



INTERIM REPORT

OF THE

SPECIAL COMMISSION

OF INQUIRY

INTO

CAMPBELLTOWN AND CAMDEN HOSPITALS

BRET WALKER SC

31 MARCH 2004

SPECIAL COMMISSION OF INQUIRY INTO CAMPBELLTOWN AND CAMDEN HOSPITALS

INTERIM REPORT

Introduction

The Governor appointed me to inquire into and report on allegations of unsafe or inadequate patient care at Campbelltown and Camden Hospitals and other related matters by Letters Patent issued on 11th December 2003. In order to ensure that the terms of reference encompassed all the nurses who had made relevant allegations about patient care at those two hospitals, I sought a minor change, accepted by the Governor on 21st January 2004. On 10th March 2004 the terms of reference were expanded to include the treatment received by the Lalic family at Camden Hospital. A copy of the current Letters Patent is annexure A to this interim report.

Powers of this Special Commission of Inquiry

The powers and duties of this Inquiry are those set out in the *Special Commissions of Inquiry Act 1983*. Principally, by subsec 4(1) of the SCI Act I am required to inquire into and report to the Governor on the matters specified in the terms of reference set out in the Letters Patent. This report is a report made as part of that task. It is interim only in the sense that there are other matters I am required to inquire into and report on before I have completed all the tasks set by the Letters Patent. It is not a provisional report: the views in it and the recommendations made in it are final with respect to the matters that are addressed in this interim report.

Under sec 7 of the SCI Act, there is a power for this Inquiry to hold hearings in public. I have not exercised that power to date, apart from the occasion on Friday 26th March 2004, which was devoted to an important question of the degree of detail about

individual cases which should be published in this interim report. I will return to that issue later. The matters which I have decided should be addressed in this interim report, and the nature of the decisions about each of them, including the process adopted to reach those decisions, combine to render hearings in public, on these particular matters, counterproductive. Further explanation of this approach is elaborated below.

As some of the recommendations made in this interim report affect certain medical practitioners and nurses, the question whether they should have been invited to answer more generally than was available for them at the hearing on 26th March naturally arises: see by way of analogy the insistence by the High Court of Australia on the need for procedural fairness even where legal rights are not affected but reputation may be, articulated in *Ainsworth v Criminal Justice Commission* (1992) 175 CLR 564. My reasons for deciding against any further opportunity, at this stage, for these doctors and nurses to be heard against my recommendations in relation to them are further elaborated below. In summary, the powers of this Inquiry extend to recommending that their conduct be the subject of statutory investigation and consideration of disciplinary prosecution – in the course of which they must be afforded what will be ample opportunities to refute any allegations against them.

This interim report will not identify those doctors and nurses. I was persuaded to this position, which had been my provisional view, by the arguments to that effect advanced by senior counsel for a number of the doctors in question on 26th March. Counsel for the nurse informants who were represented on 26th March (ie most of them) supported the approach of not naming the medical professionals in question. Together with the other aspects of the approach I have adopted in describing the cases I have addressed in this interim report, which will be explained below, this approach further justifies the decision not to entertain further answer to the allegations in question, beyond that already supplied in the files which came to this Inquiry, on behalf of these medical professionals.

As a Commissioner, I can make findings of fact and make recommendations about matters falling within the terms of reference. No Special Commission of Inquiry, including this one, could make operative decisions about the discipline of medical practitioners or nurses. That power quite properly resides with the Medical Tribunal, Nurses Tribunal and those who administer other forms of professional discipline. The law made by Parliament, relevantly the *Health Care Complaints Act 1993*, the *Medical Practice Act 1992* and the *Nurses Act 1991*, specifically provides for specialist bodies to carry out those important tasks. This Inquiry does not supplant the continued authority of the bodies and officers under those statutes, in relation to the alleged matters of poor care or misconduct at Campbelltown and Camden Hospitals.

In particular, were this Inquiry to determine, say, that some doctor should no longer be allowed to practise, not even the most emphatic statement by this Inquiry to that effect would prevent that doctor from continuing to practise. On the other hand, this Inquiry can, and does by this interim report, recommend that the conduct of certain doctors and nurses should be properly considered with a view to possible professional discipline, by the appropriate statutory bodies and procedures.

This Inquiry does not have the power to initiate proceedings before a Medical or Nurses Tribunal or any other disciplinary committee or body. That power has been granted by Parliament to the HCCC. The establishment of this Inquiry does not and cannot affect the power of the HCCC in that regard. Similarly, the HCCC has the power under its legislation to assess whether a complaint should be investigated and, if that occurs, to determine what action should be taken following that investigation, subject to complying with various procedural steps set out in the HCC Act.

This Inquiry can advise the HCCC of its views with respect to medical practitioners and nurses whose conduct comes under its scrutiny. Those practitioners in respect of whom I have formed a view that their conduct warrants investigation or further action are considered later in this interim report. This may give rise to a number of legal issues, also addressed further below.

Below, reference is also made to some proposed special legislation which would remedy what otherwise would have been difficulties in the established disciplinary processes dealing with matters about which this Inquiry makes recommendations.

The Original Complaint

Four nurses and a solicitor met with the then Minister for Health, the Hon Craig Knowles, on 5th November 2002. Each of the nurses had been employed at or was on leave from Campbelltown or Camden Hospitals. They made a range of allegations of mismanagement, patient neglect and a failure of management to address their concerns.

On that day the Minister asked the Director-General of the Department of Health to investigate the allegations immediately and interview the nurses as a matter of urgency.

On 12th November 2002, the Director of Audit within the DoH, who had been tasked with the initial investigation, reported to the D-G. She provided a summary overview of her findings, which had been made following interviews with most of the nurses who attended the meeting with the then Minister as well as two other nurses.

On 18th November 2002, the D-G referred the allegations made by the nurses to the HCCC for investigation. The HCCC was provided with a summary of the initial allegations made and the preliminary findings of the Director of Audit. The D-G indicated that further material was expected and would be forwarded to the HCCC when available.

On 21st November 2002, the Director of Audit delivered to the HCCC a statutory declaration verifying the complaint by the D-G. In addition, she provided copies of statements and evidence supplied by the nurse informants, including 18 folders of

information. She noted some material was outstanding and would be forwarded when available.

Health Care Complaints Commission investigation

Much more will be said about the HCCC's investigation in my final report. It suffices to say now that it assessed the complaint as being against Macarthur Health Service and produced an "interim Phase 1" report at the end of January 2003. This followed interviews with some but not all of the nurses and some managers and other staff within the MHS.

A copy of this report was provided to the D-G of the DoH, the Chief Executive of South Western Sydney Area Health Service and the Minister for Health. The letter accompanying that report to the D-G inexplicably stated "there have been no substantiated allegations of significant departures from State or national standards in health care". The report noted that its purpose was to update the parties to the complaint about the progress of the investigation. Nevertheless it contained some conclusions.

A preliminary investigation report was provided to SWSAHS on 18th August 2003 for the stated purpose of providing it with an opportunity to make submissions pursuant to sec 43 of the HCC Act. SWSAHS's response was provided on 20th October 2003.

The final report was provided to the D-G of the DoH and the Acting Chief Executive of SWSAHS on 9th December 2003. It is entitled "Investigation Report – Campbelltown and Camden Hospitals – Macarthur Health Service". Administratively, MHS comprises the two hospitals and some other ancillary facilities, and is part of the organization constituted by SWSAHS.

A crucial aspect of the HCCC's Investigation Report is the manner in which it concludes the analysis of 47 specific clinical incidents that occurred between June 1999

and February 2003. As noted in the Investigation Report's executive summary (p 4), the evidence obtained about those incidents strongly supported the allegations by the nurse informants about the standard of care, in some incidents so poor that the patients suffered severe deterioration in health. The Investigation Report claimed to have identified patterns of inadequate care and treatment at the hospitals.

The specific conclusions on these incidents set out extensively in Appendix A of the Investigation Report typically includes the terse conclusion thus, "Substantiated", against an entry for allegations about the quality of clinical care provided by medical practitioners and nurses. I cannot read these entries as anything other than a finding to the effect that eg the particular medical practitioners' conduct demonstrated a lack of adequate knowledge, skill, judgement or care in the practice of medicine. I turn to the legal importance of that conclusion next.

Before doing so, I note that the HCCC delivered this Report to the D-G, who published it, presumably, in reliance on the authority to do so granted by subsec 45(3) of the HCC Act. The legal significance of this occurrence, which it will be noted occurred without any medical practitioner or nurse suffering any disciplinary adjudication, is that it was quite irregular unless the HCCC was proceeding on the basis that the nurse informants' allegations were against a health organization (viz MHS) and – most importantly – were not complaints against health practitioners.

Full consideration of this sorry situation will be reserved for this Inquiry's final report, after further investigation and public hearings about the processes which produced it. However, in order to explain why this interim report is warranted, and to explain the methods adopted to prepare it, further consideration of the legal framework follows.

Legal requirements under the Health Care Complaints Act for complaint handling

For ease of reference, the summary which follows addresses the position relating to medical practitioners and does not specifically deal with the position relating to nurses. For the points which are presently relevant, there are no material differences. The two statutes at the heart of the functions for which the Health Care Complaints Commission exists in relation to the conduct of doctors are the *Health Care Complaints Act 1993* and the *Medical Practice Act 1992*. They interact in a more or less involved fashion. This is not necessarily a criticism, given the complexity of the subject matter. I will be examining and making recommendations about possible improvements to the statutory scheme in relation to complaints against health professionals in my final report. The following summary is intended to show what appears to be a serious avoidance by the HCCC of its mandatory statutory function when it received complaints concerning the conduct of medical practitioners.

A starting point is the partial definition of “unsatisfactory professional conduct” in para 36(1)(a) of the MP Act. It includes any conduct that demonstrates a lack of adequate knowledge, skill, judgement or care, by the practitioner in the practice of medicine. Under sec 37 of the MP Act, such conduct is rendered “professional misconduct” if it is of sufficiently serious nature to justify suspension of a practitioner from practising medicine or the removal of a practitioner’s name from the Register of Medical Practitioners.

An allegation that a doctor has been guilty of such conduct is obviously serious. At the lower end of the scale, inadequate care etc may well harm patients or even kill them. At the higher end of the scale, professional misconduct could well require in the public interest that a person cease to act as a doctor at all. The manifest importance to the public and as a matter of government regulation of a learned profession exercising special privileges is beyond dispute. Not surprisingly, the legislation dealing with such allegations does not give regulators an uncontrolled discretion simply to pick and choose

which complaints they will deal with, let alone to which they will apply statutory standards. The system is mandatory. It includes the identification of what is a complaint.

Complaints can be made by anybody under sec 8 of the HCC Act. It simply requires writing, particulars and a statutory declaration, in order for it to be assessed for investigation: subsecs 9(1) and (2), subsec 23(3). The HCCC staff must help someone to make a complaint if so requested: subsec 9(3).

The subject matter of a complaint may concern the professional conduct of a doctor (relevantly), or may concern a health service which affects the clinical management or care of an individual patient (a health service including hospital services): paras 7(1)(a) and (b). A complaint may also be made against a health service provider, that expression including relevantly both doctors and a health organization such as SWSAHS (or arguably MHS) being bodies that provide hospital services at Campbelltown and Camden Hospitals. The HCC Act has critical provisions for participation of other authorities such as the Medical Board (which is responsible among other things for the registration of doctors) as well as notification to persons against whom complaints are made: see eg secs 10, 16 and 17.

These are critical provisions because if the HCCC receives a complaint which is against a doctor it must notify the doctor within a fortnight. If the complaint is not against a doctor, there is no such requirement. Further, if a complaint is against a doctor, at the end of its investigation it must provide him or her with an opportunity to make submissions about its proposed action (sec 40) and it must choose to do one or more of six possible actions set out in subsec 39(1) – importantly for present purposes, this list including the prosecution of the doctor before the Medical Tribunal. Those actions do not include the option of finding an allegation “substantiated” without doing anything further.

By contrast, if a complaint is not against a doctor but is against a health organization, the list of actions from which the HCCC must choose after investigation

does not include disciplinary action against individual doctors. It does include making a report to the D-G of the DoH if it decides to make recommendations or comments to the health organization: para 42(1)(b) and subsec 42(2). It appears to me that the HCCC chose to regard the allegations by the nurse informants as not being complaints against doctors, but rather as complaints against one or other health organization.

But a complaint concerning the conduct of a doctor alleging that he or she has demonstrated inadequate care etc is, in my clear view, undoubtedly a complaint against the doctor. It is a mystery, at present, how the relatively clear provisions of secs 36 and 37 of the MP Act and 7, 16, 39 and 40 of the HCC Act, all discussed above, could have been interpreted in any other way. A complaint could scarcely allege that a doctor had demonstrated inadequate care etc (to adapt the language of sec 36 of the MP Act) without thereby be a complaint concerning his or her conduct (to adapt the language of sec 7 of the HCC Act). The fact that a health organization, which can be a health service provider just as a doctor can be (under the definition in sec 4 of the HCC Act), is also the object of a complaint clearly does not exclude the same complaint being against the doctor whose conduct is alleged to demonstrate inadequate care etc.

The very notion that a public regulator such as the HCCC could prepare a report which substantiates (to use the language of the Investigation Report) allegations of inadequate care etc on the part of identifiable doctors, without regarding those allegations as a complaint against that doctor is offensive to a sense of fairness. The possibility that the report may be published, as occurred with the Investigation Report, exacerbates the unfairness of treating such allegations in a way that avoided notification to the doctors and denied them an opportunity to make submissions against the conclusion that the allegations were “substantiated”.

Why an interim report?

As the brief narrative of this Inquiry's progress, set out below, shows, the mass of paper received by the Inquiry was early examined to identify the most likely most serious cases. This could never be completely reliable, given that it was done in order to select cases for detailed examination. As it happens, I am satisfied that the early screen has been very successful.

The "most serious" cases are, in my opinion, cases where the important function of dealing with complaints against doctors (or nurses) has miscarried or, simply, been neglected by the HCCC. In particular, the balance of accountability to the public for the quality of health services and fairness to doctors and nurses against whom allegations have been made positively requires a thorough and faithful observance of the statutory requirements noted above. The system for considering complaints is (more or less) fine, but will not work if the HCCC does not observe its detailed requirements.

The table which follows illustrates how badly the HCCC performed in complying with the straightforward requirements of the complaints system in force. It may be that this whole failure is due to the indefensible classifying of the allegations by the nurse informants as not being complaints against doctors and nurses. They were complaints of that kind. The misclassification as merely a complaint against a health organization has deprived the system of any kind of contribution by individual doctors except the incidental information which occasionally came from SWSAHS. There were not even formal notifications to the affected doctors. They have been left to find "substantiated" conclusions with respect to to allegations against them, in the Investigation Report.

Worse still, the public, as represented by the Minister for Health when announcing the appointment of this Special Commission of Inquiry, has been denied for more than a year the efficient administration of the assessment, investigation and decision by the HCCC of many complaints against a number of doctors and nurses. It has thus been denied what should have occurred in appropriate cases, viz the speedy prosecution

in the Medical or Nurses Tribunals of any practitioners who should have been subject to disciplinary prosecution.

I have been able, as a result of the processes described below, to decide that certain allegations clearly required to be assessed as fit to be investigated. After all, that is compulsory when it appears to the HCCC (acting reasonably and taking into account relevant considerations) that a complaint raises a significant question as to the appropriate care or treatment of a patient by a doctor or provides grounds for disciplinary action against a doctor (to adapt the language of subparas 23(1)(b)(ii) and (iii) of the HCC Act). Those features of a complaint will appear before investigation, as contemplated by Parliament, on the face of the material supplied, usually with an assumption that investigation will bear it out.

I have also been able, in some cases, to opine that investigation under Part 2 Div 5 of the HCC Act, and a decision under subsec 39(1), if the HCCC acted reasonably and actuated by relevant considerations, would see some of the conduct in question referred for so-called performance assessment under Part 5A of the MP Act and other conduct considered for the possibility of disciplinary prosecution.

From the nature of things, these are actions which should always occur sooner rather than later. And so long as the lapse of time does not render them irreparably unfair, such actions will often be better late than never. For these reasons, if this Inquiry's conclusions and recommendations can achieve as prompt a resumption or commencement of formal investigation of the more serious allegations, I should do so as soon as possible. Hence this interim report.

COMPLIANCE WITH HEALTH CARE COMPLAINTS ACT 1993 AS AT 9th DECEMBER 2003

Excluding duplicates and unidentified incidents

HCCC No.	Date of Incident	Date of First Complaint	Date of Complaint to HCCC or identifying information provided	Published Conclusion/Description	Consult Reg'n Board	Notify Health Practitioners	Assessed By HCCC Under Act	Completion of Investigation into Individual Health Practitioners	Statutory Compliance
1	15/1/02	21/1/02 to MHS	28/11/02	Yes	No	No	No	No	No
2	17/10/01 - 30/10/01	N/A	28/11/02	Yes	No	No	No	No	No
3	12/12/02	13/12/02 to MHS	00/12/02	Yes	No	No	No	No	No
4	6/10/01	N/A	Not known	Yes	No	No	No	No	No
5	13/6/01	N/A	28/11/02	Yes	No	No	No	No	No
7	14/2/01	N/A	00/12/02	Yes	No	No	No	No	No
10	25/11/01	N/A	Not known	Yes	No	No	No	No	No
11	14/7/02	N/A	28/11/02	Yes	No	No	No	No	No
12	28/6/02 - 13/7/02	N/A	28/11/02	Yes	No	No	No	No	No
13	19/7/02	N/A	28/11/02	Yes	No	No	No	No	No

HCCC No.	Date of Incident	Date of First Complaint	Date of Complaint to HCCC or identifying information provided	Published Conclusion/Description	Consult Reg'n Board	Notify Health Practitioners	Assessed By HCCC Under Act	Completion of Investigation into Individual Health Practitioners	Statutory Compliance
14	5/7/02 - 15/7/02	N/A	28/11/02	Yes	No	No	No	No	No
15	6/10/01 - 7/10/01	14/1/02 to MHS	(i) 28/11/02 (ii) Pre 05/03	Yes	No	No	(i) No (ii) Conciliation but no consent given by complainant; matter dealt with by direct resolution	No	No
16	25/8/01 - 26/8/01	N/A	28/11/02	Yes	No	No	No	No	No
17	8/7/02 - 13/7/02	N/A	28/11/02	Yes	No	No	No	No	No
18	05/1/01-06/1/01	00/03/03 to MHS	(i) 13/3/03 from husband (ii) 14/3/03 from Nurse Informant	Yes	(i) No (ii) No	(i) No. SWSAHS notified on 5 May 2003. Not within 14 days required by Act (ii) No	(i) On 27 August 2003. Not within 60 days required by Act. No statutory declaration obtained before or during investigation Decision made not to consider complaint against medical practitioner on 27 August 2003 (ii) No	No	No

HCCC No.	Date of Incident	Date of First Complaint	Date of Complaint to HCCC or identifying information provided	Published Conclusion/ Description	Consult Reg'n Board	Notify Health Practitioners	Assessed By HCCC Under Act	Completion of Investigation into Individual Health Practitioners	Statutory Compliance
19	?14/07/02	N/A	28/11/02	Yes	No	No	No	No	No
21	5/7/02 - 6/7/02	N/A	28/11/02	Yes	No	No	No	No	No
22	11/6/01	N/A	Not known	Yes	No	No	No	No	No
23	6/10/01	N/A	00/12/02	Yes	No	No	No	No	No
24	10/2/02	N/A	28/11/02	Yes	No	No	No	No	No
26	13/1/02 - 9/3/02	N/A	28/11/02	Yes	No	No	No	No	
27	14/5/00 - 15/5/00	N/A	05/03/03	Yes	No	No	No	No	No
30	29/6/00 - 3/7/00	N/A	14/03/03	Yes	No	No	No	No	No
33	3/11/01 - 6/11/01	N/A	28/11/02	Yes	No	No	No	No	No
34	9/6/01 - 16/6/01	N/A	14/03/03	Yes	No	No	No	No	No
35	23/10/02 - 24/10/02	N/A	Not known	Yes	No	No	No	No	No
36	13/2/03 - 14/2/03	N/A	Not known	Yes	No	No	No	No	No
37	19/2/03 - 21/2/03	N/A	Not known	Yes	No	No	No	No	No

HCCC No.	Date of Incident	Date of First Complaint	Date of Complaint to HCCC or identifying information provided	Published Conclusion/Description	Consult Reg'n Board	Notify Health Practitioners	Assessed By HCCC Under Act	Completion of Investigation into Individual Health Practitioners	Statutory Compliance
38	19/1/03 - 20/1/03	N/A	14/03/03	Yes	No	No	No	No	No
39	22/1/03	Prior to 30/1/03 to MHS	(i) 11/02/03 from the patient's husband. On 11/03/03 complainant advises HCCC that he is highly critical of treating doctor (ii) 14 March 2003 from Nurse Informant (iii) On 23 June expert panel identifies medical practitioner as practitioner who may have demonstrated a lack of knowledge, skill, judgment or care.	Yes	(i) No (ii) No (iii) Consulted on 30/07/03 concerning medical practitioner	(i) Notified on 21/08/03. Not within 14 days required by Act (ii) No (iii) Notified on 21/08/03. Not within 14 days required by Act	(i) 07/03/03. (ii) No (iii) 30/07/03 complaint against medical practitioner assessed for investigation	(i) No (ii) No (iii) No	In part
40	29/11/02	N/A	00/03/03	Yes	No	No	No	No	No
41	10/6/02	N/A	03/12/02	Yes	No	No	No	No	No
42	10/6/04	N/A	03/12/02	Yes	No	No	No	No	No

HCCC No.	Date of Incident	Date of First Complaint	Date of Complaint to HCCC or identifying information provided	Published Conclusion/Description	Consult Reg'n Board	Notify Health Practitioners	Assessed By HCCC Under Act	Completion of Investigation into Individual Health Practitioners	Statutory Compliance
43	18/4/02	N/A	28/11/02	Yes	No	No	No	No	No
44	27/6/99	N/A	28/11/02	Yes	No	No	No	No	No
45	28/4/02	N/A	28/11/02	Yes	No	No	No	No	No
46	26/6/01	N/A	28/11/02	Yes	No	No	No	No	No
59	30/6/01	N/A	00/12/02	Yes	No	No	No	No	No
60	23/6/01 - 25/6/01	N/A	00/12/02	Yes	No	No	No	No	No
61	Mid 2002	27/06/02 to MHS	05/12/02	Yes	Yes	No	Yes on 18/12/02 for conciliation Assessed on 14/5/03 for investigation	No	In part
62	11/7/02 - 30/7/02	N/A	28/11/02	Yes	No	No	No	No	No
63	10/8/99 - 14/8/99	N/A	20/03/03	Yes	No	No	No	No	No
65	18/5/01 - 21/5/01	N/A	Not known	Yes	No	No	No	No	No
66	26/9/01	N/A	Not known	Yes	No	No	No	No	No
67	31/12/01 - 16/1/02	N/A	Not known	Yes	No	No	No	No	No
68	26 /11/01	N/A	Not known	Yes	No	No	No	No	No

HCCC No.	Date of Incident	Date of First Complaint	Date of Complaint to HCCC or identifying information provided	Published Conclusion/Description	Consult Reg'n Board	Notify Health Practitioners	Assessed By HCCC Under Act	Completion of Investigation into Individual Health Practitioners	Statutory Compliance
69	30/12/01	N/A	Not known	Yes	No	No	No	No	No
70	6/12/01 - 18/2/02; 14/7/02 - 19/8/02; 31/12/02 - 1/1/03.	N/A	Not known	Yes	No	No	No	No	No

The Inquiry's progress

On and from 20th December 2003, the Inquiry placed advertisements in newspapers published in Sydney including specifically in the Macarthur area, seeking information and the expression of views. The Inquiry has also received 115 written responses, many about the treatment received by individuals and some commenting on issues of reform of the health system.

Health Care Complaints Commission Report

The first term of reference requires consideration of the HCCC's report which recorded its investigation and findings concerning allegations made about the treatment provided to 69 patients at Camden and/or Campbelltown hospital between 1999 and 2003. The report did not name the patients or the practitioners, instead a number was allocated to represent each allegation. 71 numbers were used although they refer to the care received by 69 patients.

The Inquiry sought all the HCCC files at an early stage and was given over 180 folders containing information gathered by the HCCC during its investigation. The contents of those folders have been reviewed by Inquiry staff.

In 21 of the 69 cases the HCCC had been unable to identify the patient from the information provided by the nurse informants or from other available sources. Accordingly, there was no investigation of those matters by the HCCC. More will be said about these later.

The remaining 48 of the 69 cases were investigated by the HCCC. Prior to being considered by the HCCC, some of them had been reviewed, in some form or another, by the MHS.

The Inquiry's review of the allegations under its first term of reference commenced by categorising each of the 48 identified cases according to the seriousness of the conduct of individuals involved in the delivery of care to patients. The most serious were reviewed first.

As part of that review, the Inquiry has communicated with each patient or family member whose treatment was the subject of comment in the HCCC report. The Inquiry has obtained the medical records for each patient from MHS and any other hospital where they relevantly received treatment. 17 summonses for the production of documents have been issued, mainly to MHS, seeking medical and other records. MHS also assisted us to identify the names and positions of various medical practitioners and nurses, a no mean feat, given the legibility of some of the medical records.

The Inquiry also sought, received and considered the submissions made by any of the nurse informants. In addition, submissions by the patient or family of the patient and the findings of any review conducted by MHS into the treatment of the patient were taken into account. 18 folders of material were obtained from SWSAHS which have been reviewed. The SWSAHS is the agency responsible for the MHS which in turn is responsible for the operation of the two hospitals.

The Inquiry then engaged the services of six experts in the fields of emergency medicine, psychiatry, anaesthetics, nursing, obstetrics and gynaecology and surgery. The Inquiry has met with each of the experts at least once and with a couple of them on four or so occasions to understand the treatment afforded to each patient in each case and the standard of care provided by each relevant medical practitioner or nurse. Their assistance has been extremely valuable and indeed essential.

After gaining an understanding of the clinical issues, I interviewed each nurse informant in relation to each case in which they were involved in the delivery or review of patient care. All eight nurses were interviewed, one over a number of sessions. Over

25 hours of interviews with the nurses have been conducted thus far generating over 500 pages of transcript.

During those interviews, most of nurses were legally represented and the inquiry greatly benefited from the assistance provided by those lawyers prior to and during the interview process. Directions were made from time to time, restricting the publication of material arising from these interviews and provided during the preparation for them.

At the interviews, the views of each nurse were sought on the clinical issues involved and importantly, what further action they believed should be taken, additional to, or different from, that recommended by the HCCC.

A number of other interviews with participants in the treatment delivered or family members of patients have also been conducted.

My initial goal has been to identify those health practitioners, whose apparent conduct warrants investigation with a view to some form of action, including disciplinary action, being taken with respect to them. With the benefit of the opinions of the nurses, other participants in the care of some patients, family members and those expressed by the inquiry's experts, I have been able to reach final or provisional conclusions about the standard of care delivered in 44 cases. The final four will be resolved shortly.

Conduct warranting investigation

As follows from the opinion expressed above about the HCC Act, where I have formed the view that the conduct of a medical practitioner or nurse warrants investigation with a view to disciplinary action being considered, I have informed the HCCC of that opinion. Practically, that means that that information becomes the subject of a complaint to the HCCC. Then, the provisions in the HCC Act according procedural fairness operate with the effect that each practitioner will be afforded opportunities to know the complaint

against him or her and respond to it and to any action the Commission may propose at the end of the investigation.

At the time of writing this report, I have formed that view in relation to 12 medical practitioners in respect of the care of ten patients and I recommend that the HCCC investigate the conduct of each of them. I have made substantial progress in identifying those nurses whose conduct warrants investigation by the HCCC. I hope to be in a position to recommend publication of a further interim report about their conduct before the end of April.

I have decided not to name the practitioners whose conduct I believe warrants further attention. Had their conduct been properly investigated by the Commission from the beginning, they would not be subject to any publicity, indeed the Act requires that their details not be disclosed, if and until they reached a relevant Tribunal hearing. And then the power to direct that certain matters including the identity of the practitioner not be published resides in the relevant Tribunal. I do not propose that they be subject to any more publicity through my process than otherwise would be the case.

I have, however, decided to provide a brief description of the condition of the patient and the treatment or lack of treatment provided by each of the medical practitioners. As that may permit some to identify the practitioners concerned, I wrote to each of them advising that I proposed to take this course of action and inviting submissions as to publication of such details. I have taken into account the submissions received.

For the purposes of this report I will call the medical practitioners Dr 1 through to Dr 12.

Dr 1 was a visiting medical officer (surgeon). Drs 2 and 3 were surgical registrars. Dr 1 obtained consent from the relative of a patient to perform a mastectomy on the patient. The consent form was incomplete and referred to the wrong site for the

mastectomy. The procedure was performed with each of Drs 1, 2 and 3 participating. The wrong breast was removed. The diseased breast was later removed.

Dr 4 was a career medical officer (locum). In relation to a patient who had fallen next to the bed, he recorded in the medical notes the results of an examination he carried out of the patient. An x-ray and examination the following day detected a pelvic fracture. Dr 4 had not recorded that he detected a pelvic fracture. It is alleged by a witness that Dr 4 did not carry out the examination which he had recorded in the medical records.

Dr 5 was a visiting medical officer (surgeon). Dr 2 was a surgical registrar. Dr 5, assisted by Dr 2, performed a laparoscopic cholecystectomy on a patient. The patient died five days after the surgery, it appears from post operative intra abdominal sepsis. This condition had not been promptly diagnosed or treated.

Dr 6 was a visiting medical officer (physician) who had visiting rights at Campbelltown and Camden Hospitals. He discharged two patients from hospital, one of whom died before reaching home, the other died within less than 24 hours after discharge.

Dr 7 was a visiting medical officer (surgeon) who had visiting rights at Campbelltown and Camden Hospitals. Dr 8 was a career medical officer (emergency). Each had responsibility for the care of an elderly patient who developed an ischaemic foot. Dr 8 did not diagnose the condition. Dr 7 did not review the patient when the diagnosis was made by a third medical practitioner.

Dr 7, a visiting medical officer (surgeon) and Dr 8, a career medical officer (emergency) treated a patient who presented with a possible perforated peptic ulcer. A period of about 12 hours elapsed before the patient was transferred from a hospital which did not perform other than day surgery, to one that did. The patient died six days after the transfer.

Dr 9 was a career medical officer (emergency) who attended a patient who had attempted suicide. He is recorded as having prescribed and administered a drug to which the medical notes indicated the patient was allergic.

Dr 10 was a career medical officer (anaesthetics). Dr 11 was a visiting medical officer (physician). Drs 10 and 11 treated a patient who had acute asthma. Dr 11 is recorded as providing certain advice to Dr 10. Dr 10 is recorded as not following that advice. Dr 10 administered certain drugs to the patient. The patient died four hours after admission to the hospital.

Dr 12 was a career medical officer (emergency) who treated a patient who attended acutely unwell. The patient's systolic blood pressure was low and the patient required resuscitation. Dr 12 did not contact the visiting medical officer promptly. He did not resuscitate the patient who died some 12 hours later after being transferred to another hospital.

Conduct warranting performance assessment

The Health Care Complaints Act provides that the HCCC can refer a complaint, or part of a complaint to another person or body if, during the assessment, it appears that the complaint raises issues which require investigation by the other person or body (s.26).

Part 5A of the Medical Practice Act permits the Medical Board to have the professional performance of a registered medical practitioner assessed if it comes to its attention that that person's professional performance is unsatisfactory. Professional performance refers to the knowledge, skill or care possessed and applied by the practitioner in the practice of medicine. Unsatisfactory means below the standard reasonably expected of a practitioner of an equivalent level of training or experience.

At the time of writing this report, I have formed the view, and recommend that the conduct of five medical practitioners in relation to their treatment of five patients be

considered by the HCCC for referral to the Medical Board pursuant to s.26 with a view to performance assessment. For the purposes of this report I will call them Dr A through to Dr D. Dr 12 is the fifth medical practitioner.

Dr 12 was a career medical officer (emergency) who did not accurately diagnose a patient who ultimately died.

Dr A was an obstetrics and gynaecology registrar who treated a pregnant woman with a history of asthma. The specialist obstetrician was not asked to attend the patient until about four hours after her presentation. She was transferred to another hospital where she and her baby survived.

Dr B was a career medical officer (emergency) who treated a patient who had presented with sharp pain. Dr B recommended to the visiting medical officer Dr 6 that the patient be discharged, ten hours after presenting. The patient died less than 16 hours later.

Dr C was an intensive care registrar who conservatively treated an elderly patient. There was no record of discussions between Dr C and the patient or the patient's family concerning end of life matters.

Dr D was a medical registrar and Dr C an intensive care registrar. The medical practitioners treated a patient who attended the hospital at about 4.30 am and ultimately died some seven hours later. For a lengthy period following the admission, the medical practitioners did not prescribe antibiotics.

Unidentified allegations

As indicated, the HCCC was unable to identify the patient in 21 of the cases in which the nurses raised allegations of inadequate patient care. Efforts have been made by the Inquiry to identify those cases. There has been some success in this area. To date, of the

21 allegations not identified by the HCCC, 12 have been identified during the course of the Inquiry. Of these, five have been identified as duplicates of other cases investigated by the HCCC. The patients' names have been ascertained in the remaining 7 cases which are now being investigated by the Inquiry. The remaining nine have not been able to be identified by the Inquiry. More will be said in the final report about the efforts of the HCCC and others in this regard.

Additional Allegations

The second term of reference requires inquiry into allegations of unsafe or inadequate patient care or treatment at Campbelltown or Camden Hospitals made by any of the eight nurse informants during the Inquiry.

Following extensive correspondence with the nurses' legal representatives as well as discussions during interviews, there have been 56 allegations made to the inquiry. Some of these are very broad in nature, some not attended by sufficient information to enable the Inquiry to identify the patient or practitioner. Of the remaining allegations, real progress has been made in reviewing the conduct of the practitioners concerned. The Inquiry is in the process of communicating with each patient or family member, where they can be identified, whose treatment has been the subject of allegation by a nurse.

Conclusions should be able to be formed over the coming weeks about the allegations which form the second term of reference.

Future progress

I am continuing the process of identifying those cases or incidents arising from the MHS investigation in which further investigation is warranted to deal with individual accountability. I believe that most of those have been considered, however, for more prudent caution, I note at this stage that there may be more medical practitioners whose

conduct warrants investigation by the HCCC. As indicated above, there will be nurses whose conduct, in my view, warrants investigation.

The general performance of the HCCC in relation to the MHS investigation and its administration and regulatory arrangements will be dealt with in my final report. Public hearings will be announced shortly in which the conduct of the HCCC in the investigation will be the subject of evidence. In addition, there will be a public hearing into the response of the SWSAHS to the complaints made to the HCCC.

I also propose to hold discussions in public concerning the way forward for Camden and Campbelltown Hospitals and for the HCCC. Announcements will be made in due course.

A theme appeared in some of the responses by SWSAHS to the HCCC which has been echoed in certain public comment, with which this Inquiry will engage in its next phase. The idea appears to be that the investigation of individual doctors and nurses in response to complaints which allege that their conduct had demonstrated inadequate care etc is somehow inappropriate. It is evident from this interim report as a whole that, whatever my views may be on the question of broad policy, Parliament has clearly decided that such complaints must be considered and, depending on their merits, will result in individuals being held to account by formal disciplinary processes.

In the next phase of this Inquiry, opportunities will be provided for those who espouse the view that the medical and nursing disciplinary system is excessively concerned with blame and thereby sacrifices systemic improvement, to explain and defend it. For my part, as a preliminary to the next phase, I should say that this Inquiry to date discredits the notion that individual accountability through professional discipline is inconsistent with systemic improvement of clinical care and institutional administration. The health system requires individual professionals to do their work well. Improvement of the system cannot possibly require removal of the possibility of disciplinary sanction for those who fall badly below proper standards of conduct. It will be interesting to

discover in the next phase how serious these suggestions are, which have been reported to the effect that the disciplinary system is an impediment to improvement of the health system.

The next phase of the Inquiry will also consider some proposals of which I have very recently been made aware, by which formal arrangements are made for continuous attention to systemic improvement, apart from, independent of but informed by the disciplinary system administered by the HCCC and the registration authorities. The proposal can be labelled as one for the “Clinical Excellence Commission”. It is evidently based on recent experience with the Institute of Clinical Excellence and represents an attempt to enhance and boost that kind of approach.

As a preliminary to the next phase, in this regard, I record my emphatic view that the body charged with addressing health care complaints should not have, or see itself as having, a frontline rôle in the monitoring, for the purpose of improvement, of clinical care and related services in our health system. Rather, the intelligence which should be used for continuous improvement will include but will not be restricted to the harsh lessons of disciplinary complaints determined adversely against doctors, nurses and hospitals. It is inherently unlikely that an approach to continuous improvement which restricted itself to the lessons thrown up by dealing with delinquent or incompetent practitioners would be an adequate means of discharging that function.

Health Care Complaints Commission in 2004

Until recently Bill Grant was the Acting Commissioner of the HCCC. I understand that he has introduced a number of structural and administrative changes since he took office in early December 2003. Importantly in relation to the investigation of the conduct of practitioners at Campbelltown and Camden Hospitals, arising from its investigation as well as from complaints from other sources, he has established a separate team. I understand that it does not comprise any of those HCCC staff involved in the MHS investigation, and is headed by counsel from the private bar and located away from

the HCCC's offices. This accords with the view I hold, which I had earlier expressed to the then Acting Commissioner.

In addition, I am told that he proposes to involve legal and medical input at an earlier stage in the assessment and investigation process and secure additional expertise and resources for the investigation of cases. He has set a performance standard for the Commission that requires 90% of investigations to be completed within 12 months of commencement. A strategy to address the backlog of investigations has been developed and is currently being initiated.

My final report will contain a detailed assessment of the Commission's performance in the MHS investigation as well as recommendations in relation to its regulatory and administrative structure.

Remedial Legislation

As I indicated above, I am conscious that the HCCC, the registration authorities, professional standards committees and the Medical and Nurses Tribunals remain the bodies to make determinations with respect to investigations and disciplinary action, and to carry out other related functions in relation to registered health practitioners. This Special Commission of Inquiry is not an ad hoc substitute for any of them.

Necessarily, I have formed and will continue to form opinions about the conduct of medical practitioners and nurses at Campbelltown and Camden hospitals. Those opinions have been and will be expressed to the HCCC with the intention that they will be taken into consideration. As the legislation does not contemplate or permit such interventions, subsequent prosecutions may be subject to argument that they are unlawful because of this interference in the decision making process which preceded them. In my opinion, this is by no means an argument which may safely be ignored.

There has already been a deplorable delay in investigations and prosecutions. In order that those practitioners whose conduct require it, face disciplinary bodies, I am of the opinion that consideration should be given to legislation which protects the actions taken by the HCCC following any recommendations expressed by me or my Inquiry. I have had the benefit of reviewing draft legislation designed to have this effect and I recommend that draft as the kind of legislation urgently needed to permit these overdue investigations and possible prosecutions to be completed on their merits.

Publication

It is arguable that a recommendation that this interim report be published is governed by subsec 10(3) of the SCI Act. If so, I so recommend. Alternatively, because the whole point of this interim report is that the public has been denied the benefit of the accountability which should have been afforded by certain complaints being dealt with under the HCC Act properly, in my opinion it should of its very nature be published.

The currently confidential records of the Special Commission contain a document identifying by name the practitioners who have been given coded designations in this interim report. That document is not part of this interim report. It may form part of the final report. It is unlikely that I will recommend that it be published. Publicity in relation to disciplinary action should, as near as practicable, be the same for the doctors and nurses dealt with by this Inquiry as it would have been had they been dealt with by the existing system, and should certainly be the same as has applied in the past and currently to other health professionals. By way of illustration, in practice and by reason of statutory secrecy provisions that will usually prevent identification of such doctors or nurses until the commencement of hearings in a Tribunal, and perhaps not until an adverse finding against them: see sec 37 of the HCC Act and cl 6 of Sched 2 of the MP Act.