(c) reasonable grounds for dismissing, dispensing with the services of or otherwise terminating the services of a public official, or*
>
> *(d) in the case of conduct of a Minister of the Crown or a Member of a House of Parliament - a substantial breach of an applicable code of conduct.*

Three steps are involved in determining whether or not corrupt conduct has occurred in a particular matter. The first step is to make findings of relevant facts. The second is to determine whether the conduct, which has been found as a matter of fact, comes within the terms of section 8(1) and/or (2) of the ICAC Act. The third and final step is to determine whether the conduct also satisfies the requirements of section 9 of the ICAC Act.

In applying the provisions of section 9 of the ICAC Act it is appropriate to recall the approach outlined by Priestley JA in *Greiner v Independent Commission Against Corruption* (1992) 28 NSWLR 125. His Honour said that the word "could" was to be construed as meaning "would, if proved". In the course of discussing the proper construction of section 9(1)(a) of the ICAC Act, he said:

> *Despite s8, conduct does not amount to corrupt conduct unless, in the case of a criminal charge which could be tried before a jury, the facts found by the ICAC as constituting corrupt conduct would, if the jury were to accept them as proved beyond reasonable doubt, constitute the offence charged …*

Such a construction is applicable to sections 9(1)(b), (c) and (d).

A finding of corrupt conduct against an individual is a serious matter. It may affect the individual personally, professionally or in employment, as well as in family and social relationships. In addition, there is no right of appeal against findings of fact made by the Commission nor, excluding error of law relating to jurisdiction or procedural fairness, is there any appeal against a determination that a person has engaged in corrupt conduct. This situation highlights the need to exercise care in making findings of corrupt conduct.

In Australia there are only two standards of proof: one relating to criminal matters, the other to civil matters. Commission investigations, including hearings, are not

criminal in their nature. Hearings are neither trials nor committals. Rather, the Commission is similar in standing to a Royal Commission and its investigations and hearings have most of the characteristics associated with a Royal Commission. The standard of proof in Royal Commissions is the civil standard, that is, on the balance of probabilities. This requires only reasonable satisfaction as opposed to satisfaction beyond reasonable doubt, as is required in criminal matters. The civil standard is the standard which has been applied consistently in the Commission. However, because of the seriousness of the findings which may be made, it is important to bear in mind what was said by Dixon J in *Briginshaw v Briginshaw* (1938) 60 CLR 336, 362:

> *… reasonable satisfaction is not a state of mind that is attained or established independently of the nature and consequence of the fact or fact to be proved. The seriousness of an allegation made, the inherent unlikelihood of an occurrence of a given description, or the gravity of the consequences flowing from a particular finding are considerations which must affect the answer to the question whether the issue has been proved to the reasonable satisfaction of the tribunal. In such matters 'reasonable satisfaction' should not be produced by inexact proofs, indefinite testimony, or indirect inferences.*

This formulation is, as the High Court pointed out in *Neat Holdings Pty Ltd v Karajan Holdings Pty Ltd* (1992) 67 ALJR 170, 171, to be understood:

> *… as merely reflecting a conventional perception that members of our society do not ordinarily engage in fraudulent or criminal conduct and a judicial approach that a court should not lightly make a finding that, on the balance of probabilities, a party to civil litigation has been guilty of such conduct.*

See also *Rejfek v McElroy* (1965) 112 CLR 517, the report of McGregor J into Matters in Relation to Electoral Redistribution in Queensland in 1977 and the report by the Hon W Carter QC into An Attempt to Bribe a Member of the House of Assembly (Tasmania) in 1991.

As indicated above, the first step towards making a finding of corrupt conduct is to make a finding of fact. Findings of fact and determinations set out in this report have been made applying the principles detailed in this Appendix.

Appendix 2: The Commission's role

The Commission was created in response to community and Parliamentary concerns about corruption, which had been revealed in, inter alia, various parts of the public service, causing a consequent downturn in community confidence in the integrity of that service. It is recognised that corruption in the public service not only undermines confidence in the bureaucracy but also has a detrimental effect on the confidence of the community in the processes of democratic government, at least at the level of government in which that corruption occurs. It is also recognised that corruption commonly indicates and promotes inefficiency, produces waste and could lead to loss of revenue.

The role of the Commission is to act as an agent for changing the situation which has been revealed. Its work involves identifying and bringing to attention conduct which is corrupt. Having done so, or better still in the course of so doing, the Commission can prompt the relevant public authority to recognise the need for reform or change, and then assist that public authority (and others with similar vulnerabilities) to bring about the necessary changes or reforms in procedures and systems and importantly, promote an ethical culture, an ethos of probity.

The principal functions of the Commission, as specified in section 13 of the ICAC Act, include: investigating any circumstances which in the Commission's opinion imply that corrupt conduct, or conduct liable to allow or encourage corrupt conduct, or conduct connected with corrupt conduct, may have occurred; and cooperating with public authorities and public officials in reviewing practices and procedures to reduce the likelihood of the occurrence of corrupt conduct.

It is not part of the Commission's function to prosecute for offences that an investigation undertaken by the Commission may reveal. However, the Commission may form and express an opinion as to whether or not any act, omission or decision which falls within the scope of its investigation has been honestly and regularly made, omitted or arrived at, and whether consideration should or should not be given to the prosecution or other action against any particular person or persons, be they public officials or not.

I·C·A·C

Independent
Commission
Against
Corruption