

SPECIAL COMMISSION OF INQUIRY
INTO ACUTE CARE SERVICES IN NSW HOSPITALS

Before Mr Peter Garling SC, Commissioner

At Bathurst Convention & Function Centre
Howick Street, Bathurst

On Monday, 17 March 2008, at 10am

Counsel Assisting: Mr Terence Tobin QC

Solicitor to the Inquiry: Ms Catherine Follett

. 17/3/2008

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1 THE COMMISSIONER: Good morning, ladies and gentlemen.
2 This is a sitting of the Special Commission of Inquiry into
3 Acute Care Services in NSW Public Hospitals. It's
4 necessary that in commencing this sitting I give the
5 following direction. Having directed on 6 February 2008
6 that it is desirable, by reason of the content of the terms
7 of reference and the nature of the inquiry, that all
8 hearings take place in private, I direct the hearing today
9 at Bathurst, on 17 March 2008, is to take place in public.

10
11 The purpose of today's hearing is so I can receive
12 evidence from workers, in the health sector in Bathurst and
13 from its surrounds, who wish to draw my attention to any
14 matters that relate to my terms of reference. It's also so
15 that I can hear from any members of the public, or anyone
16 who has been a patient, or has had experience of patient
17 care at the Bathurst Hospital, or indeed any other public
18 hospital, either in this region or another.

19
20 It is necessary in the course of these hearings for
21 witnesses to be sworn in. They will have to take an oath,
22 or make an affirmation to tell me the truth. That's
23 necessary for a couple of reasons. One is, I'm not
24 interested in anything other than the truth. The second is
25 that it provides to witnesses protection against
26 discriminatory action, defamation or any other adverse
27 consequences of giving me evidence and telling me the
28 truth.

29
30 I need to remind those who wish to give evidence that
31 what they say will be recorded, and so that when speaking
32 they will need to keep in mind that the recorder has to
33 keep up with them, and if they go too fast their words will
34 be lost.

35
36 The other matter that I wish to draw to everybody's
37 attention is that this is an Inquiry into acute care
38 service in all of NSW public hospitals. I do not have a
39 commission which roves into the entirety of the healthcare
40 system, although clearly there are matters which affect the
41 delivery of acute care services, which are not directly
42 those service themselves.

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44 What I am interested in is hearing about what the
45 position is on the ground, how those service are being
46 delivered, what the problems are in the delivery of those
47 services, and what the solutions are that maybe people can

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suggest to me.

I have been provided with a list of those who wish to give evidence, and I will call them forward. They will be asked to take an oath or make an affirmation. I will ask them some details about who they are and then I will invite them to tell me what they wish to tell me. Mr Tobin, of Queen's Counsel, who is present, is my senior counsel assisting. Either he or I may ask questions, but the purpose of these hearings is not to conduct some adversarial inquiry, but is to find out with sufficient specificity the details we need to help us in this Inquiry.

I'm very grateful to see a significant number of people here this morning and I am grateful for your attendance. Perhaps against those introductory remarks, we might commence.

1 < CHRISTOPHER HALLOWAY, sworn: [10.08am]

2
3 THE COMMISSIONER: Q. Would you mind giving me your full
4 name?

5 A. Dr Christopher Halloway.

6
7 Q. What is your present role at the Bathurst Hospital?

8 A. I'm the Chair of the Medical Staff Council at the
9 Hospital, and I have been in rural specialist practice
10 since 1981, half the time in Dubbo and half in Bathurst.

11
12 Q. What is your particular specialty?

13 A. Obstetrics and gynaecology.

14
15 Q. Has the half of time since 1981 in Bathurst been the
16 more recent half?

17 A. That is correct, yes.

18
19 Q. That is about 12 years or so in Bathurst?

20 A. Yes.

21
22 Q. What would you like to draw to my attention?

23 A. I'm making a submission on behalf of the Medical Staff
24 Council and also at the behest of the AMA. I would like to
25 look at four points of relevance to clinical care in the
26 area.

27
28 Point one is the use of clinicians as management
29 advisers. There appears to be an obvious disconnect
30 between clinicians and management. We need a clinical
31 board of general practitioners, and other specialists, to
32 inform management of local community health needs, and to
33 advise of possible outcomes of management decisions. The
34 clinicians will stay the course, only if their advice is
35 given the respect of a hearing and the likelihood of
36 acceptance. In rural practice, it can be inappropriate for
37 Dubbo clinicians to advise on Bathurst needs and vice
38 versa, and thus we need the facility for local input for
39 local needs.

40
41 The second point is the workforce planning. For a
42 rural health care, it's important for NSW Health to
43 facilitate the specialist colleges training role for
44 general, rather than subspecialty specialists. As a more
45 basic need, the numerical expansion of medical students
46 into rural hospitals requires that NSW Health work closely
47 with the local clinicians, as well as the universities, in

1 setting the balance between service and education needs.
2 Rural clinicians have a high service workload and require
3 an increase in their numbers to adequately train students.
4 Departments need more infrastructure in personnel as well
5 as equipment. This development should be facilitated by
6 NSW Health, rather than await the asking. Unless our
7 students and post-graduates have a rewarding rural
8 experience, why would they return to serve?
9

10 Third point: role and services in hospitals. We need
11 an area consultative process with representatives of
12 clinicians from all its hospitals to determine and support
13 networked role delineations across our facilities. This
14 should be done with a primary aim of consistent and safe
15 services.
16

17 The fourth point: Area amalgamation. There are
18 positives here, as implicit in the previous point. Concern
19 is raised, however, to the strains that being rural places
20 on standards and on safety. Communication and travel are
21 the key determinants in addressing these concerns.
22

23 I would like to thank the Commission on behalf of the
24 medical staff council.
25

26 Q. If I could just ask some questions, if you wouldn't
27 mind. There is an area health advisory council, isn't
28 there, in this area of health service?

29 A. That's right, yes.
30

31 Q. What is the break-up of that? Is it partly
32 clinicians, partly community representatives?

33 A. I believe so. But, the reason I believe so is that I
34 don't see it as very representative nor active.
35

36 Q. That saves me the next question which was what sort of
37 interaction, if any, do you have with it, and the answer
38 seems to be little, if any.

39 A. Yes, I think it's a good idea but I would have thought
40 maybe the construct would work better if there were
41 representatives directly taken from, in our circumstance,
42 the medical staff councils, because they wouldn't be there
43 if they weren't locally representative.
44

45 Q. You also drew, in your first point, to my attention
46 the divide between clinicians and management. That's
47 something that the Inquiry has heard about in a number of

1 other areas and locations. You suggested that a clinical
2 board would be an appropriate model of addressing that
3 divide. This area of health service has a particular
4 feature about it which is its geographic size, compared
5 with the other area health services. Do you have in mind
6 one clinical board for the whole area health service or
7 perhaps smaller boards, one in Bathurst, one in Orange, one
8 in Dubbo, for example of that kind, or do you not have a
9 view about that?

10 A. I do, and I think the development towards clusters
11 within the area health service may form the basis of an
12 answer. Perhaps a cluster of Orange and Bathurst would be
13 appropriate, because at least within there, and with the
14 constraints of travel, can be gained adequate face-to-face
15 discussion with one's colleagues. The video conferencing,
16 as such, would facilitate the more global area meetings,
17 but I don't think you can replace the face-to-face.

18

19 Q. Would you see that board as having both a review
20 function, looking at the performance of clinical services
21 in the cluster for example, as well as an advisory function
22 about improving models of care going forward?

23 A. I think certainly the second, where the first engaged
24 a certain expertise in management, then I would hope
25 management would perform a lot of that function, engaging
26 clinicians where they really would be most useful.

27

28 Q. One of the matters that has been drawn to our
29 attention, again as we go around, is that improved models
30 of care, and improved quality and safety of care, needs to
31 be largely driven by the clinicians, be they medical or
32 nursing staff, rather than being imposed on a statewide
33 basis. Is that something you would agree with?

34 A. To an extent. I don't see any necessary problem by
35 being imposed on a statewide basis provided that statewide
36 authority is, again, informed and informed by coal face
37 clinicians as well as others.

38

39 Q. Then you spoke about workforce planning. Are there
40 some particular features of the workforce here that needs
41 strengthening or are weaker than other parts of the
42 workforce. If so, how does that work?

43 A. Within our own hospital, there's a deficiency in
44 resident and registrar numbers. There is a deficiency in
45 ability to train these people, and some potential flow
46 through to deficiency in service capability as well. I
47 would see that that could be addressed by a greater

1 development of personnel infrastructure, like staff
2 specialists and registrars in the different craft groups or
3 departments, but also that these people would be engaged in
4 a very necessary educative function that would give
5 post-graduates, but also medical students, a decent
6 experience in rural health that might entice them to
7 return, because that is a major concern.

8
9 Q. Are the residents and registrars for Bathurst streamed
10 through from another hospital, or how do you get your
11 residents and registrars?

12 A. Yes, they come streamed through from RPA and I think
13 occasionally from Nepean.

14
15 Q. Is that relationship working satisfactorily from your
16 point of view?

17 A. Yes, I think. Relationships probably along referral
18 lines are ones that might work best. If you have the
19 structure up and running, it almost doesn't matter who the
20 central tertiary hospital relationship is.

21
22 Q. I understand your point about not having too many
23 subspecialties in terms of the workforce, particularly as
24 one comes into rural areas where one doesn't have the
25 volume for many subspecialties. We came across one model
26 of that in one of the smaller city hospitals, where they
27 have a number of staff that they described as
28 "hospitalists". Have you come across that model?

29 A. No, no.

30
31 Q. I will see if I can describe it in 30 seconds. This
32 is not to do it justice but it would be taking a
33 generalist, putting them into the hospital environment and
34 they could cover all patients in the hospital, regardless
35 of the particular subspecialty, so that you have a 24-hour
36 cover with hospitalists, who are obviously more senior than
37 residents and registrars, but who are not specialist
38 orthopaedic surgeons or specialist obstetricians or
39 specialist physicians, but have sufficient adequate
40 knowledge to be able to treat the patients and then call in
41 or seek specialist help if necessary. That is not to do it
42 justice, that is the sort of general nature of it. Is that
43 applicable in a rural environment?

44 A. It is in places. I can see that hospitalist
45 designation may fit a bit with a CMO.

46
47 Q. It's very similar to a CMO.

1 A. That is the model that works in Lithgow, which until
2 recent times was part of our area. I could see it,
3 perhaps, working in certain other hospitals, but at least
4 within our own region, the bigger hospitals tend to have
5 all the general specialties, and the smaller hospitals are
6 supported by general practice clinicians. So, I'm not
7 entirely sure that the hospitalist form, that you put
8 forward, would have great relevance.
9

10 My referral to subspecialties was more subspecialties
11 within surgery or subspecialties within obstetrics or
12 gynaecology or physicians. There is potentially a real
13 crisis coming, in that many of our junior trainees are
14 looking more towards going straight into subspecialty and
15 bypassing the general option. That will have very severe
16 effects on health care delivery in rural areas. We need to
17 support the colleges to the extent they need it in
18 encouraging them to maintain the general surgeon training
19 and general physician training and the general O&G -- I'm
20 sure there are other craft groups too -- general
21 paediatrics, because we won't be able to provide a service
22 if we are full of subspecialists.
23

24 Q. There's a real risk in those subspecialists not
25 keeping their skills sufficiently adequate and current if
26 they don't have a good volume of patients in their
27 subspecialty?

28 A. That's right.
29

30 Q. They, in fact, lose skills. It's counter productive,
31 as I understand it, the way in which the practice would
32 work?

33 A. Yes.
34

35 MR TOBIN: Q. With regard to the general specialties,
36 if I can use that term, how would you suggest that the
37 junior trainees be encouraged into the general specialties
38 rather than the subspecialties.

39 A. I think it becomes part of the structure of the
40 training. Traditionally, training in all the specialties
41 used to go via the general model first and then to the
42 subspecialty. I think it's a matter of supporting the
43 maintenance of that structure rather than encouraging
44 anything different.
45

46 Q. Why has that happened, do you think?

47 A. I don't know.

1 Q. You used the term "networked role delineation" as I
2 recollect. Could you explain what that means?
3 A. I am looking at that perhaps in our own context here,
4 and particularly with Bathurst and Orange services, that
5 our only way to survival is networking and coming closer to
6 home in obstetrics. We will only survive if we network our
7 service from one department and organise one roster across
8 all the specialists. Otherwise, into the future we are
9 trying to attract specialists to a one-in-two or
10 one-in-three roster, helpfully, but on the short term,
11 supported by locum services. That is not a long-term
12 solution if you want to build a department and have
13 processes and protocols.

14
15 THE COMMISSIONER: Q. Does that mean in the context of
16 obstetrics, as an example, with Bathurst and Orange that
17 you would network obstetrics across that area?

18 A. Yes, and this would require the support, again, of
19 very senior trainees and not the junior ones; senior ones
20 who could operate, to a large extent, on their own an hour
21 away from hands-on supervision.

22
23 Q. Does that also mean that one has to have some good
24 retrieval capacity?

25 A. Absolutely.

26
27 Q. What is the retrieval capacity like in the Bathurst
28 and Orange area?

29 A. Not bad, but I don't think it's up to scratch with
30 this sort of proposal, but there are simple things, at
31 least, that I have looked at in obstetrics that could be
32 done. There are ways of low flying from here to Mudgee
33 that I have experienced myself on occasions where the
34 travel time is half.

35
36 Q. Do you low flying in the air or on the ground?

37 A. On the ground with the assistance of the police; not
38 escaping but assistance of. So, I could see that if we had
39 a well-oiled procedure with the police, between Bathurst
40 and Orange, that we could bring that hands-on supervision
41 down to half an hour. That might be needed only once or
42 twice, maybe three times a year, but it would need to be
43 there.

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45 <THE WITNESS WITHDREW

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<DAVID CHARLES HEMPEL, sworn: [10.30am]

THE COMMISSIONER: Q. Would you mind giving me your full name?

A. My name is David Charles Hempel.

Q. You are a resident of Bathurst?

A. I'm a resident of Blayney.

Q. What would you like to draw to my attention?

A. What I believe to be inadequacies in relation to hospital treatment in terms of people with intellectual disabilities. I could read this out to you as, maybe, some indication of what I am actually about.

Q. If that would be easier for you.

A. It's more comprehensive and more detailed rather than.

Q. You go ahead.

A. The NSW Guardianship Act of 1987 was legislated to protect the rights and welfare of the vulnerable intellectually impaired. Contained within this Act and also in the NSW Health Department's legal and mandatory policy directive 2005/406, and the Guardianship Tribunal is substitute consent for medical procedures by the person responsible for when a patient is unable to give their own consent.

Since 1987 the legal requirement to obtain substitute consent for medical procedures appears to have not been acted upon, with GWAHS doctors and hospitals not presenting the patient's person responsible with the consent form conforming to this legally required substitute consent. The repercussions for this being required medical procedures carried out, without this legally required substitute consent, would be invalid medical procedures on the intellectually disabled, with intellectually disabled patients and their person's responsible rights status and protections affectively removed.

Our inquiries to the NSW Health Minister in this regard have gone ignored, other than her stating that substitute consent was a requirement for a patient unable to give their own consent. Indeed, our daughter an intellectually disabled adult, experienced first-hand at Bathurst Base Hospital on 15 June 2005 what can occur when legislation is not adhered to by doctors and hospitals for

1 medical treatment in the NSW public hospital. GWAHS did
2 not comply as to legislation and neither did the doctors,
3 neither did Bathurst Base Hospital.
4

5 My daughter, a 23-year-old adult, who by the way does
6 not come under the Mental Health Act, has on record an
7 invalid consent form as being a child. Her medical
8 conditions were not recorded, resulting in status and
9 rights of Sharon for a person responsible, which was me,
10 her father, being removed. Hence Sharon, back then an ASA3
11 patient was denied a premeditation, which was asked for, to
12 control the anxiety, because she was autistic. No
13 precautions were in place. She had a laryngeal
14 instability, plus other problems; down syndrome, narrow
15 airways. There were no precautions put in place for her.
16

17 Pre-op clinical check amounted to pulse and finger
18 oximeter only. No consultation took place and reminders
19 for this went ignored. Medical staff for Sharon, two
20 general anaesthetic and surgery team, used restraint,
21 bodily holding her down while Sharon was screaming and
22 resisting in fear. This was done under the false pretence
23 of an emergency. The procedure was unstoppable. I told
24 them "She can't go in like this". They just said "She must
25 go in". Sharon, my daughter, was screaming as she has no
26 vocal skills. The person responsible, that was me,
27 objections were rejected; medics confident in the knowledge
28 they could not be held accountable. We have since found
29 that out. Sharon was traumatised and is still suffering
30 severe long-term life threatening physical injuries from
31 this treatment. She was discharged with no post-op checks.
32

33 Now, she is not only intellectually disabled but
34 physically disabled, losing her mobility. The anaesthetist
35 involved stated in the HCCC report that patients such as my
36 daughter were not rare on operating lists at Bathurst, and
37 present challenges in their medical treatment. He was
38 quite happy with the assistance by nursing staff in the
39 physical restraint on Sharon.
40

41 The HCCC, after 29 months of our lobbying, and a
42 reinvestigation, said "When it's all said and done
43 everything was okay". Kieran Pehm, Commissioner, stated
44 that doctors make the decision on the day; in other words
45 can't be stopped. Since we complained to the HCCC and the
46 health minister, we have had difficulty in obtaining
47 treatment for Sharon's injuries. We are forced to go

1 overseas to get a second medical opinion from America's top
2 hospital, at great cost to us, which indicated the extent
3 to Sharon's injuries.
4

5 NSW senior doctors have been dismissive of this
6 medical second opinion. The NSW health minister is after
7 all this time still looking at the legalities of substitute
8 consent. In our inquiries to date, nobody has heard, let
9 alone been presented with a substitute consent form for
10 medical procedures. How many other intellectually disabled
11 patients, such as Sharon, who are not subjected to the
12 Mental Health Act have been subjected to such injurious and
13 unlawful treatment since 1987?
14

15 Q. Thank you, Mr Hempel. Can I just tell you that the
16 terms of reference under which I operate require me to
17 refer all individual patient complaints to the Health Care
18 Complaints Commission?
19

20 A. Correct.
21

22 Q. I gather from what you have told me, your complaints
23 already have been there, and they have dealt with it,
24 although you think inadequately. Is that right?
25

26 A. Very much so. Two investigations and they allowed us
27 another appeal for a third one. If we had gone into that,
28 we probably would have been over the five years and they
29 would have closed it anyway. Also, when there's an
30 investigation taking place, you can't do anything about it
31 anyway. You can't really speak out because whenever you
32 do, they say "It's under investigation". We couldn't see
33 any purpose in really continuing.
34

35 Q. I wanted to ask you about a systemic issue which you
36 have identified which is this issue of the substitute
37 consent form.
38

39 A. Yes.
40

41 Q. Do I understand what you are referring to there to be
42 this; that where consent for whatever the procedure which h
43 is necessary, the guardian gives that consent, firstly.
44

45 A. Yes.
46

47 Q. And secondly, there is however an exception, isn't
there, if it's emergency medical treatment, that the
practitioners can proceed with this medical treatment
without obtaining the relevant consent?
A. Yes.

1 Q. What you seem to have identified are two things: one
2 is you don't seem to have ever seen a substitute consent
3 form at all; is that what you are saying?
4 A. You could draw it off the computer and get it. It's a
5 four-page document which is very detailed. It is very
6 specific. It will ask specific questions in relation to
7 the patient's health. What precautions have to be put in
8 place? That I am satisfied with what the doctor has told
9 me in terms of he knows what he is going to do. What the
10 risks are. What communication skill that patient may have,
11 and so on and so forth.
12
13 Q. That four-page form, is that produced by the
14 guardianship services, or is that produced by the health
15 service?
16 A. I believed the health service so far as I know.
17
18 Q. Is that meant to be filled in, as you understand it,
19 before each treatment?
20 A. Yes.
21
22 Q. Or each episode of admission to hospital?
23 A. Yes, in other words we would see a surgeon, possibly a
24 week before the procedure was to take place. That form
25 would be presented. He would say "Who is the person
26 responsible?" because it would require my signature, and
27 the very fact I am responsible for that patient, it's my
28 responsibility to tell all for the benefit of that patient,
29 so there's a safe passage through that treatment. It's a
30 guarantee, you might say, in reducing the risks.
31
32 Q. How many occasions, approximately, in the last five
33 years say since 2003 would your daughter have been treated
34 in a public hospital?
35 A. Possibly two or three times.
36
37 Q. Have those occasions been when you have attended with
38 her at an emergency department, or have they been, what I
39 might call, planned treatment?
40 A. Planned treatment.
41
42 Q. Where people have said "In a month's time, or week's
43 time or two months' time you need to go to hospital for
44 this or that"?
45 A. In answer to that, prior to that procedure, in that
46 five years she would have been in two or three times. It
47 would not have been an emergency procedure, it would have

1 been a planned procedure.
2
3 Q. Did she go through the emergency department or just in
4 through the general hospital admission?
5 A. In through the general hospital. One was private, I
6 think one was public prior to. The other was probably
7 public.
8
9 Q. Was there any difference in the procedure that was
10 adopted at the private hospital compared to the public
11 hospital?
12 A. Very much so.
13
14 Q. What was the difference in procedure?
15 A. When you go and see the doctor beforehand, not that we
16 were presented with a substitute consent form and possibly
17 there was not -- I have to think, possibly there may not
18 have been a requirement for one. I believe there was but I
19 couldn't be dead certain on that. But, for example, if you
20 were to take my daughter in, they immediately take time
21 out. There would be a consultation by the doctor, a
22 pre-sedation will be administered. They will then do the
23 pre-op. checks, and once she is settled, my daughter will
24 be compliant. She will help. She will get on a trolley
25 and I will walk in with her, and they will give her an
26 anaesthetic and I will walk out. She will walk up in a
27 good state of mind, and post-op check and we will take her
28 home, no worse for wear.
29
30 Q. I think I should tell you, Mr Hempel, that the staff
31 of the Inquiry have informed me that the written submission
32 you made has been referred by us, as we are required to, to
33 the Health Care Complaints Commission, but we will keep an
34 eye on what, if anything happens to that, and we will let
35 you know.
36 A. Can I say one thing? Consider this: In the first
37 investigation, despite much lobbying from us, the HCCC
38 insisted there were two signatures on that bit of paper
39 that was presented to us. That was my wife's and my own.
40 Therefore, consent was valid. Now, there was no signature
41 from me because I was not required to give one, neither was
42 I talked to or consulted with.
43
44 Despite the lobbying at the outcome, they said there
45 was not a problem; two signatures. We appealed to them and
46 they said "Sorry, there is only one". Then we went into a
47 second investigation, and then the farcical roundabout

1 continued. Then, once again, you come out with an outcome
2 where black is white, white is black, and how far have you
3 got to go with this? If they have a problem, for example
4 restraint, that restraint was never touched on. They
5 refused to touch the restraint. They said "No." As Kieran
6 Pehm said to me, "We haven't got the resources to tackle
7 that". He said that to me verbally. That is the most
8 injurious part for Sharon.
9

10 If, indeed, it was an emergency, they would have had
11 to record it as an emergency. It was not recorded. It was
12 not recorded; it was never ever an emergency. The
13 emergency, if you could construe it as being an emergency,
14 would have been created and they could have stopped. If I
15 intervened and stopped it, they could have called security
16 and had me taken away. That is the bottom line. There is
17 stuff all over the walls; what you can do and what you
18 can't do. How far have I got to go? You trust. You might
19 turn to me and say "How was it that I knowing fully well
20 she didn't get the pre-op checks that were required, didn't
21 get the presedation after constant reminders, how come they
22 could turn around and say to me 'She must go in', and why
23 would I be accepting of this and not say 'She shouldn't go
24 in'". The point was this; they asked me to don some
25 surgical attire.
26

27 Q. Gown and so on?

28 A. They couldn't find the slippers. I was away for 12
29 minutes. When I came back, there was bedlam. Sharon was
30 trying to tear away, they are trying to get her on a
31 trolley. I went up and said "What is going on?" "She must
32 go in." I thought an emergency had taken place. I thought
33 something had happened. She ended up being force marched
34 into theatre. I entrusted myself to them. Something had
35 happened. Maybe they had given her the wrong presedation.
36 I don't know. There was no time for questions. They had
37 no authority, no right to even touch her as far as I am
38 concerned, how they injured her, and it's all above board,
39 it appears even though the law, according to that
40 legislation, they didn't adhere to them.
41

42 THE COMMISSIONER: Thank you I have the sense of what you
43 are telling me. Thank you for coming forward.
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45 <THE WITNESS WITHDREW
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3 Q. Would you give me your full name?

4 A. June Lily Darke.

5
6 Q. Mrs Darke, are you at the Bathurst Hospital?

7 A. No, I'm a retired educator.

8
9 Q. What would you like to draw to my attention?

10 A. I don't want to give you a history lesson but I would
11 like you to know Bathurst was formed as an outpost of Empire
12 in 1817. It was provided with a hospital then, by the NSW
13 government. The government took it away in 1822, because
14 they didn't have to look at any more convicts in this area.
15 From 1882 onwards, the citizens of this city have been very
16 concerned with the provision of health. They went shilling
17 for shilling for that old hospital up there.

18
19 Q. When was that built, approximately?

20 A. 1876. Then they put their hands in their pockets
21 again for our rehabilitation centre on the other side of
22 the city; then for the Daffodil Cottage and so on. If you
23 walk through the city, you will find there's this amazing
24 sense of ownership, and because of that ownership the
25 Bathurst and District Health Watch Committee was
26 established as an apolitical community organisation when
27 mid west health was formed. The aims: To press all
28 appropriate bodies to maintain a satisfactory level of
29 hospital staffing at all times; two, to ensure the
30 performance level of all key equipment is consistently;
31 high; three, to safeguard the standards of health care in
32 this steadily expanding region.

33
34 Since 1997 we have been instrumental in the following
35 acquisitions for our base hospital: one, patient transport
36 between Bathurst and Orange Hospitals; two, the funding for
37 the airconditioning of the Daffodil Cottage; three,
38 provision of improved facilities for day surgery patients;
39 four, installation of the original CAT scanner; five,
40 replacement of obsolete ultrasound unit and provision of a
41 mobile machine for ward usage; and six, installation of
42 four television sets for the dialysis unit.

43
44 Since the establishment of Greater Western Area Health
45 Service communication with the Hospital has been phased
46 out. Our inquiries into recent hospital concerns are now
47 conducted through the office of Gerald Martin MP and, in

1 particular, the restoration the hydrotherapy pool in the
2 rehabilitation complex. The committee has now decided to
3 wait for the completion of the building, before attempting
4 to restore constructive communication, and we are currently
5 concerned about the organisation of a palliative care unit
6 which we had before, but is now going to be quite different
7 we hear, and we are concerned about the staffing of a newly
8 established mental health unit. Thank you.
9
10 Q. Can you tell me who is on the health watch committee?
11 Is it the citizens of Bathurst?
12 A. Citizens.
13
14 Q. Does it have doctors on it at?
15 A. No.
16
17 Q. Any health professional at all?
18 A. No, but if we asked them, they are usually very happy
19 to come and talk to us about it.
20
21 Q. What sort of size is your committee?
22 A. Right at the moment there are only six people on it
23 because we have had four deaths in the last 18 months and
24 we are now waiting. We will try to enlarge our committee
25 once we feel we can be active again by having communication
26 with greater west.
27
28 Q. You said that there really has been two parts of
29 communication; one was quite good communication, one was
30 not so good communication. When you had good
31 communication, who was the line of communication with?
32 A. Was directly with the Hospital, the general manager,
33 right through, right down to the wards.
34
35 Q. You gave a list of things which the committee had
36 achieved, a remarkable list. Are you able to give me, very
37 approximately, what sort of dollar figure has been involved
38 with the committee over those projects in total?
39 A. No, we are not a fundraising organisation. We are the
40 fox terriers who find the money elsewhere, and I do not
41 have any idea of what those figures would be.
42
43 Q. Do you have any sense from you and your colleagues on
44 the committee of whether there are any particular problems
45 in the public hospitals in this area, or not? You
46 mentioned, for example, the hydrotherapy pool seems to have
47 a question mark over it.

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A. I think the question mark has finally been removed, although we still don't have a pool up there but there is a hole in the ground which I think is going to be the pool.

Q. That's a start.

A. Yes.

Q. Do you have a sense of whether services in the public hospitals in this area are good, bad or indifferent; what is the sense with you and your colleagues on your committee?

A. My sense is we have amazing staff here, who work more than they should reasonably be asked to work, I think. But, we do not have sufficient staffing. We are very concerned about that mental health ward that is coming; it has about 10 beds in it and we want to make sure we have specialty nursing there. That is why we are a bit concerned about that at the moment. But, we have to wait until the building is finally fixed.

THE COMMISSIONER: Thank you, Mrs Darke, for coming and informing me of the health watch committee and giving up your time this morning. I very much appreciate it.

<THE WITNESS WITHDREW

1 <LEWIS WILLIAM FURNER, sworn: [10.55am]
2
3 <WITNESS ASSISTING
4
5 <ADRIENNE LOUISE FURNER, sworn:
6
7 <WITNESS ASSISTING
8
9 THE COMMISSIONER: Mr Furner, could you give me your full
10 name please?
11
12 MR FURNER: Lewis William Furner.
13
14 THE COMMISSIONER: And Mrs Furner?
15
16 MRS FURNER: Adrienne Louise Furner.
17
18 THE COMMISSIONER: Are you both residents of Bathurst?
19
20 MRS FURNER: Cowra.
21
22 THE COMMISSIONER: You have travelled up today?
23
24 MR FURNER: Yes.
25
26 THE COMMISSIONER: I understand that you are the parents of
27 Ms Rebecca Murray.
28
29 MR FURNER: Mrs Rebecca Murray.
30
31 THE COMMISSIONER: What would you like to draw to my
32 attention?
33
34 MR FURNER: In the case of terms of reference, case
35 management including supervision of junior clinical staff,
36 clinical notetaking and record keeping and communication
37 between health professionals involved in the care of
38 patient. We have some documents for you. I think you may
39 have some of them already anyway.
40
41 THE COMMISSIONER: We will make sure we get them and if
42 they are your only set we will get them back to you.
43 Ms Follent will speak to you when you have finished and
44 sort the documents out. Please go ahead.
45
46 MR FURNER: Rebecca Murray was booked into Bathurst Base
47 Hospital by Dr Halloway for delivery of her third child by

. 17/3/2008

461 L W FURNER A L FURNER
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1 caesarian section, due to the baby being in breach
2 position; the elective surgery date being 4 July last year.
3 Rebecca presented to the maternity section of Bathurst Base
4 Hospital at 0500 hours on Sunday, 24 June 2007 after her
5 water broke at 0330 hours in the morning. The attending
6 medical officer, and the local obstetrician, decided to
7 wait as they thought they could deliver the baby naturally
8 even though it was breach. At 0700 hours when the unborn
9 child was in foetal distress, the medical staff --

10
11 MRS FURNER: -- decided to do the emergency C section. Had
12 the medical team read Rebecca's medical notes and opted for
13 the caesarian option before the baby went into foetal
14 distress, would the outcome have been different? At 0830
15 hours Rebecca was transferred to recovery and her initial
16 post-operative blood pressure was recorded at 91 over 53.
17 The anaesthetic registrar was informed and thought, via the
18 phone, that the lower BP most likely was attributable to
19 the spinal anaesthetic. At 0836 hours Rebecca's blood
20 pressure was sufficiently low to meet the hospital criteria
21 for calling the medical emergency team. However this never
22 occurred.

23
24 Rebecca had lost sufficient blood to soak through two
25 pads, absorption pads, and spill onto the linen. At 0850
26 hours the recovery room nurse then connected the
27 anaesthetic registrar and Rebecca's blood pressure dropped
28 to the critical low level of 54 over 22. The anaesthetic
29 registrar gave orders over the phone and Rebecca continued
30 to haemorrhage.

31
32 At 0910 hours the recovery room nurse informed the
33 local obstetrician and the GP VMO of the emergency. At 10
34 o'clock Rebecca was returned to the operating theatre where
35 a hysterectomy was performed to control the bleeding. At
36 1110 Rebecca sustained a cardiac arrest. At 1610 Rebecca
37 arrived at Nepean Hospital intensive care where her
38 condition continued to decline, and at 1052 hours on 25
39 June she suffered another cardiac arrest and was declared
40 deceased.

41
42 From the RCA report we were given, medical analysis
43 report on page 4, under the recovery room issues, found
44 that there was no specific handover processes occurred
45 between the scrub nurse and recovery nurse. The usual
46 practice at the rural base hospital did not include an
47 expectation for recovery room staff to measure blood loss

1 in absorption pads. The nursing staff lacked experience in
2 the recognition of a post-partum haemorrhage which also
3 contributed to an underestimating of blood loss.
4

5 On page 3 of this report, in a summary of the RCA team
6 findings, it is noted by the RCA team that this facility is
7 exposed to a critical post-partum and obstetric emergency
8 in the operating theatre and recovery infrequently,
9 approximately one to two times a year. The theatre staff
10 are relatively inexperienced in dealing with these. The
11 RCA also considered that relative inexperience and the
12 tremendous demands imposed by the overwhelming emergency of
13 the situation contributed to inadequate coordination of the
14 resuscitation.
15

16 The final report covers all the items in the terms of
17 reasons mentioned earlier. However, there are additional
18 items that need to be discussed. Bathurst Base Hospital
19 management report and recovery room report both have actual
20 times over written and, in some instances, chronological
21 order is out of step. The RCA report on page 5 under --
22

23 THE COMMISSIONER: Is that the Bathurst notes, the
24 handwritten --
25

26 MR FURNER: Yes.
27

28 THE COMMISSIONER: -- nursing notes or continuation notes?
29

30 MRS FURNER: That is correct. The RCA report under page 5
31 under antenatal issues states that the local obstetrician
32 had not seen the patient at the medically based antenatal
33 clinic which contributed to her unfamiliarity with the
34 patient's obstetric history. The first interaction with
35 this patient was in the operating theatre.
36

37 The medical staff were informed by Rebecca's husband,
38 Jim Murray, at approximately 0330 hours when he rang to say
39 he was bringing his wife in for the birth of their baby.
40 They had ample opportunity between then and 500 hours to
41 read Rebecca's medical reports, which were on file at the
42 hospital. Rebecca's husband, Jim Murray, you will be
43 talking with him.
44

45 THE COMMISSIONER: I will ask the Inquiry staff to find a
46 convenient time so we can talk.
47

1 MR FURNER: The RCA report on page 5 states:
2

3 The RCA team was unable to determine conclusively
4 whether the outcome of this patient was preventable.
5

6 This is a huge statement and we, as Rebecca's parents,
7 believe if Rebecca and Jim were told of the inexperience
8 and unpreparedness, if there is such a word, of the staff
9 and equipment at Bathurst Base Hospital, they most
10 certainly would have stayed in Sydney for the latter part
11 of Rebecca's pregnancy. Their first born, Lachlan, was
12 born at Royal North Shore Private and the second, Amelia,
13 at Gosford Private Hospital. Both births were quick; under
14 four hours.
15

16 Rebecca was fearful of the surgery after having the
17 two natural deliveries, and was prepared to try to deliver
18 vaginally. Here, she was being guided by Dr Rickard-Bell,
19 and although fully dilated the baby never moved into the
20 birth canal, and hence the planned C section become an
21 emergency.
22

23 Bathurst Base Hospital recovery room report shows
24 confusion with actual times, lack of proper report keeping.
25 Obviously the scene was chaotic, one was nurse left to care
26 for the patient with no back-up except doctors on the
27 telephone. Maybe if one of these doctors had come and
28 looked at Rebecca sooner, the outcome could have been
29 different.
30

31 My wife Adrienne commented to Jim that everything must
32 be okay now, that they had stopped running. We were left
33 in the waiting room with very little information watching
34 the staff run in and out of the operating theatre for blood
35 product. We heard the medical emergency team called around
36 11am and thought "Someone is in a bad way", only to find
37 out later it was our Rebecca. When asked later why we
38 weren't kept better informed, we were told they couldn't
39 afford to send anyone from the room and had to wait for the
40 arrival of more staff.
41

42 We are of the strong opinion that Rebecca's life was
43 doomed from the time she set foot in Bathurst Base Hospital
44 on that Sunday morning due to understaffing. Again, we
45 will never know if she would have survived if the surgery
46 had gone ahead on a weekday, when staffing levels were
47 greater. As lay people, we feel funds need to be injected

1 into the health system so that hospitals can be better
2 staffed on weekends.
3

4 We have all seen the weekend exodus of patients so the
5 skeleton staff can cope. Patient care should be the most
6 important issue, not money. Would it be wiser to return
7 nursing students to the hospitals, instead of the
8 universities? Surely these trainees would pick up life
9 skills during their time on the ward as they did in the old
10 days. We may then keep our nurses in the hospital system,
11 instead of gaining their degrees and opting for higher paid
12 nursing agency jobs. All rural areas have trouble
13 retaining medical staff. Could another option be to teach
14 medical staff at larger rural centres to entice them to
15 remind in the bush?
16

17 The main issues that arise from our daughters care
18 are: The hospital was informed at 3.30 in the morning it
19 would be an hour before my wife arrived to look after the
20 kids. Why didn't they access Rebecca's records and have
21 the theatre and staff ready? The length of time before the
22 surgery took place. The family not informed of problems as
23 they arose. Rebecca's husband was left for over an hour
24 alone with the baby while Rebecca was in recovery. After
25 Rebecca returned to surgery, the family was again left with
26 no information. We should have been able to sit with
27 Rebecca before being transferred to Nepean Hospital. Staff
28 told family on 24 June this was all caused by an amniotic
29 fluid embolism. All the hospital documents reflect a
30 post-partum haemorrhage. At no time has a local
31 obstetrician contacted, or commented, to our knowledge.
32 The hospital times are incorrect and written over. Doctors
33 seemingly unavailable to view patient. Vital machinery not
34 working; for example, blood warming machines turning off
35 and on for no apparent reason. The iStat machine was
36 password protected. In an emergency area, staff were
37 unfamiliar with operation. The drugs necessary for
38 treatment of post-partum haemorrhage not available in
39 hospital, others not in the theatre but kept in maternity
40 so delay in getting treatment. Insufficient training for
41 emergency situations. The delay in calling the medical
42 emergency team.
43

44 Was there a delay in transfusion? Records seem to
45 indicate blood products not given until 5 to 10 in the
46 morning. If the Rebecca had been bleeding since 8.30,
47 should this have been started earlier? If staff were

1 inexperienced in emergency situations, they should be not
2 left alone in one. This nurse should have had more back-up
3 than a telephone. Existing hospital protocols not
4 followed. The uterus was sent to Orange and not available
5 for coroner's office to inspect with all other remains and
6 we would like to know why that happened.
7

8 There are many issues that arise from our daughter's
9 care, and none will be fixed quickly. It is time the
10 government stopped passing the buck and actually did
11 something to improve hospitals, funding to hospital
12 systems, staffing, pay rates and working conditions,
13 training of medical staff and putting them back into
14 hospitals. We thank you, Mr Garling, for your time today
15 and wish you well in your inquiry as it is time to make a
16 difference.
17

18 THE COMMISSIONER: Do you mind if I ask you a couple of
19 questions?
20

21 MR FURNER: No, certainly.
22

23 THE COMMISSIONER: Rebecca's transfer to Nepean, that was
24 by road ambulance?
25

26 MR FURNER: No, by air.
27

28 THE COMMISSIONER: She must have been in Bathurst for some
29 time ready to be transferred before that happened. Was
30 she?
31

32 MR FURNER: That's correct.
33

34 THE COMMISSIONER: Did I understand you to say during that
35 period of time, while she was waiting to be transferred,
36 you couldn't sit with her?
37

38 MR FURNER: That's correct?
39

40 THE COMMISSIONER: Were you ever given a reason for that?
41

42 MRS FURNER: No, we weren't.
43

44 THE COMMISSIONER: Was she in the recovery ward during
45 that time?
46

47 MRS FURNER: She was. I'm not sure if she was in the

1 recovery ward or the operating theatre still. She had been
2 stabilised. The helicopter arrived around 2pm and she
3 wasn't transferred until after that. It was about 4.10
4 when she arrived in Sydney.
5
6 THE COMMISSIONER: That is about a half-hour flight or a
7 bit more?
8
9 MR FURNER: I'm not sure how long.
10
11 THE COMMISSIONER: I will find out the detail.
12
13 MRS FURNER: There would have been approximately, from my
14 understanding, three hours that family could have been
15 sitting with her, instead of her just being in the room
16 with medical staff.
17
18 THE COMMISSIONER: The other thing, you made mention of
19 some drugs not being available. What were you referring to
20 there?
21
22 MRS FURNER: There are various drugs that can be
23 administered during a post-partum haemorrhage. From my
24 understanding of reading the notes, the first one that they
25 would have chosen to use was not available in the hospital.
26
27 THE COMMISSIONER: At all?
28
29 MRS FURNER: At all.
30
31 THE COMMISSIONER: Did they use a substitute or a
32 different drug to achieve the same purpose?
33
34 MRS FURNER: Yes, they then went to the next drugs, which
35 were not in the operating theatre but up in maternity
36 where, of course, normally the children would be born.
37
38 THE COMMISSIONER: Where presumably they would needed to
39 be used more often.
40
41 MRS FURNER: Yes.
42
43 THE COMMISSIONER: I understand that. May I ask you this
44 question? After all of this had happened, and there was
45 obviously the cause analysis process taking place, were you
46 both involved in that, in the sense of there when the
47 result was given to you? Or, was it given to Mr Murray

1 first and then passed onto you? How did that work?
2
3 MR FURNER: It was given to Jim first. He was on his way
4 down to see us. He told the staff then that he wanted time
5 to look at this, so he come down and had a look at it and
6 then we met with them the following morning.
7
8 THE COMMISSIONER: The three of you met with staff. Who
9 did you meet with?
10
11 MRS FURNER: We had the general manager, Ray Dennis, the
12 anaesthetic, Andrew Dupic - whatever his name was.
13
14 THE COMMISSIONER: The anaesthetist, whoever.
15
16 MRS FURNER: There were two other ladies who did give us
17 their standing in the hospital.
18
19 THE COMMISSIONER: Was your sense they were nursing and
20 midwives, or was your sense they were administrators?
21
22 MRS FURNER: They were administrators. Some of them did
23 have nursing backgrounds, medical backgrounds, but a couple
24 of them didn't.
25
26 THE COMMISSIONER: How long did that meeting go for?
27
28 MRS FURNER: About two hours.
29
30 THE COMMISSIONER: Were you able to ask questions?
31
32 MR FURNER: Yes, we were.
33
34 MS FURNER: We did.
35
36 THE COMMISSIONER: And look at documents they had there?
37
38 MR FURNER: Only the report itself.
39
40 THE COMMISSIONER: Not the notes.
41
42 MR FURNER: No. Those reports, there was a lot in that
43 that they hadn't read themselves.
44
45 MRS FURNER: They were of the impression that Rebecca
46 hadn't actually been booked in for a caesarian at all. It
47 wasn't until we brought the subject up that they realised

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it was a planned.

THE COMMISSIONER: She had a booking for a week or so, 10 days later?

MRS FURNER: Yes.

THE COMMISSIONER: This is only for my information at the Inquiry level, is there to be a coronial inquest?

MR FURNER: They haven't made up their mind. They were going to do it a couple of weeks ago and they have put it back to April.

THE COMMISSIONER: We'll make sure that nothing we do affects that. We will interact with others.

MRS FURNER: It has been referred to the HCCC and they are looking into it as well.

MR FURNER: They have been out to see Jim and interviewed him as well.

THE COMMISSIONER: Thank you very much, both of you, for coming. Is there anything more you wanted to add out of that discussion we have had?

MRS FURNER: No.

THE COMMISSIONER: Thank you very much for coming up this morning. I do appreciate you drawing that to our attention. Would you mind liaising with one of the solicitors to make sure we have all those documents, that be good? Thank you.

<THE WITNESSES WITHDREW

1 <HEATHER MARGARET DUNN, sworn: [11.11am]
2
3 THE COMMISSIONER: Q. Would you mind giving me your full
4 name.
5 A. Heather Margaret Dunn.
6
7 Q. I have a note that you wanted to draw to my attention
8 some issues related to Daffodil Cottage.
9 A. That's correct.
10
11 Q. You better tell me what Daffodil Cottage is.
12 A. I thought I would do that first. Daffodil Cottage is
13 a purpose-built oncology unit that was built by the people
14 of Bathurst. The general public contributed the funds for
15 it and the electricians, plumbers, builders, all
16 contributed their time to build it, and it's built in the
17 grounds of the Bathurst Base Hospital and it opened around
18 about December 1996.
19
20 Q. What services are provided at Daffodil Cottage?
21 A. Chemotherapy treatment for the patients who come in
22 and, unfortunately, we are getting more and more patients
23 in, and also we have visiting doctors come out from St
24 Vincent's Hospital in Sydney. We have a medical
25 oncologist, a radio oncologist and a haematologist who
26 comes out. The first two I mentioned come out once a
27 fortnight, and the haematologist comes out once per month.
28
29 Q. Care is provided in the Daffodil Cottage?
30 A. That's correct.
31
32 Q. Do people stay overnight there or is it just a day
33 treatment area?
34 A. They come in for treatments. Treatments can vary from
35 20 minutes to six hours or eight hours, depending on the
36 sort of chemotherapy they have to have.
37
38 Q. What is your particular involvement at the cottage?
39 A. I'm a member of the voluntary palliative care group,
40 and have been for 11 years.
41
42 Q. What does that group do?
43 A. We help at the cottage with the patients when they
44 come in. We provide morning teas for them. We provide
45 lunches for them on the days when the doctors are there.
46 Somebody from our group is on duty everyday there.
47

1 Q. On the days the doctors aren't there, is there nursing
2 staff there?
3 A. The nursing staff are always there. They are the ones
4 that administer the chemotherapy.
5
6 Q. What is your particular concern that you want to draw
7 my attention to?
8 A. Our concern at the moment is that there have been
9 rumours abounding that ambulatory care services may be
10 introduced into Daffodil Cottage, and our concern is for
11 the cancer patients. As you are probably aware, cancer
12 patients have a very low immune system, and if we have
13 ambulatory patients attending the same area, infections can
14 be passed on quite easily and that is our concern.
15
16 Q. Using the term "ambulatory care", you mean patients
17 with a broad range of conditions, not just cancer related?
18 A. Not cancer related. They come in to have dressings
19 changed on wounds, they may have an infection that they are
20 having treated. These can be passed on to cancer patients
21 very easily, because their immune systems are so low.
22
23 Q. May I ask you this question: is there a lot of spare
24 room in Daffodil Cottage?
25 A. We have four treatment rooms there, and we have two
26 doctors' rooms as well, and they are all used. I have been
27 there on days when I have been on duty and there haven't
28 been enough rooms available for the patients being treated.
29 They have had to make use of waiting rooms for treatment.
30
31 Q. It's not as though there is half a house empty?
32 A. No.
33
34 Q. That is really what I was asking.
35 A. It varies from day-to-day. Some days there aren't as
36 many patients in. That depends on the needs.
37
38 Q. Your concern is what is to happen with the future use
39 of it?
40 A. Future use of Daffodil Cottage, that's correct.
41
42 Q. I will see what I can find out for you, Mrs Dunn. I'm
43 not sure what I can do, I don't know, but I will give it a
44 go?
45 A. Thank you very much and thank you for listening to me
46 this morning.
47 <THE WITNESS WITHDREW

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<AI LEEN HULBERT, sworn: [11.17am]

THE COMMISSIONER: Q. Would you mind telling me your full name?

A. Aileen Hulbert.

Q. I had a note that you were a patient at Bathurst Hospital.

A. Yes.

Q. Is that relatively recently?

A. Yes; three weeks or a bit longer.

Q. How long were you in hospital for; three weeks?

A. No, three weeks back.

Q. For how long were you in hospital?

A. I went in on the Thursday, I was to have an operation on the Friday, and they put me on a drip, which actually was in preparation for the operation. Then this South African doctor sent me home on the Thursday afternoon and I get a phone call at 20 to 10 that night from Dr McGarrity to ask me what I was doing. I said that I was only doing what I was told, I was sent home. He said "I wanted you in surgery at 9 o'clock Friday morning".

Q. That was the next morning?

A. Yes. He said "You will have to go into hospital at 9 o'clock tomorrow morning and I will have to put your operation back until later in the afternoon." So, I went into hospital at 9 o'clock, and I waited until half past 1, and had the operation. I came out of recovery and I was put in the recovery room, and then I was taken up to ward A, I believe that is what it is called, it's a surgical ward. The next morning they woke me up and my temperature was 200 over 85 --

Q. Your blood pressure?

A. Blood pressure was 200 over 85, and she said "Oh dear, I will have to see your doctor. Dr McGarrity will be in shortly". However, he came in, but he didn't stay long and I didn't see him. I was to see his offsider. I waited and waited and waited, and they said "Simon will be in shortly". But, I'm sorry, Simon didn't arrive until 20 to 6 that night, and then my temperature went up to 210 over 100.

1 Q. Blood pressure?
2 A. Yes.
3
4 Q. Can't be your temperature, I don't think. I
5 understand what you are saying.
6 A. He said "Why didn't you have any medication this
7 morning?" I said "I asked for it but they wouldn't give it
8 to me until it was approved by you". He said "That's
9 wrong, you should have had it", and he sent me for x-rays
10 and gave me the medication, of course. I mean, I want to
11 know why I had to wait nine and a half hours for a doctor,
12 when I was awoken with my blood pressure at 200 over 85. I
13 think there was something they could have done to bring my
14 blood pressure down without waiting for the doctor.
15
16 Q. I understand your concern. As I understand it,
17 there's a question mark, firstly, as to why you were sent
18 home for what reason.
19 A. Exactly.
20
21 Q. And, secondly, on the day after your surgery, there is
22 a question about the availability of medical staff, how
23 quickly they saw you, and secondly, what could the nursing
24 staff have done before the doctor arrived.
25 A. Yes.
26
27 Q. What we will do, Mrs Hulbert, is after you finish
28 here, I will ask one of the solicitors assisting the
29 Inquiry to get some further details, and we will make some
30 contact with you to get a more detailed description of all
31 of this, so we can organise to have it referred to the
32 Health Care Complaints Commission for them to look at. I
33 understand your complaint about the system is there was an
34 inadequate communication about being sent home. You
35 obviously weren't given any reason for that --
36 A. Yes, that is the first one.
37
38 Q. -- that you can bring to mind. The second was the way
39 in which you were treated on the Saturday.
40 A. Yes. I just can't understand why they couldn't get
41 some doctor, even if it wasn't Simon, to approve that I
42 could take medication, instead of letting me go there for
43 nine and a half hours getting worse. I could have been
44 real serious. I could have had a stroke.
45
46 Q. When you say "Simon", who are you referring to? Do
47 you know if he has a surname?

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A. Of course, he has a surname.

Q. But you don't know it?

A. My general practitioner does. I don't. I was never ever told.

Q. When we adjourn a little later, if you could wait I will have one of the staff speak to you.

A. Simon is Dr McGarrity's offsider. You will soon find out who he is.

<THE WITNESS WITHDREW

1 <JULIE ANNE MAHER, sworn:

[11.23am]

2
3 THE COMMISSIONER: Q. Would you mind telling me your
4 full name.

5 A. My name is Julie Anne Maher.

6
7 Q. Mrs Maher, I have a note that you are associated with
8 the area health council; is that right?

9 A. That's right. I'm a member of the Bathurst Health
10 Council.

11
12 Q. It's just the Bathurst Health Council, it's not the
13 whole area health service advisory council?

14 A. No, we have one in each area, but we liaise in the
15 eastern sector with Blayney and Orange and Oberon. Mostly
16 it's just in Bathurst.

17
18 Q. Could you tell me a bit about that council, how many
19 members are on the?

20 A. There are 12 members.

21
22 Q. Is that both doctors and community representatives?

23 A. No, they are community representatives. Doctors could
24 come occasionally as guests, and we have a member of the
25 hospital staff who comes to our meetings.

26
27 Q. What does the health council do? What is its
28 purpose?

29 A. Its purpose is to liaise on behalf of the community
30 with the health service, and to take back from the health
31 service anything the community wants to know.

32
33 Q. How long have you been associated with that
34 organisation?

35 A. Probably three or four years now. At the moment I am
36 acting chair.

37
38 Q. What would you like to draw to my attention?

39 A. The group is all voluntary, and they come from all
40 different walks of life. We try to really incorporate
41 anyone from the community that we can. I also personally
42 have a physiotherapy background. Do you mind if I read?

43
44 Q. Not at all.

45 A. We have been assured that this Special Commission of
46 Inquiry Into Acute Care Service in NSW Public Hospitals
47 will be heard without fear or favour. Previous reports of

1 experiences from Campbelltown, Camden and Bundaberg give us
2 a degree of concern. However, we have faith that those who
3 speak out openly, truthfully and in good faith should not
4 fear retribution, nor be victimised either overtly or
5 covertly.
6

7 It's public knowledge there are numerous problems with
8 Bathurst's new hospital. Some of these are major
9 structural problems that will, no doubt, take time to fully
10 address. Other problems, although the cause of serious
11 disruption, have been or are being addressed as a matter of
12 urgency and expeditiously. It is the opinion of many in
13 the community that had there been ongoing consultation and
14 communication we would not now be in this position.
15 There certainly has been a lack of transparency since the
16 commencement of this program. People who questioned plans,
17 or asked pertinent questions have been silenced or
18 castigated.
19

20 We are extremely fortunate in Bathurst, we have
21 wonderful professional clinical staff, medical, nursing,
22 allied health and those supported by other staff members
23 who are essential to the running of an efficient and
24 superior health facility. To think the incompetence that
25 has caused these people to lose confidence and suffer the
26 stress they are under is a travesty of justice. Some staff
27 members have even been pilloried by some sections of the
28 community. It would be a tragedy if we lose any of these
29 valuable people from the health system, due to their
30 frustration and feeling of being so devalued.
31

32 There are some who suggest these problems are
33 politically motivated. I personally do not subscribe to
34 that theory, as I have no knowledge of it. Sufficient to
35 say, these problems are real, they are here and they have
36 to be fixed. Let others play the blame game. Maybe ICAC
37 is the only organisation able to sort out who truly is to
38 blame.
39

40 I would like to make a comment about some good things
41 that have come out of this. Perhaps, the fact the hearing
42 is being held in Bathurst today. Most emphasis on health
43 is directed to major metropolitan hospitals. It is
44 reassuring to have you here, Commissioner Garling, and for
45 you to see first-hand what complex and brilliant work is
46 undertaken to the west of that sandstone curtain. The
47 community has every reason to continue to feel confident in

1 the care they receive at Bathurst Base Hospital. We should
2 also be grateful to the Medical Staff Council who had the
3 intestinal fortitude to bring their concerns to the fore.
4 Without that group, we would be in a serious situation,
5 although hidden of unsafe service delivery.
6

7 I would also like to pay tribute to those from the
8 western area health who have faced the problems and
9 outrage. They have brought new found transparency to our
10 health council, and therefore allow feedback to the
11 community. Dr Claire Blizzard has made herself readily
12 available to meet with the health council and Sue Ann
13 Redman's tireless efforts, staying on in Bathurst, facing
14 each day with calm resolve, has gained for her the faith of
15 the staff and encouragement of community representatives.
16

17 A great deal of our tax payer dollars have been spent
18 on what we were lead to believe was a facility of
19 excellence for Bathurst well into the future. This has not
20 been realised this far. Public outrage at the scrapping,
21 albeit covertly, of the hydrotherapy pool has had it
22 reinstated. Work is currently underway for that. Now, our
23 promised ambulatory care unit has somehow been misplaced
24 but promises of its reappearance are now real and ongoing.
25 It has been said, and oft repeated, that bad things happen
26 because good people don't speak out. We have some very
27 good people in Bathurst and it's time they were listened to
28 and I thank you.
29

30 Q. Can I ask you a couple of questions to help me? What
31 can you or your council see into the future? Once the
32 hospital is opened, and let's assume what I might call the
33 building problems, whether the pipes work or don't work,
34 but things related to the construction work are ironed out,
35 how do you think that will help acute services in Bathurst?
36 Do you think there will be a real improvement then?

37 A. I think there will be. I think the staff will feel
38 better about themselves and the community will too. At the
39 moment there's so much negativity going on that both groups
40 are feeling quite thwarted I think, and that is very sad.
41

42 Q. What's your best, from your perspective, time frame of
43 when the hospital will be up and running? Have you any
44 sense of that?

45 A. I think the more minor things that can be fixed
46 immediately are well underway. I would suggest that it
47 could be months, maybe even a year or so, before the major

1 structural things are done. Hopefully each day is a day
2 ahead.
3
4 Q. The hydrotherapy pool, I heard earlier from someone,
5 at least there was a hole in the ground.
6 A. There is a hole in the ground.
7
8 Q. What is the position about the hydrotherapy pool?
9 A. As the council we were shown the plans. Obviously, it
10 was very hard to get plans prior to that last major meeting
11 and we went down and inspected the site, and it's going
12 ahead and, hopefully, it will be opened, I don't know by
13 when. Maybe July. The other thing is the other
14 hydrotherapy pool at our insistence has been kept open for
15 use, out at the old rehab. centre. There is hydrotherapy
16 happening in Bathurst at the moment.
17
18 Q. When you said there was some difficulty in getting
19 plans, was your council shown the plans of the new hospital
20 complex?
21 A. Very early we were, and then when we looked later,
22 they were always fairly secretive and we couldn't get any
23 information on them. Not being an architect or builder I'm
24 certainly not good with plans. We do have some men on the
25 council.
26
27 Q. Who had some sense of it?
28 A. Yes, we couldn't get the answers we were asking for.
29
30 Q. Were you ever asked, as a council, what you thought
31 was necessary in the new hospital, or what should be there,
32 or shouldn't be there?
33 A. I think initially most groups were asked, and I think
34 that was what was called "consultation". I don't think
35 anyone listened, and I don't know whether any of those
36 things went forward, and consultation ceased as far as I
37 could see.
38
39 Q. When you say "initially", can you tell me about how
40 long ago that was?
41 A. Well before the hospital started; when it was all up
42 in the air and the excitement was there we would get a new
43 hospital.
44
45 THE COMMISSIONER: Thank you for coming and drawing that
46 to my attention.
47 <THE WITNESS WITHDREW

1 <GENEVIEVE CATHERINE CROAKER, sworn:

[11.32am]

2
3 THE COMMISSIONER: Q. Would you mind telling me your full
4 name?

5 A. Genevieve Catherine Croaker.

6
7 Q. What would you like to draw to my attention?

8 A. I'm a member of the Bathurst volunteer palliative
9 care. I have been for 15 years. I would like to bring to
10 your attention that I believe that a palliative care
11 facility within a public hospital, or a private hospital
12 for that matter, should be available to the general
13 community, and by that I mean a private area that is set
14 aside, like we did have in the old hospital, which was set
15 up for the patient and his or her immediate family, or
16 carers to be with them, in the last hours of their life.
17 Those facilities at the base hospital were very, very
18 convenient, and they were very much appreciated.

19
20 I do believe that this is not available in our new
21 hospital, although I think there are two rooms available if
22 this situation becomes necessary, but to me that is not
23 good enough. It should be a permanent facility that is
24 there whenever needed, for every time it is needed for.

25
26 Q. May I just ask you a couple of questions? At the old
27 hospital, was there a whole ward set aside or what sort of
28 facility was set aside?

29 A. Yes. One of the original older wards was set aside
30 with a combined situation where the patient was on one side
31 of the area, and on the other side there was a bed set up
32 with a small lounge, table and chairs, and tea and coffee
33 making facilities could be utilised to be with that
34 patient.

35
36 Q. For the family?

37 A. For the family, yes, or whoever was in close contact
38 with them. But, there was also plenty of room there for
39 the medical staff, or the doctors and machinery to do
40 whatever was necessary for that patient. There are some
41 patients who, by virtue of the fact of their condition,
42 have to die in a hospital situation and not at home, as a
43 lot of people would prefer to do. Some people just don't
44 like that type of environment.

45
46 Q. In the old facility, the old hospital, how many
47 palliative beds were there?

1 A. There was only the one.
2
3 Q. But it was in a very roomy --
4 A. Very convenient.
5
6 Q. -- comfortable environment?
7 A. Yes.
8
9 Q. I get the sense from you, as you understand it, in the
10 new hospital there is not getting to be a dedicated space
11 for that.
12 A. No, not to my knowledge.
13
14 Q. There are said to be some single rooms that will be
15 substituted for that purpose?
16 A. That's correct, yes. I believe that it is not only
17 necessary in our hospital, but it's necessary in all
18 hospitals.
19
20 Q. Can you give me a sense -- I'm not asking you to be in
21 any way precise -- of how frequently that facility was used
22 in the old hospital?
23 A. Very frequently.
24
25 Q. Would it be two or three times a week, or once a
26 month? Just give me a general sense, if you could.
27 A. It would depend on the time of the patient being put
28 there, and how long they have to stay there before they
29 pass away. I was involved in a number of people. Some
30 were there only 24 hours. Others were there for days and
31 days, and one particular person was there for 10 days and
32 that was ongoing.
33
34 Q. Would the bed have been occupied most days of the
35 year?
36 A. No, not most days. It depends, as you would
37 appreciate, the number of people who become deceased in the
38 hospital which is lesser today than what it used to be, but
39 still it is very necessary that it is available.
40
41 Q. Is there anything more you wanted to add to that, I
42 understand what you are telling me.
43 A. I think that is what is necessary and needed in the
44 community.
45
46 <THE WITNESS WITHDREW
47

1 <IRENE SHIRLEY BOTTOM, sworn:

[11.37am]

2
3 THE COMMISSIONER: Q. Would you mind telling me your
4 full name?

5 A. Irene Shirley Bottom.

6
7 Q. I have a note that you wanted to draw my attention to
8 some emergency department issues. Can I ask about your
9 background. Are you a resident or user? How do you come
10 to know about these issues?

11 A. My son is a regular patient up there. Because of a
12 disability I'm his carer, so I'm there quite regularly. If
13 you don't mind, I have written some things down, and I have
14 also got some answers from some of the greater western
15 health area.

16
17 Q. You go ahead.

18 A. My son, Matthew Bottom, has uncontrolled epilepsy.
19 He's 39 years old and attends Glenray Industries where he
20 works in the wood products division. He completed his
21 school certificate, but because of his seizures he cannot
22 work in certain areas. Fits are not his biggest problem,
23 it's where he has them that causes the damage. Scores of
24 times he has been to emergency at the Bathurst Hospital
25 over the last 10 to 12 years, and many of these visits
26 leave a lot to be desired. There's only the last one,
27 which was at the new hospital; the others have been at the
28 old hospital.

29
30 Actually, I don't know where to start but I will read
31 you a letter that I sent to the paper, the Health
32 Department, Gerald Martin and the Minister for Health. I
33 sent in February this year. The answer:

34
35 In reply to the feedback you provided in
36 relation to your son's medical treatment at
37 the Bathurst Hospital, Dr Marshall, who is
38 the Director of Emergency Department, has
39 investigated your concerns and
40 provided the following information:

41
42 In relation to Matthew's injured finger,
43 the doctor, who reviewed Matthew on Friday
44 night, advised that he found no significant
45 abnormalities. The ambulance records and
46 the nurse assessment also indicated no
47 abnormalities.

1 How this came about, my son's quite normal, for the
2 want of another word. He goes to the bank himself, all
3 those sorts of things. Quite often I get a phone call from
4 the ambulance to say he has had a fall down the street and
5 they have put him in the ambulance and they are taking him
6 to hospital. If I can get to the ambulance before he gets
7 to hospital, I take him home, but most times they have got
8 in the ambulance and they take him off to the hospital. So
9 when we went up to the hospital, I couldn't park near the
10 place.

11
12 Q. This is the new hospital?

13 A. This is the new one. I drove down and they said "You
14 can't park there". I said "Where's my son? I want to see
15 my son." "You have to park in Howick Street." I went out
16 there, there is no parking. I went round into the under
17 car park, which had a little sign written on the concrete
18 wall in red texta, "Lift". That's all the sign was to tell
19 you how to get into the hospital. I have got bad feet
20 which makes it very hard to walk. I got up in the lift,
21 and then you had to go right back through the scaffolding
22 and everything, and I would have been about 20 feet away
23 from him where I was parked in the first place. I got in
24 there and found he wasn't serious. He was in there and he
25 was coming around, out of his fit.

26
27 Once they did all the things that they usually do,
28 they put the little prick in his finger and put the blood
29 pressure or something on his finger as well. After about
30 an hour, they found he could tell them what day it was,
31 could tell them where he lived and how old he was, and so
32 forth, so they sent him home. They said "He's right to go
33 home". When we got home he said "My finger is sore".
34 "What is the matter with your finger?" This finger was
35 broken and bent, and bruised right down into here
36 (indicated). That was Friday night. I rang them back that
37 Friday night and I said "The finger you have been treating
38 him with is broken". They said "Don't bring him back
39 tonight, because you have had such a doing tonight, bring
40 him back tomorrow." I took him back the next day. They
41 x-rayed his finger, and they put it in a -- I think they
42 call it a buddy, where they strap the two fingers together
43 and they made an appointment for me to take him on the
44 Wednesday to see Dr Haig in the fracture clinic.

45
46 They assured me the doctors had found nothing wrong
47 with the finger; the two doctors in the first place. I

1 will continue with the letter that I got back from western
2 health:

3
4 The information available indicates that
5 you returned Matthew on Saturday morning
6 and he was seen by a doctor who appears not
7 to have seen Matthew before. On this
8 occasion an x-ray was performed. The x-ray
9 report indicated that no abnormalities were
10 detected. Dr Marshall has discussed our
11 concerns with the doctors that attended
12 Matthew in emergency both on Friday and
13 Saturday. Please be assured that we, on
14 both occasions, are satisfied the medical
15 staff acted in Matthew's best interests.

16
17 I just added the bit in there: Why did they send him
18 to the fracture clinic?

19
20 Also in your letter you stated it was
21 organised for Matthew to go to Orange Base.
22 Dr Marshall has reviewed the medical
23 records which indicate that Matthew
24 attended Bathurst Base Hospital on the
25 Saturday morning. Orange Hospital had no
26 record of Matthew attending in 2008.
27 Dr Marshall discussed this situation with
28 two doctors caring for Matthew at Bathurst
29 Base who advised that Orange was never
30 mentioned.

31
32 The fact they couldn't see anything wrong with it, but
33 they sent me to the fracture clinic. The other thing was
34 about him going to Orange; that was three years before. A
35 different finger, a different doctor, a different time.

36
37 On the other occasion he broke that finger in another
38 fall down the street, they rang me. I went up and I said
39 "Is he okay?" They said "He has just a bit of skin off his
40 face." When I got up there I said "Are you okay, mate?"
41 He said "Look at me hand." His finger is sticking out, all
42 bruised and whatever, and I said to the doctor "What about
43 his hand?". A doctor came and x-rayed it, and she said
44 this bone was splintered in five places and pushed up
45 through the knuckle. She said "I can set it but it won't
46 be straight. Does that matter?" I said "Yes, it does
47 matter." She said "Does he use his left hand much?" I

. 17/3/2008

483 I S BOTTOM
Transcript produced by Merrill Legal Solutions

1 said "I don't care if he uses his left hand much or not, I
2 want it straight." "In that case, you will have to take
3 him to Orange." That was three years before this one, and
4 this was the answer I got in here about going to Orange.
5

6 Q. When you were earlier describing to me your experience
7 on this most recent occasion, you didn't say anything to me
8 to suggest that anyone had raised Orange with you.

9 A. No-one raised Orange whatsoever. With this experience
10 in Orange, and I wrote to the Health Department then, about
11 them saying about his finger being crooked and all that,
12 and him having to go to Orange.
13

14 Q. I don't know that I am going to be able to go back
15 three years. Keep going about your most recent incident.

16 A. This includes the recent incident because they said I
17 had written it in a letter. I said "I didn't put it in a
18 letter he was going to Orange". The lady wrote back and
19 said "Yes, you did. I have it in your own handwriting". I
20 said "I didn't put it in my handwriting, I typed it out and
21 my daughter sent it on the computer back to you. It's not
22 in my handwriting." We had a meeting up at the hospital,
23 last Thursday week, and she said "It's there in your own
24 handwriting". I said "That's the letter I sent three years
25 ago, not the letter I sent this week about the finger.
26 It's a different finger, a different time".
27

28 It was five interviewed me that day, five different
29 people. The nurse said to me "Well, you can understand the
30 misunderstanding, because it was all put in the one file".
31 I said "But surely when it's three years apart, I know,
32 it's a medical file and it's not life threatening, but
33 after all it is a medical file, and if you can't get it
34 right, three years apart, two different fingers, two
35 different times, what hope have we got?"
36

37 There has been so many incidents up there with him,
38 but this was the only one in the new hospital, but in the
39 old hospital as well. On another occasion he fell, we took
40 him up there and he had bruised the palm of his hand and I
41 was worried he might have broken it or something. A doctor
42 that had seen him at least three times previously said to
43 him "How did you come to fall over?" He said "I had a
44 seizure", and the doctor turned to me and said "Why don't
45 you talk him to a doctor and get drugs for this boy? He
46 shouldn't be having seizures"; this is a doctor that has
47 seen him. He has a file at the hospital that thick

1 (indicates) and I said "He's on 26 tablets a day, had
2 epilepsy for 24 years and had two brain operations", so
3 then they run off and took the x-rays and things like that.
4

5 Another time he had a fall against a wrought iron
6 railing. I couldn't get him up so I got the ambulance.
7 The ambulance come to him, took him to the hospital and
8 because after he has had a fit and his brain's -- his left
9 hand doesn't know what the right hand is doing. It takes a
10 while to get him back coherent again. He kept saying he
11 had a pain. He couldn't tell anyone where it was. As soon
12 as he could tell them his date of birth and that they send
13 him home. He complained about a sore side, but the doctor
14 said it was muscular. After about five days I took him to
15 another doctor and he had sprung two ribs off his spine,
16 and they just send him home as soon as they can, as soon as
17 they think he is coherent and I tell them every time and,
18 like, I'm a stupid mother. He's 39 now. He has been
19 epileptic since he was 12 and they take no notice.
20

21 Another time he was in a seizure and they couldn't get
22 him out of it and the doctor was going to put a cannular in
23 this arm. I said "For 26 years they have been trying to
24 get a vein in that arm. They can't." This doctor said
25 "That's a challenge, isn't it?" I said "You are not going
26 to do it." He come around this side and going up his arm.
27 He was peering at it. I said "The light is not good
28 enough." He went away and got a portable light and sat it
29 there and said "That was a good idea you had". Surely it's
30 not up to me to tell them to go and get another light if
31 they can't see.
32

33 Then he said, "Because of the trauma, his veins have
34 collapsed, so we can't put it in." He is laying in the
35 bed. The doctor went away, rang the registrar and the
36 registrar said "You have to put the cannular in". All the
37 time I was saying "Give him a Valium. He will go to sleep
38 and he will come out of it." They said "Can't do it." I
39 said "I have been doing it for 20 years." "We have to put
40 the cannular in." "I am going home, do what you like". I
41 went back the next morning and I said to him "Did they put
42 the cannular in?". He said "No, they gave me a Valium and
43 I went to sleep".
44

45 He has been a epileptic for 26 years, and the last 10
46 or 12 we have lived down here, and every time we have come
47 in there has been some misdiagnosis, missed injuries and

1 things they don't just ever think about. Dr Marshall, who
2 is the head apparently of the doctors in emergency and said
3 to me after our interview a couple of weeks ago, "What
4 would you like me to do about it?" I said "You are the
5 boss, you fix it. It's not up to me to tell you how to do
6 your job". I don't know whether he liked that or not, but
7 I don't think it's my job to tell the doctors in emergency
8 how to do their job.

9
10 I think the new hospital, some of it's very good, some
11 of it's very bad. I put a letter in the paper and I have
12 had so much feedback from people who hardly know me about
13 things that went wrong, the only thing I can say, the
14 people that are sticking up and saying everything in the
15 hospital is wonderful, they are either frightened of losing
16 their jobs or else they haven't been a patient themselves
17 in emergency. I'm sorry if that upsets anybody, but that
18 is my story and that's my son that I am trying to look
19 after.

20
21 Q. Can I ask you a couple of questions?

22 A. Certainly.

23
24 Q. Just let me limit my question, firstly, to the last
25 incident. When your son was sent home, was that after a
26 doctor had seen him, or a nurse, or both?

27 A. Both.

28
29 Q. Was the doctor a relatively junior doctor, or didn't
30 you know?

31 A. I didn't know. The first one that saw him was a lady
32 doctor that I hadn't seen before. That was on the Friday
33 night. He kept complaining about his sore finger, but he
34 had the thing on whatever, and I thought it was because
35 they had pricked it for the blood. I wasn't concerned
36 about it being broken. Surely they would have seen his
37 finger. He was in hospital for about an hour or so. When
38 I got home I noticed it was bruised and bent and stiff.
39 That is when I rang back.

40
41 Q. I will come to that. He was in hospital for about an
42 hour, approximately, on the Friday night?

43 A. Yes.

44
45 Q. He was seen by, at least, a doctor and probably a
46 nurse as well?

47 A. There was a marvellous nurse up there, yes.

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Q. When you went back the next day, which was then a Saturday, were they able to take an x-ray that day?

A. They took an x-ray.

Q. That day?

A. That day, yes.

Q. And then he got referred to the fracture clinic?

A. They took an x-ray on that Saturday morning. We come back to emergency and, as I said, they did the buddy thing and strapped them both together, and they made the appointment for me to go and see the fracture clinic on the Wednesday.

Q. Stopping you there, when you are talking of "they", I am keen to understand whether it's a doctor or a nurse that is treating you in emergency on the Saturday.

A. The doctor. Another doctor, not the first one, it was a man doctor the second time.

Q. The clinic on the Wednesday, the fracture clinic is with an orthopaedic surgeon, is it?

A. It was Dr Haig, yes.

Q. You took the x-ray to him?

A. The x-ray was on the computer.

Q. Already there. So he looked at it?

A. Already there.

Q. He told you he didn't think there was a fracture.

A. It was a fracture. He said "It's fractured through the knuckle." He put a splint on it and taped it up and that sort of thing.

Q. Do I have a sense that what you are telling me is that part of your frustration, with your son being a regular visitor to the emergency department, is because you are striking different doctors all the time, in the emergency department, that you don't have a sense they know your son's background and therefore how to properly treat him? Is that what you are saying to me?

A. No, what I am saying is if it was - this is probably getting away from it - a dog or horse that couldn't speak, they would examine that because he couldn't talk to them. If it was a horse with a sore leg or pain somewhere, they

1 would examine him properly. Because Matthew at that time
2 can't explain everything, and I can explain until I'm blue
3 in face "give him a Valium" or anything, they don't take
4 any notice. You are talking about different doctors at
5 different times. We have had the same doctor up there
6 about three times, at least three times, and still, they
7 just look at the outside image being he can talk again,
8 let's get him out of here.

9
10 Q. When you go there, you said to me a little while ago
11 he has notes that are quite thick. Are those notes
12 available in the emergency department when you go there?

13 A. They would be easy to get.

14
15 Q. No, that is not what I asked you.

16 A. No, they are not there at that time. No.

17
18 Q. Do you think that is one of the reasons why there is
19 some delay in doing either what you say or finding out the
20 right thing to do?

21 A. No, I think it's just pure ignorance on the doctors'
22 parts. Even if he was a new patient that had never been
23 there before, they still should take more interest. If
24 somebody went in with a car accident and had a broken arm
25 they would go all over them to make sure they are all
26 right. Because he is there so often, they think it's just
27 a seizure and "We will fix him and send him home". I sit
28 there quietly, and when I get home I'm furious. It's not
29 fair to him to be left.

30
31 With his epilepsy, it's serious because it's
32 uncontrolled. His tablets we give him at six in the
33 morning, two and 10. They are eight hours apart and this
34 was in Orange Hospital. He was in there after seizures
35 once and I went in at lunchtime and he said "They gave me
36 my tablet at half past 10 this morning". I said "They
37 probably won't give you your next lot until half past 3."
38 This was half past 12. He said "No, I have already had my
39 second lot." I let him live his life but I protect his
40 health as much as I can. You put him in somewhere like
41 that; the neglect and she'll be right mate.

42
43 With the hospital up here, too, I went in one morning
44 about 10 o'clock and he said "Haven't had me tablets yet"
45 so I asked a lady, one of the nurses, and she said "The
46 pharmacy doesn't open until 8 o'clock" and I said "It's 10
47 o'clock now". We set the alarm for 6 o'clock so he can

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have his tablets on time, because they are called a short life or something, and when he has anything up to 10 fits a day, you do absolutely anything to control them. He could come in here and talk as well as I am on a good day.

Q. Thank you very.
A. What can we do about it?

<THE WITNESS WITHDREW

1 <MARGARET CLAIRE WILSON, sworn:

[12.01pm]

2
3 THE COMMISSIONER: Q. Would you mind giving me your full
4 name?

5 A. Margaret Claire Wilson.

6
7 Q. I understand that you are a psychologist.

8 A. I'm a senior psychologist with community health.

9
10 Q. Would you like to tell me where the community health
11 service is based in Bathurst? Is it at the hospital?

12 A. It is now at the hospital, the last five weeks.

13
14 Q. Prior to that, where was it?

15 A. We were temporarily housed out at Gorman's Hill in the
16 old CRS, the commonwealth rehabilitation and before that,
17 most of the time that I have worked for health, we were in
18 Williams Street in Bathurst.

19
20 Q. How long have you been associated with the community
21 health service?

22 A. 1981 I joined health. 1984 I was then primarily
23 employed by community health. Prior to that I was
24 regional.

25
26 Q. What would you like to draw to my attention?

27 A. I know this is an Acute Care Inquiry. What I thought
28 you may be interested in -- I have enough complaints about
29 our circumstances but that is not the purpose of your
30 inquiry -- it seems to me that what we are inhabiting was
31 never built for community health, it wasn't purpose built
32 and we are actually taking away space that I suspect acute
33 care needs. The treatment rooms that we have for
34 patients -- we call them clients -- are internal rooms.
35 They are hour-long consultations usually. These seem to be
36 built as rooms for fairly quick consultations. There is no
37 windows in them. We have clients, patients that are
38 claustrophobic that find an hospital environment toxic, or
39 traumatic for them in some way.

40
41 Q. Are these patients with mental health or mental
42 illness disability?

43 A. Can be, but generally the psychosis is treated by the
44 mental health service which is below us, and in actual fact
45 that mental health, our service, and rehab. don't seem to
46 me to be part of an acute hospital. They should be housed
47 somewhere else and much more accessible in a private way, I

1 suppose; particularly for community health and for some
2 patients in mental health.
3
4 Q. Would it be your view that community health premises,
5 community health centres, or where community health
6 services are located ought to be away from the hospital?
7 A. Yes, I feel very strongly they should be.
8
9 Q. And in the community?
10 A. In the community as we were in William Street so
11 anyone would walk in at any time. It had nothing to do
12 with acute services.
13
14 Q. Do you find that some of your patients who, when they
15 do come to see you, are in fact in need of some acute care?
16 A. No. In my clinical life, which is 24 years, I never
17 had -- that's a lie, once, I have had somebody once. In
18 that case you take them up to the hospital. If it's a
19 psychotic, and they are in need of the acute mental health
20 services, they used to be with us, and then they were
21 across the road from us in a house.
22
23 Q. Did I get from your earlier evidence they are now
24 located below you?
25 A. Yes.
26
27 Q. Different floor?
28 A. Different floor, not easy to get into. There are a
29 whole lot of issues which I'm sure someone has talked to
30 you about of communication and all sorts of strange things,
31 but that's not what I am here about.
32
33 Q. Do I correctly summarise what you are telling me that
34 your view is that the premises that you are presently
35 occupying would be more appropriately suited for acute
36 care?
37 A. Yes.
38
39 Q. And that premises for the service, of which your
40 consultative role is a part, ought not to be on the
41 hospital's grounds but ought to be in the community and
42 thereby more easily accessible?
43 A. That is correct. They are just unsuitable premises
44 for patients. We have no soundproofing. They are
45 windowless, claustrophobic. The airconditioning; they have
46 been built for 15 minute consultations for ventilation. I
47 have heard that the airconditioning man said that you have

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to get up and open the door every 15 minutes.

Q. Where are they adjacent to? What else is on your floor?

A. Right next to obstetrics. I went downstairs last week into the big foyer that comes into the hospital, where our patient/clients come in, and there is somebody, I don't know whether they were going to theatre or coming from theatre. It's a hospital. It has have a hospital feel. There are gowned doctors around. It's a hospital. It's an acute care.

Q. I understand that, is there anything else you would like to draw to my attention?

A. Not that's relevant to what you are trying to do.

<THE WITNESS WITHDREW

2
3 THE COMMISSIONER: Q. Would you mind giving me your full
4 name.

5 A. Beverley Ann Walsh.

6
7 Q. What would you like to draw to my attention?

8 A. I want to draw to your attention what happened when I
9 took my husband to the Bathurst Base Hospital last May. My
10 son and I took him in a great deal of pain. It was very
11 obvious he had a problem with a hernia. When I got there,
12 he was admitted in quite quickly.

13
14 Q. Was that through the emergency department?

15 A. Yes, through the emergency department. He was seen by
16 one of the doctors. It was obvious he was trying to see
17 what was happening. He came up in reasonably good time,
18 gave him painkillers, which brought his discomfort under
19 control. He said that his hernia obviously was out and had
20 strangulated. He made several attempts to put it back in.
21 They were totally unsuccessful. He said he would have to
22 ring the registrar to come and have a look at it. That
23 happened. We were told then that his bowel was coming out
24 of his hernia, and he needed an emergency surgery. I was
25 told unfortunately, no, there is no surgeon available.

26
27 Q. What time of the day or night was this?

28 A. It was a Saturday evening. Probably by this time it
29 might have been half past 9, 10 o'clock. He would have to
30 be transferred to Orange Base. They did that by ambulance.
31 I went with him in the ambulance. My son went to let the
32 rest of the family know what was happening. We got to
33 Orange Base and were brought into the emergency area again.
34 They called a doctor who was -- I find it hard to explain.
35 He was a very arrogant young man who dismissed what we had
36 told him, that he had been sent to Orange for an emergency
37 operation.

38
39 When my son, who had been in the emergency area at
40 Bathurst Base with me the whole time, tried to say
41 something, he asked him and my daughter to leave the area.
42 He just was very offhanded and said "That can wait until
43 morning, there is nothing wrong there. He's okay. It can
44 wait until morning". He did point out that if my husband
45 had a flat stomach, like he had, he wouldn't have a hernia,
46 which I thought was totally unnecessary. I could have
47 pointed out my husband was quite slim and the hernia was

1 caused by heavy work. We were told to go. I came home. I
2 was very well aware of how serious it was.
3

4 Q. You came back to Bathurst?

5 A. I came back to Bathurst. I rang early Sunday morning
6 expecting him to be in theatre. He hadn't been seen by
7 anyone at all. The staff were quite surprised that I
8 suggested that he should have been seen by a surgeon at
9 that stage. I went to Orange Base. I asked my husband if
10 he wanted me to come up then. I had to insist that I
11 needed to speak to him. There's no phones near patients at
12 Orange Base, but they did bring the phone to him and I
13 spoke to him. I said "Do you want me to come up now?" It
14 was Sunday morning and I normally would attend church. He
15 said "You go to church. Come up after church." I did
16 that. When I got there he was in surgery, in theatre. My
17 son and I waited for over three hours outside of theatre.
18 When the surgeon came out he asked if there was anyone
19 belonging to my husband. I went to him. He was obviously
20 trying very hard to tell me what happened without being
21 critical of his care. He said "Unfortunately by the time I
22 saw him, and got him to theatre, a part of his bowel had
23 died, it needed to be removed." Consequently it was much
24 more major surgery than it would have been Saturday night.
25

26 On the Sunday evening, when I got home, my daughter
27 had been talking to a friend who said I should have
28 insisted on a surgeon on Saturday night. I said "It's very
29 hard to insist because you are relying on the medical staff
30 being honest with you, and that they are doing what is best
31 for the person you have there."
32

33 I found it incredibly hard because I knew how serious
34 it was. Fortunately, my husband didn't realise how serious
35 it was for him, his tear. His recovery was longer than
36 what it would have been had it been attended to. The worst
37 part, this is the part I find incredibly hard, I think it
38 was Monday afternoon or Tuesday morning, I was told there
39 was a surgeon available, and he had been totally furious
40 when he had heard. He was being told in a casual
41 conversation by a friend of the family what a trauma we had
42 been through at the weekend, and he said "I was on call on
43 Saturday night. I should have been called". It's very
44 hard to know that the staff, for whatever reason, had
45 chosen to send us to Orange. We, the family were very
46 fortunate --
47

1 Q. The surgeon who said he was call, was that on call at
2 Bathurst or Orange?
3 A. He was on call at Bathurst Base Hospital that night.
4 In the country, with no public transport or anything, it's
5 a long way. It's very expensive to get to Orange and back
6 to be with a member of your family, and whilst we were able
7 to do it, there would be a lot of people who wouldn't be
8 able to do it. Being transferred out of town when the same
9 service is available in your town puts an incredible strain
10 on everyone. I was told at Bathurst Base he could transfer
11 back. Who do you transfer back under? If you transferred
12 back to Bathurst, the surgeons here wouldn't be familiar
13 with what had happened, what had been done in the
14 operation.
15
16 Q. I understand that. Can I ask you this: did you lodge
17 any complaint with the Health Care Complaints Commission or
18 not?
19 A. I hadn't. My husband's recovery was quite full. He
20 wasn't aware for several weeks afterwards, and I exploded
21 one day, because I had heard another similar type of story
22 and I said I know what I have gone through and finding out
23 the surgeon was available and this didn't have to happen,
24 and I honestly couldn't work out who I could go to, where I
25 thought I would be listened to.
26
27 Q. To your knowledge, did either Bathurst or Orange have
28 any form of staff member who was described as a complaints
29 officer or patient advocate or anything of that kind?
30 A. I'm not aware of one.
31
32 Q. If there was such a person, it didn't come to your
33 attention?
34 A. No.
35
36 Q. I don't know if there is, I was just wondering.
37 A. I thought of a lot of things. I know about the
38 Hospital Watch. I did know a gentleman that was on it but
39 unfortunately he was quite ill at the time and I thought he
40 didn't need to listen to my problems. He has passed away
41 since then. He was the only person I thought I could go to
42 and tell, and I knew he would do something about it, but I
43 didn't want to burden him with something when his health
44 was not good.
45
46 Q. From what you tell me, the first issue is staff at
47 Bathurst knowing who is on call and who wasn't on call, and

1 what services were available on the Saturday; is that
2 right? That is the first issue. The surgeon has told you
3 he was on call and yet your husband was sent all the way to
4 Orange.
5 A. I have tried very hard to think what might have been
6 the reason. The only logical thing I could come up to,
7 because it was May and hospitals have budget blow-outs,
8 they were trying to save emergency staff coming in for
9 operations. That is the only logical thing I can think of
10 that would make any sense.
11
12 Q. That is your assumption. Has anybody from the
13 hospital told you that?
14 A. No, that is my assumption, because we have an adequate
15 number of good surgeons in Bathurst. I couldn't understand
16 why, on one night, there was not one surgeon. I know
17 doctors swap shifts if there is something they need to
18 attend to, other doctors cover for them. I couldn't
19 understand. If it had been an orthopaedic problem, I know
20 we don't have an orthopaedic surgeon to cover, but a
21 general surgeon, we have enough general surgeons in
22 Bathurst to cover adequate care.
23
24 Q. Then there was another problem at Orange where the
25 initial doctor, who you described as quite young --
26 A. He was a youngish.
27
28 Q. -- seems to have made an incorrect --
29 A. He made a number of incorrect decisions, from what my
30 husband said.
31
32 Q. -- decisions about your husband's care?
33 A. My husband didn't see the surgeon until he was on
34 general rounds. When he did come, there was a lot of hurry
35 to get him to theatre. As soon as he had seen him it was
36 very obvious he needed immediate attention. The doctor
37 often made, on his rounds, suggestions on my husband's
38 treatment. Almost always that treatment was dropped when
39 the surgeon arrived. He would put him on food when he
40 wasn't allowed to be on food. His knowledge seemed to be
41 relative inadequate.
42
43 Q. Relatively junior with what seemed to you to be
44 inadequate knowledge and experience?
45 A. Yes, he was very junior.
46
47 Q. Is there anything more you wanted to draw to my

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attention?
A. No, thank you.
<THE WITNESS WITHDREW
LUNCHEON ADJOURNMENT

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UPON RESUMPTION:

THE COMMISSIONER: Good afternoon, Ladies and gentlemen, we will resume the hearing of the inquiry. Mr Gibbs, would you like to come forward?

<RODNEY HILTON GIBBS, sworn: [1.15pm]

THE COMMISSIONER: Q. Would you mind telling me your full name.

A. Rodney Hilton Gibbs.

Q. You wanted to draw something to my attention about dialysis services?

A. Dialysis machines, the lack of dialysis machines in Bathurst Hospital.

Q. You tell me what you would like to say.

A. They have only got four machines up there. They have been promised another two machines, and they have been apparently on order, and they were supposed to be in use by the middle of this month. As at the moment, I have to travel from Bathurst to Orange which is 55 kilometres up and 55 kilometres back. I cannot drive myself, because you can't drive after you have had dialysis. The wife has to take me. We don't get any help with any fuel or costs or anything else. I reckon they should have put more thought into putting more machines in Bathurst, than what they have, because kidney disease is on the increase and they are not catering for it.

Q. Let me see if I can ask you a few questions, if you wouldn't mind. How often each week, or each month do you go for dialysis?

A. Three times a week; Tuesday, Thursday and Saturday.

Q. How long does each session take? Roughly?

A. About four and a half hours on the machine. You are looking five and a half hours by the time they put you on there, or six hours, by the time they put you on and take you off.

Q. For how long have you been in the Bathurst area?

A. I have been living here all my life but only I have just started dialysis in January in Orange.

Q. All of your dialysis has to be in Orange?

1 A. Yes, because they have no room in Bathurst here.
2
3 Q. Is that because they have a limited number of
4 machines, as you have been describing and the list of
5 treatment is full?
6 A. Yes. There are five people travel from Bathurst to
7 Orange, that I know of, to have dialysis.
8
9 Q. As you understand the position, it will be that when
10 and if these new machines arrive, and get commissioned and
11 set up and organised, you will be able to take your
12 dialysis in Bathurst?
13 A. Hopefully if they can fit me in there. I got two
14 plastic valves in the heart. I have had them for 40 years
15 and my cardiologist and surgeon in Sydney wrote to Orange
16 and said that I would be better off to have dialysis in
17 Bathurst, because the travelling backwards and forwards is
18 knocking me about too much.
19
20 Q. You are saying there are four people in the same
21 category as you?
22 A. Yes.
23
24 Q. So five in total?
25 A. Yes, that I know of.
26
27 Q. Do you know if in either Bathurst or Orange, it
28 doesn't matter, there is any dialysis being done at home?
29 A. I'm not sure.
30
31 Q. You don't know.
32 A. I can't do it at home, because they can't put a
33 fistula in me, because of my heart. In about two months
34 time, I have to go back into hospital again and have the
35 open heart surgery, and the valve replaced back in the
36 heart because they are worn out. From what I can gather
37 from the people up in Orange, the nursing staff and the
38 people in the dialysis ward up there, when they build the
39 new Orange Hospital, instead of having 11 chairs like they
40 have now, they are going to be knocked back to eight.
41
42 Q. Bathurst has four chairs, you were saying, does it?
43 A. Four chairs.
44
45 Q. There were another four?
46 A. Another two have been ordered.
47

1 Q. And not yet set up.
2 A. Apparently they are going to remove a wall between
3 ambulatory care and extend the dialysis and put more
4 plumbing in there. But, I don't know when they are going
5 to do that.
6
7 Q. So far as you are aware, is there no allowances at all
8 available to assist with the cost of transport?
9 A. No, there are no allowances. The only allowance you
10 get, if I have to go to Sydney to see the specialist, which
11 is over 100 kilometres, you get IPTAS. They pay a certain
12 amount on your fuel. Because you are not doing 100
13 kilometres in one way, you don't get nothing. I'm only on
14 a disability pension, it's a fair bit to fork out.
15
16 Q. I understand that. You are dependent on your wife to
17 transport you?
18 A. Yes.
19
20 Q. Is there any transport provided by the area health
21 service?
22 A. There's one day a week a community service takes me up
23 and it costs me \$15 to go with them.
24
25 Q. They bring you back as well?
26 A. Yes.
27
28 Q. I understand the problem. I don't know what the
29 solution is, I understand the problem.
30 A. I think they should have more --
31
32 Q. Services in Bathurst?
33 A. Yes, because travelling back and forward to Orange is
34 too much.
35
36 Q. I understand that. Thank you very much for coming and
37 telling me about that.
38 A. Thank you.
39
40 <THE WITNESS WITHDREW
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1 <ROBERT LLOYD HOOPER, sworn: [1.19pm]
2
3 <WITNESS ASSISTING
4
5 <IAN LLOYD WEYLAND, sworn: [1.20pm]
6
7 <WITNESS ASSISTING
8
9 THE COMMISSIONER: Mr Hooper, could you give me your full
10 name?
11
12 MR HOOPER: Robert Lloyd Hooper.
13
14 THE COMMISSIONER: You are presently the Mayor of Oberon?
15
16 MR HOOPER: Correct.
17
18 THE COMMISSIONER: And a resident of Oberon or the
19 district?
20
21 MR HOOPER: Resident of Oberon.
22
23 THE COMMISSIONER: In the town itself?
24
25 MR HOOPER: No, in the rural area, in the shire.
26
27 THE COMMISSIONER: Mr Weyland, your full name?
28
29 MR WEYLAND: Ian Lloyd Weyland.
30
31 THE COMMISSIONER: You are the Chairman of the Oberon Aged
32 Care Committee.
33
34 MR WEYLAND: That's correct.
35
36 THE COMMISSIONER: Are you a resident of Oberon too?
37
38 MR WEYLAND: That's correct.
39
40 THE COMMISSIONER: What would you like to draw to my
41 attention? Let me say I spent a little over an hour at the
42 Oberon MBS this morning. I think I have some understanding
43 of Oberon and the services that are available. Please go
44 ahead.
45
46 MR HOOPER: Just to introduce myself and supporting from
47 the council: Oberon has been pushing for more aged care

1 and more beds in the hospital for many years, and the
2 particular problem there is the aged care taking up the
3 acute beds in the hospital and, generally speaking, we are
4 looking for more beds in the hospital. But I will hand
5 over to Ian to give the detail.
6

7 MR WEYLAND: Our problem has been in the making of many
8 years. At the moment we have got four aged care patients
9 taking up acute beds. The situation is when we get to the
10 point of those acute beds being required, the aged care
11 people are then asked to leave town. This is a matter of
12 driving at least to Bathurst, our closest facility,
13 sometimes twice the distance, some people to Dubbo or even
14 further. These people are people that are at the frailest
15 time of their life, at the time when they most need family
16 and friends, and it's the hardest thing to force them to
17 leave our town.
18

19 Now, the situation, just to sum it up: 40 years ago,
20 the Oberon Base Hospital had 12 aged care beds. Since our
21 new MPS was built in the late nineties, we now have eight
22 aged care beds, that are continually filled and people of
23 the town are basically waiting for somebody to die to
24 acquire a bed within the hospital within their town. I
25 don't think I need to stress the heartache and the pain
26 there is in taking somebody from a country community and
27 putting them away in a total strange environment.
28

29 City people don't realise it. If this should happen
30 in the city, it's a matter of moving from one suburb to the
31 next suburb, or a few minutes down the road. 40 kilometres
32 from Oberon means there is an 80 kilometre round trip to
33 Bathurst alone. When you have somebody frail, and at that
34 age, they need visitors as often as they can receive them.
35 It's a near impossibility for people to travel to Bathurst
36 to visit their family and their friends. For that reason,
37 I request that the State government find us some extra beds
38 for the purpose of aged care.
39

40 THE COMMISSIONER: Do I understand these facts about
41 Oberon; you have a catchment area of about 5,000 people in
42 the shire?
43

44 MR HOOPER: Five and a half.
45

46 THE COMMISSIONER: Of whom 2700 approximately are in the
47 town. Of whom about 490 are above 70, is that right?

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MR WEYLAND: That would be so, yes.

THE COMMISSIONER: The Commonwealth's ratio for aged care beds is 22 per thousand high care beds, 22 per thousand low care beds and 25 home packages per thousand.

MR WEYLAND: That is so, yes.

THE COMMISSIONER: Per thousand people above the age of 70, is that right?

MR WEYLAND: That is correct. At present we have eight high care beds in the hospital, we have 11 low care beds and I can't say how many packages are going out to Oberon because they are lumped together with Bathurst and this, I believe, is part of our problem. Oberon seems to be put together with Bathurst and Lithgow, this district. When you look at the overall district numbers they meet ball park. There is not a problem foreseen on paper. When you get to the individual town, because we have not been allocated the beds that we should have been allocated to keep within Federal standards we are way behind the eight ball.

THE COMMISSIONER: You have eight high care beds at the MPS, and there are another two there, in fact, aren't there, that used to be the maternity beds, although they are not funded as high care nursing beds?

MR WEYLAND: That is so.

THE COMMISSIONER: There is a bit of a fiddle going on to try and get more beds.

MR WEYLAND: When we first came together 18 months ago and we said that we needed more beds, the first thing they did, the maternity ward had been closed down and turned into a palliative care ward, so they turned that into a double high care aged care facility.

THE COMMISSIONER: You have also got another aged care facility not at the MPS, haven't you, or low care aged facility?

MR WEYLAND: That is so, with something like 11 beds. There is also a waiting list of some five or six people for

1 that at most times.
2
3 THE COMMISSIONER: I was told it was 12 beds, I am not
4 going to argue whether it's 11 or 12.
5
6 MR WEYLAND: 11 full-time and one respite.
7
8 THE COMMISSIONER: You have a waiting list for that, and
9 then there is also, as you pointed out, the bed blockage of
10 your acute ward, because of the high care nursing patient
11 needs.
12
13 MR WEYLAND: That is right. If the high care could be
14 relieved, it would mean a number of people could be moved
15 from the low care facility quicker in the high care, thus
16 making more spaces at a low care level. But, people are
17 hanging on, not game enough to put their hands up saying "I
18 need high care", because they know the first thing they
19 will be told "If you need high care leave town".
20
21 THE COMMISSIONER: Am I right in understanding that
22 nursing care patients, for whom a bed can't be found in
23 Oberon, are dispersed sometimes to Lithgow?
24
25 MR WEYLAND: That is correct.
26
27 THE COMMISSIONER: And any further east than Lithgow?
28
29 MR WEYLAND: I don't know. It becomes a personal matter at
30 the time, and it's up to the family to find a bed and there
31 are people that have been sent to Forbes, Dubbo. Bathurst
32 is the main area because it is our closest town. If you
33 cannot find a bed in Bathurst, you keep going until you
34 find one.
35
36 THE COMMISSIONER: I think I have a real understanding of
37 the problem. In one sense, it's easily solved by
38 construction of additional aged care facility. The
39 question is where's the funding for that come from, and
40 where does the staffing come from.
41
42 MR WEYLAND: This is what we have been fighting for. We
43 have been seeing Miss Maher to ask if the State government
44 in conjunction with the Federal government might be able to
45 find the funding jointly. The State government is saying
46 aged care is a Federal government issue, but the MPS, being
47 a State run organisation, the federal government hasn't

1 wanted to put money into the MPS. That has been our
2 probl em.
3

4 There may be some change in the wind happening at the
5 moment. I don't know whether that eventuate. We don't
6 care where the money comes from, as long as we acquire some
7 beds for our people, so our old people are not forced to
8 leave town.
9

10 THE COMMISSIONER: One of the other problems, I gather, is
11 that the number of attendances at emergency is increasing,
12 so that the requirement for the acute care beds, or the
13 demand for acute care beds is increasing.
14

15 MR WEYLAND: That is so.
16

17 THE COMMISSIONER: Which then creates more of a problem
18 from your perspective.
19

20 MR WEYLAND: This is the dilemma that the doctors face.
21 They need the acute beds for the general community. When
22 they have an aged care person there, they sooner or later
23 say to them "Sorry, time for you to go elsewhere".
24

25 MR HOOPER: I believe there is a problem with the funding
26 from the Federal government if aged care are in beds that
27 are not for aged care anyway.
28

29 THE COMMISSIONER: I can't claim to understand the funding
30 situation yet. I am sure that is right. Whatever you say
31 sounds right to me. Funding is clearly an issue. I will
32 need, in the course of this Inquiry, to make myself
33 familiar with it. It's quite complex, from what I can
34 gather.
35

36 MR HOOPER: Should we leave with you the documentation that
37 has been given to the minister?
38

39 THE COMMISSIONER: That would be very kind, if you make it
40 available to the Inquiry staff. My Inquiry is not into
41 aged care services. It is into acute care services. It
42 seems to me, and I have expressed the view, that in looking
43 at acute care services, I can look at ways in which people
44 come into the hospital to get acute care service, and what
45 stops people from getting acute care services, which is
46 often discharge issues, and in your particular case, aged
47 care facilities into which patients can be discharged. I

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think I can look at that but I can't say I am inquiring into aged care as such. I understand the nature of your problem it was very articulately explained to me this morning when I visited the MPS, where you have a very good staff, it would seem me.

MR WEYLAND: Yes, I would second that, we do have very good staff, very loyal.

THE COMMISSIONER: Is there anything else you wanted to draw to my attention?

MR WEYLAND: No.

THE COMMISSIONER: Thank you very much for coming.

<THE WITNESSES WITHDREW

1 <STAVROS NICHOLAS PRINEAS, sworn:

[1.30pm]

2
3 THE COMMISSIONER: Q. Would you mind giving me your full
4 name, please.

5 A. Dr Stavros Nicholas Prineas.

6
7 Q. Do you have a particular speciality?

8 A. I am an anaesthetist.

9
10 Q. Are you on the staff at Bathurst?

11 A. Yes, I am.

12
13 Q. How long have you been on the staff at Bathurst?

14 A. I have been working in Bathurst as a kind of
15 itinerant, as a long-term locum for about four years, but I
16 am here for the duration.

17
18 Q. What would you like to draw to my attention?

19 A. I would like to make a statement, a brief statement,
20 about how acute care services in Bathurst is relevant to
21 the design of the hospital and the recent experience that
22 we have had in terms of engagement with clinicians and
23 other issues with respect to the provision and the future
24 of acute care service here.

25
26 Q. Go ahead.

27 A. When the Minister for Health and Director-general came
28 to Bathurst a few weeks ago, they sat down with a group of
29 senior doctors, nurses and administrators to hear our
30 concerns. They brought with them a highly wanted advisor
31 with many years experience of building hospitals including
32 one recent metropolitan project in the State which shall
33 remain nameless. In his opening reassurance he said that
34 when this new hospital was first opened, the paging system
35 didn't work for four weeks. When one of us said that she
36 would not have commenced services in this situation, his
37 reply was, "I did and I was in charge".

38
39 It seemed to every clinician in the room that this
40 particular person had many years experience in not
41 prioritising patient safety. It is tempting to dwell on
42 the political, the bureaucratic, the moral and legal
43 aspects of Bathurst's predicament. But, I wish in these
44 brief pages, to focus on patient safety as it relates to
45 this Inquiry. I am not interested in taking scalps, but
46 rather I want to ensure the people of Bathurst get the
47 acute care services they need and deserve and through this

1 inquiry we can make sure the State learns to not repeat the
2 mistakes made here.

3
4 Hospitals are, by nature, hazard rich environments. A
5 place in which vulnerable people, often with devastating
6 injury or disease, present and interact with complex and
7 powerful technology. In unwitting hands, any drug is a
8 potential poison; any piece of medical equipment can render
9 serious harm. It's often left to the clinicians, the
10 nurses, doctors, allied health personnel to carry the front
11 line burden of risk management in hospitals. They see
12 patients. They examine them. They balance benefit versus
13 risk. They make clinical decisions. They administer
14 treatment. Mostly, they are highly trained but many are
15 also in training, and they are all human and will make
16 mistakes.

17
18 No amount of training, experience or goodwill can make
19 clinicians perfect. But, if on top of this, they are
20 having to contend with an environment which is ill designed
21 for their needs, they become distracted, exhausted,
22 disaffected and then, in turn, are more likely to make more
23 mistakes. It is a well established phenomenon in legal
24 research that medical catastrophes are rarely the result of
25 a single blunder. Incompetent, negligent and even criminal
26 individuals exist in all walks of life, including all
27 levels of health care, but far and away the most adverse
28 events are the result of a chain of often minor errors made
29 by otherwise intelligent, knowledgeable and
30 well-intentioned people. It, therefore, stands to reason
31 where there are fewer opportunities for error, it's less
32 likely a lethal chain of errors will form.

33
34 There are two important concepts in error reduction.
35 Training, that is the adaptation of human thinking to the
36 needs and limitations of the environment, and ergonomics,
37 the adaptation of the environment to the needs and
38 limitations of human thinking. Each idea gets you part of
39 the way, but you need both to get as far as you can and
40 while there are many important training issues, and I trust
41 and hope that others will talk to them, I wish to focus on
42 ergonomics.

43
44 A safe hospital needs to be more than just a safe
45 building. There is much more to patient safety than fire
46 exits. A hospital is the one community building that
47 should have, implicit in its design, the same kind of

1 integrated safety features that you would find in a modern
2 family car. Everything about it is designed around the
3 safety of its occupants, and the ability of the driver to
4 perform in a range of emergency situations; air bags,
5 crumple zones, advanced braking systems are all now
6 standard. Sure, there are plenty of older cars on the road
7 without these features, but no manufacturer is allowed to
8 build a new car without them.
9

10 Hospitals need to be designed around clinical
11 performance and patient safety. In a well designed
12 hospital, it is easier for clinicians to perform everyday
13 tasks more safely, to make medical errors less likely and
14 when errors do occur, they are easier to detect and correct
15 rapidly to mitigate the potential for harm. This is so
16 obvious to clinicians and yet those who planned, inspected
17 and commissioned the Bathurst Hospital clearly did not
18 embrace this idea. It's the collective opinion of the
19 Bathurst clinicians that their consultation process was an
20 aggressive exercise in stakeholder management. Clinicians
21 were perceived to be a liability, whose expectations needed
22 to be adjusted, rather than a resource for getting
23 information critical to the safe and functional design of
24 the new facility.
25

26 Many astute clinicians saw this early on and withdrew
27 their participation. Many others, to their credit, stayed
28 on, and predictably their input was ignored or even
29 actively rebuked. Clinicians were only shown plans for a
30 short period of time at any one sitting, and were never
31 allowed to take plans or drawings away to mull over. When
32 changes were proposed, they were told those changes were
33 not possible or it was too late. When one senior
34 clinician -- there were many clinicians who were forbidden
35 from liaising directly with architects or builders. Even
36 after designs were apparently finalised, planners spoke of
37 a contraction phase where rooms such the ED resus. bay were
38 shrunk to fit the arcane footprint and which was explained
39 to clinicians as a normal part of the design process. Many
40 clinicians refused to sign off on plans because they
41 weren't what was agreed, but they went ahead anyway.
42

43 To some extent expectation management may still be
44 happening in our remediation process and, if so, it needs
45 to be curbed. What is worse about this approach, is that
46 the developers in the State deny themselves the opportunity
47 to learn how to build better hospitals on each subsequent

1 occasion, at the risk of pumping out the same disergonomic
2 design each time. With over \$3 billion in hospital
3 development projects in the pipeline this is potentially
4 both extravagant and dangerous for the tax-paying community
5 of NSW. There is good evidence that user-centred hospital
6 design results in a more functional product and a similar
7 and, in some cases, cheaper cost.

8
9 The risk associated with decanting from an old
10 hospital into the new are grossly under estimated. While
11 it's convenient for politicians to speak of the usual
12 teething problems, anything that increases the likelihood
13 of clinical errors or delays by orders of magnitude is very
14 dangerous to patient safety. Decanting a major hospital
15 facility should always be a staged and carefully monitored
16 process. An old hospital should never be decommissioned
17 until the new hospital is confirmed to be fully functional.
18 Commissioner, why are these not statutory requirements?

19
20 This brings me to my final point. The Australian
21 Council for Quality and Safety in Health Care defines
22 safety as a state in which risk has been reduced to an
23 acceptable level. Safety is seen to be a relative rather
24 than an absolute term, and rightly so. Even with all the
25 money and brains in the world, you can't eliminate risk in
26 health care.

27
28 When it comes to the safety of acute care service in
29 this State, a more practical question which this Inquiry
30 must address is: Who decides what risks are acceptable?
31 Should it be those who hold the purse strings, the
32 administrators and politicians, or those who hold the
33 knowledge, the clinicians, or those whose lives are at
34 stake, the community? It's attractive to say, "Well all
35 three". But this requires good leadership, structured
36 dynamic dialogue and a commitment to share strategic
37 decision making which is fundamentally different to the
38 Mr Fix-it approach I cited earlier.

39
40 There was a time when clinicians were more actively
41 involved in strategic health care planning. Matrons and
42 medical superintends had greater influence. There were
43 local hospital boards with real authority. The loss of
44 clinical and community oversight has led to a unhealthy
45 rise of corporatised bureaucracy which is largely unbridled
46 to date. We don't provide health care to patients any
47 more, we provide health services to consumers. In this

1 environment, safety is no longer an integral part of care,
2 but rather just one component of a quality service; a
3 target rather than a deal breaker.
4

5 I use a new prescription form for an IV patient
6 control analgesium, and I meant to bring it with me here
7 today. It was produced by GWARS committee far away from
8 here. The old form was based on the equipment we use
9 locally. The new form admits parameters without which the
10 prescription is unsafe. As an experienced anaesthetist I
11 can get around the form, but an unsupervised young trainee
12 will render an unsafe prescription. That is not good
13 enough.
14

15 The way administrators, clinicians and the community
16 interact needs fundamentally to change to address this
17 imbalance. In ruling out discussion of resources in this
18 Inquiry the politicians appear to be asked "How much safety
19 can we buy for this much budget?".
20

21
22 Q. Just repeat that.

23 A. In ruling out of discussion of resources in this
24 Inquiry --
25

26
27 Q. Where is that ruled out?

28 A. I read it on a web site that was the case, if that is
29 the case I am greatly heartened.
30

31
32 Q. It's not ruled out by me.

33 A. Excellent. Excellent, Commissioner.
34

35
36 Q. But equally, I have been telling people that one can't
37 close one's eyes to the reality of State finances?

38 A. I agree completely.
39

40
41 Q. We don't have an unlimited budget in this State,
42 whether it be for health, education, transport or anything
43 else. There will always be a limit to the budget.

44 A. I agree with that completely. We live in a real world
45 with finite resources. Perhaps a more ethical approach
46 might be for politicians and administrators to engage
47 directly with clinicians and community directly and ask

1 "What are the minimal, acceptable standards for safe
2 service provision?" and then we can work with the
3 politicians and administrators to meet those standards in
4 the most cost effective manner.

5
6 There are all sorts of political, professional
7 industrial, economic and organisational agendas that can be
8 invoked to obscure the path to improving acute services in
9 this state. But if I could offer a simple principle that
10 should be at the top of everyone's list, something that
11 everyone can respect and abide by, something to guide every
12 planning, administrative, financial and clinical health
13 care decision, it would be three small words: patient
14 safety first. Thank you.

15
16 Q. A couple of things I wanted to ask you about. The
17 first is, you made a statement something like this, "There
18 is plenty of evidence that user designed facilities are
19 safer and more effective"; something to that extent.

20 A. A more functional design.

21
22 Q. What is the evidence to which you were referring?

23 A. There are, of course, the Australian Health Facility
24 Guidelines which are oriented around ergonomic principles
25 themselves, and that is an entire research facility devoted
26 to that, and there is a web site you can visit to see the
27 results of their research.

28
29 In a more practical vein, there is a CEO of a major
30 American health service, by the name of John Reiling, who
31 has published a number of papers. He was given US\$54
32 million, which is very, very similar to the budget that was
33 given here to Bathurst, to build an entirely new facility
34 in St Josephs in Wisconsin. From the very beginning, he
35 assembled a user group of planners and architects and
36 clinicians, and the brief to the builders and planners was
37 very, very specific. The clinicians will present you with
38 problems, you will solve them, and everything about the
39 design of the hospital was focused around solving and
40 addressing the clinical needs of the user groups.

41
42 As a result they built a hospital which had a lot of
43 very, very interesting and new ideas, such as making sure
44 that every single room was exactly the same. The basic
45 building principle we have is we tend to mirror rooms. We
46 put the piping and electrics down one wall and we mirror
47 rooms off, so when clinicians walk into a room, and

1 patients walk into the room, they will often be disoriented
2 because one time they walk in and it will be one way and
3 one time it will be another way. They designed everything
4 so every room it was identical. That may sound more
5 expensive, but the extra money they spent on their basic
6 units, they saved phenomenally on prefabricating
7 everything. The result, they came in \$9 million under
8 budget.

9
10 Q. Is this written up in the journal or some other
11 scientific publication?

12 A. Yes, I can forward that to you.

13
14 Q. If we provide you with address details, would you let
15 us have that?

16 A. Absolutely.

17
18 Q. The other thing you raised was a submission that you
19 said that certain features of what I would describe as
20 transition arrangements, between an old and new hospital,
21 ought become statutory requirements. What did you have in
22 mind?

23 A. I had in mind that basically if you are going to be
24 moving a facility of the size of Bathurst Base Hospital,
25 from an old facility to a new, and you are going to be
26 moving critically ill patients, you are going to be moving
27 maternity wards, moving emergency departments, you are
28 going to want to make sure that the basic functionality of
29 the hospital works: That the switchboard people know what
30 to do, the paging system works, the lines of communication
31 are in; that basically the operating theatres are actually
32 functioning appropriately; the emergency department is up
33 and running. You wouldn't move your lower acuity people
34 until you had sorted out that the emergency services were
35 working.

36
37 Q. Do you mean higher acuity?

38 A. I mean having the ability to deal with emergencies is
39 dealt with before you actually start to move in elective
40 patients which are, at the end of the day, optional. So,
41 you want to be able to demonstrate that you have a fully
42 functional basic service, and then you can start ramping
43 up, putting the throttle down and increasing the activity
44 of the hospital. You need to be sure you have solved all
45 your basic issues, not infrastructural issues but staffing
46 issues. We have a much larger hospital and we didn't
47 realise because of the poor lines of sight in some

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facilities, we are going need more staff in order to deal with the larger spaces we are working in. That has nothing to do with the number of patients we are dealing with, but having to deal with the disergonomic nature of the facility.

Q. You are really talking about then a commissioning process which is a planned and stepped commissioning process to ensure the new facility is properly commissioned and functioning?

A. Absolutely.

Q. Was there not such a commissioning process here?
A. I leave that to others to answer. All I know is that we were moved in and I don't know what the details were of how the hospital was commissioned.

Q. Thank you very much. Is there anything more you wanted to add along the lines of the questions I have asked you?

A. No, thank you, very much.

Q. Would you mind making that available to the staff so we can double-check against our transcript that we have every word you have said.

A. If I can be provided with an email address I will email it to you.

<THE WITNESS WITHDREW

1 <BRUCE HOWARD McGARRITY, affirmed [1.50pm]
2
3 THE COMMISSIONER: Q. Would you mind giving me your full
4 name.
5 A. Bruce Howard McGarri ty.
6
7 Q. What is your special ty?
8 A. I am a physi cian, practi sing in gastroenterology and
9 general medi cine.
10
11 Q. You are a VMO at Bathurst Hospital?
12 A. Yes.
13
14 Q. How long have you been in Bathurst?
15 A. 17 years.
16
17 Q. Have you been at the hospital all that time?
18 A. Yes.
19
20 Q. What would you like to draw to my attention?
21 A. I would like to try and dissect some of the reason for
22 the breakdown in the relations between bureaucrats in the
23 Health Department and clinicians, and by clinicians I mean
24 doctors and the nursing staff.
25
26 Q. By bureaucrats, do you mean Health Department in the
27 city or do you mean the area health service as well?
28 A. I mean area health service primarily because they are
29 the people we deal with.
30
31 I guess, having been here for 17 years, and now into
32 the third different sort of health area set up, it's become
33 obvious over that time there has been increasing hostility,
34 almost, and suspicion on both sides; that is on the one
35 side the local area bureaucrats, and on the other the
36 clinicians. I think when you look at the reasons why this
37 has happened there are several. I think, on the Health
38 Department side, the objectives of the health bureaucracy
39 locally seem to be quite different to the clinical
40 objectives at times. By that I mean that the health
41 bureaucrats are very much concerned with financial aspects
42 of running the health system; the money imperative. They
43 are also very concerned with ensuring that waiting lists
44 and waiting times and problems within the health system are
45 kept out of the newspapers; what I called the political
46 imperative.
47

1 Then, following on from that, then we look at the
2 Health Department health care objectives. On the other
3 hand, the objectives of the clinicians are to ensure that
4 the individual patients receive safe and up-to-date medical
5 care, and in some cases, it's true that there is empire
6 building, of course, and people will try and advance
7 particular interests in some cases, in their own areas of
8 expertise.
9

10 Unfortunately, because these objectives often differ,
11 this has allowed a certain degree of hostility and
12 suspicion to evolve on both sides. More than that, I think
13 despite one of the objects of the Lemma reforms to reduce
14 bureaucracy, what we have seen locally is a vast
15 enlargement of the bureaucracy, not just the numbers and
16 layers of bureaucrats but also the bureaucratic processes
17 that go on. It seems nothing can be decided without
18 several meetings, and simple decisions seem to take months.
19 As one example; the advertising of posts locally has often
20 been held up for months in the Dubbo recruitment office,
21 whereas an ad. could have been placed in a newspaper within
22 minutes if there had been the will to do so.
23

24 Q. Is that for medical or nursing or allied health staff
25 or all three?

26 A. Both, all three. I think, part of the reason for the
27 enlarged bureaucracy locally was the fact that when the
28 Health Department decided to make those changes it tried to
29 apply a metropolitan model to the country area which, of
30 course, is enormous in extent, with a very large number of
31 very different facilities.
32

33 The upshot of that, of course, was there was then,
34 while the new organisation got to grips with this very
35 large health area, there was administrative paralysis for
36 about 12 months and no decisions were made over that time
37 of any import. At the moment, we have these additional
38 layers of bureaucracy. It's very difficult often to
39 identify which particular manager one should approach if
40 there is a problem that needs fixing. The decision making
41 is very opaque often, and finally managers seem to come and
42 go with great frequency, which means there is a loss of
43 corporate memory and there's an even worsening response or
44 poor rapport with clinicians.
45

46 As well as that, it means the decisions have often
47 become very short term. I have been here 17 years. I

1 really can't identify any bureaucrats who have been here
2 for a fraction of that time.
3

4 The short-term approach has meant that at times
5 attempts to introduce change or innovation has been
6 discouraged, often on financial grounds and, as one
7 example, when the hospital here in Bathurst bought some new
8 endoscopic equipment about 18 months, two years ago, the
9 company also provided some equipment for a Peal camera
10 service, which is available in most metropolitan centres.
11 The process that we went through to try and get that
12 approved took a number of months, and by the time that had
13 happened, the Peals, that the company had provided free of
14 charge -- there are about half a dozen of them worth about
15 \$700 each -- the batteries in them had gone flat. At the
16 outset of that, we indicated that in fact the net cost to
17 the area health service was going to be very small, or
18 negligible. In spite of that, it took many months for
19 approval to come through.
20

21 Along the same lines, it seems difficult to get any
22 innovation or change up and running unless there is no
23 cost, or at least there is cost shifting to the
24 Commonwealth. Under these circumstances it's not
25 surprising the redevelopment here has met with such
26 problems and, I think, at the outset of the new hospital,
27 the site of the hospital, which clinicians and the council
28 had recommended be out of St Vincent's Hospital, there was
29 some politicking in the background of which I am not aware
30 of the details, but it was then decided that the hospital
31 would be best built on the same site, even though there
32 were substantial costs with digging out a large part of the
33 hill to do so. Beyond that, the initial planning and
34 design process was compromised, not just because of the
35 failure to listen to clinicians, but also, and I think in
36 most part because of the failure of the area to ensure that
37 its objectives in the new hospital were met, in other words
38 it didn't properly supervise the planning process and the
39 planner involved.
40

41 After the initial planning and design process,
42 obviously there was a lot of incompetence in terms of
43 testing out the new facility and then the decanting, which
44 I am sure others will speak on. I think it's difficult for
45 me to make suggestions about how things can be improved,
46 but I think in the first instance, I would like to make a
47 plea that bureaucrats do start to involve clinicians, many

1 of whom are very experienced and have been in health
2 facilities for a long time, and many of whom have talents
3 outside of the medical area as well.
4

5 Q. You are not the first clinician to raise with the
6 Inquiry this apparent divide between administrators and
7 clinicians. One of the matters that has been suggested to
8 me as being a relevant feature of the health industry to
9 help address that, has been the area health advisory
10 councils. Have you had any experience of that advisory
11 council?

12 A. I haven't personally, and I must say I am not even
13 aware as to who is on that particular committee.
14

15 Q. That must mean what it does and what effect it has
16 must follow from what you say.

17 A. That I can't say.
18

19 Q. The other matter that your submission raises is this
20 question of the tension between clinicians saying "I can do
21 things better and more effectively and more safely with
22 better patient results, at either no or negligible or small
23 amount of cost"; are you aware of what the financial
24 delegation structure is in the area of health services as
25 an example? I don't know yet but do you know officer X has
26 delegation to approve this much, and officer Y has
27 delegation to approve that much? In other words, is that
28 sort of material available to clinicians, so that you know,
29 for example, to get an innovation which is going to cost
30 \$10,000 approved, it has to be done by a person at this
31 level or that level or whatever it may be?

32 A. I have no idea actually how that financial structure
33 works.
34

35 Q. That is not something that is available to clinicians
36 to know who has to do what in the administrative structure?

37 A. No.
38

39 Q. There is one other matter I wanted to ask you about,
40 and it has nothing whatsoever to do with you, I want to
41 make absolutely plain, or with Bathurst, but it's something
42 I have struck elsewhere. That is that one hears about the
43 feature of bed block in the course of the health sector;
44 namely, patients being discharged at a rate slower than
45 patients arriving who need to be admitted. One of the
46 features - again, I absolutely want to make it plain I am
47 not describing you or Bathurst - that has been raised with

1 us is the timing of consultants visiting hospitals to
2 perform the predischARGE examination. You can understand
3 that if consultants come at 5 o'clock in the afternoon, a
4 patient who might be discharged in the morning has occupied
5 a bed for some hours during the day, that might otherwise
6 be made available to someone coming into the hospital. Do
7 you have any experience, through discussion with your
8 colleagues and learning generally, that would help me work
9 out how I can get people discharged earlier in the day than
10 later in the day? You can see the problem, can't you? If
11 people aren't being discharged until the end of the day
12 beds aren't being made available when emergency departments
13 are often at their busiest?

14 A. Undoubtedly that is a contributor to bed block. I
15 could name a number of other reasons as to why bed block
16 occurs.

17
18 Q. What would they be?

19 A. For example, often times it takes a while for patients
20 post discharge follow-up arrangements to be organised.

21
22 Q. That is medication, appointments, allied health
23 arrangements and, particularly in rural but often in
24 metropolitan area, transport to the place to which they are
25 being discharged?

26 A. Yes. Often times in the country patients in the
27 hospital may live some hours away, and to get a relative to
28 come and pick them up, it might take half a day or longer
29 or sometimes patients have to stay in an extra day because
30 it's not possible for their relatives to pick them up and
31 of course there is no public transport. In fact, I think
32 here in Bathurst that would probably be a greater
33 contributor to bed block, than just the timing of the
34 consultants' rounds.

35
36 The other things that contribute to bed block are on
37 weekends, a lot of facilities are closed. Tests can't be
38 done on the weekend. That often adds a couple of days to a
39 patient's stay. Over certain holiday periods -- Easter is
40 come up -- there are a number of days there aren't going to
41 be facilities such as stress testing available, for
42 example, so patients with chest pain may be left in for an
43 extra day or two, simply for that reason. I think there's
44 a whole raft of reasons that could improve the situation.

45
46 I have to say, if we are looking at these, what I
47 would consider relatively minor changes to improve problems

1 with bed block, it suggests to me that there's a problem
2 with a number of beds in particular hospitals. Coming back
3 to the Bathurst case, when the planner came down to make
4 the plans, about the first thing he said was "The Health
5 Department has said we can't open any extra beds here in
6 Bathurst", and I can tell you already we have had several
7 days here, since the new facility opened, where there has
8 been bed block and we have had to transfer patients to
9 other centres, and you must remember, of course, this is at
10 a time when perhaps we haven't been as surgically active as
11 we will be later in the year. It's summer, the wards
12 aren't full of old folks with pneumonia.
13

14 Q. It's not peak time yet?

15 A. That's right. I think the elephant in the room of the
16 new hospital, if you like, is the number of rooms that have
17 been put into it.
18

19 Q. The number of beds?

20 A. The number of beds.
21

22 Q. When you said rooms -

23 A. Yes, I mean beds.
24

25 Q. I understand that.

26 A. I think we are yet to see the problems that is going
27 to create.
28

29 <THE WITNESS WITHDREW
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<DONNA REGINA HOLLIS, sworn: [2.01pm]

THE COMMISSIONER: Q. Would you mind giving me your full name, please?

A. Donna Regina Hollis.

Q. What would you like to draw to my attention?

A. I'm not as well spoken as those guys, but I will tell you my story. I was admitted to Bathurst Base Hospital on 31 August for a partial hysterectomy.

Q. In 2007?

A. Yes. I was told the operation would be done abdominally along my caesarian scare, and my uterus would be removed, leaving my ovaries and cervix. I never dreamt this operation would almost cost my life. As I usually get panicky with surgery I was given something to relax me. I don't remember going into theatre. They had trouble waking me in recovery. I would wake to groan "Painkiller". I was given a painkiller once post-operative. My husband came to recovery and was told they were very worried because my blood pressure was low and I wasn't waking, and also I had had a bad reaction to something I had been given. They wouldn't give me painkiller as to the fact I wouldn't wake and my low blood pressure.

Having had three Caesarians and a ruptured ectopic I had experienced this type of surgery. This pain was much worse. I don't remember my family visiting me, but my mother tells me when they voiced their concerns I appeared much the same as after my ectopic, where I had bled internally, she was told I needed rest and perhaps they should leave me. Somewhere around 9.30 to 10 o'clock that night, I was helped to the bathroom. As I sat on the toilet, I was shocked when blood spurted over the walls and floor. My abdominal wound had ruptured.

I was helped back to bed and told to grip the bed as nurses pushed towels on to the right side of my wound. I remember as they pressed I felt a warm sensation spread on the left side of my body as the blood spurted from that side as well. I could see by the way the nurses looked at each other this was not good. I remember them rolling me to remove the blood-soaked sheets several times.

To my knowledge, I was never given any painkillers. I believe the intern came at some point and my surgeon came

1 around midnight to authorise a blood transfusion. I don't
2 remember any of this. Throughout this I was experiencing
3 terrible pains in the chest from trapped air, which made it
4 difficult to breathe. Hours passed in a blur of pain,
5 worried looks, whispered words, and whenever I was awake I
6 wondered why a doctor wasn't coming, why wouldn't anybody
7 come, surely this needed to be fixed.

8
9 I believe it was around 4am Saturday morning when I
10 was taken back to theatre, six hours after I had first
11 ruptured. I believe many, many phone calls had been made
12 that night from nurses trying to get someone to see me but
13 no-one would come. Why wouldn't a doctor come to see me?
14 I can't understand why I was left bleeding on the bed for
15 six hours. The pains in my chest made breathing difficult.
16 When I was told I was being taken to theatre, I was scared
17 I would die under anaesthetic. I remember saying to the
18 doctor "Please don't let me die I have four little
19 children". I asked for my family to come, and I was told
20 we didn't have time to wait. My husband lives four
21 minutes from hospital. We waited six hours and we couldn't
22 wait four minutes. It turned out my cervical stump had not
23 been sealed off properly, and I had been bleeding from
24 there all this time. I had been given blood thinners with
25 my operation, due to having a previous suspected clot in my
26 lungs.

27
28 Saturday morning my TED stockings were removed for a
29 shower and not replaced, even though I questioned this. I
30 knew I had to get moving to recover quicker. I was never
31 watched or helped, even though I complained of a rapid
32 pulse, breathlessness, weakness and worse, an excruciating
33 headache, a very loud pounding of my own heart beat through
34 my head. The headaches never let up and made it difficult
35 to sleep. I was given a cold pack once which didn't help.
36 Just turning over in bed would make my pulse race, and I
37 would feel light headed. I had complained to many nurses
38 on every shift about this and my headaches. It wasn't
39 until Monday morning, 48 hours after my section operation,
40 that a nurse suggested I had my HB checked. To my
41 knowledge I had no blood test over the weekend, and my HB
42 was around 70 when it was taken. I was only given one unit
43 of blood which only helped a little.

44
45 I have other issues, like with some of the nurses,
46 their attitude. After my operation I asked for water to
47 drink, and I was told to get out of bed and follow her into

1 this little staffroom. She swung open the big heavy wooden
2 doors and told me to grab the door. I clutched my stomach
3 and said "Wouldn't it be heavy?" to which she answered, "I
4 have had a hysterectomy you will be fine".
5

6 I had another nurse wouldn't come into my room because
7 my flowers smelt. When I asked her medical questions, she
8 put her hands in front of her face and said "You have to
9 excuse me, I can't be in this room, the flowers are too
10 strong".
11

12 I left hospital at 5.30 on Wednesday. No obs had been
13 taken since 6.30 that morning. When I got home I was weak
14 and had headaches and a feeling of sadness. I had four
15 little kids, so I couldn't feel this way and I insisted on
16 another blood transfusion. When I did return for the
17 transfusion, I was told that I would be checked every hour
18 for obs. Nobody came near me the whole time, until I
19 buzzed at the end of the four hours to say my transfusion
20 was finished.
21

22 I have made a complaint to the hospital. My main and
23 most important question was why I had been left for six
24 hours bleeding on a bed. I received a reply. I am still
25 waiting for an answer for that question. Had it not been
26 the persistence of my caring nurse, Janice, I probably
27 would have bled to death that night. I wonder what would
28 have happened to me had I not got up to go to the toilet
29 and ruptured. Would I have bled to death internally? In
30 the letter I received back from the hospital they assured
31 there would be signs and symptoms that would alert doctors
32 and nurses to any complications occurring such as internal
33 bleeding. These changes in pulse and blood pressure would
34 enable them to instigate treatment.
35

36 In saying that, I was bleeding internally and they
37 didn't pick it up. I know a mistake was made when my
38 cervix wasn't sealed properly. I don't understand that,
39 but I accept mistakes can happen. Most frustrating is why
40 no-one will me why I was left bleeding for six hours before
41 taking back to surgery. Why wasn't the bleeding picked up
42 earlier? Why wouldn't a doctor come? Why wasn't my HB
43 checked earlier than 48 hours after my operation?
44

45 I would like to praise my two nurses that looked after
46 me that night, Janice and Kate. I can't fault them and I
47 only wish more in the medical field had their care and

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persistence. I thank them for my life.

Q. Thank you for that. That is a very heartfelt story. Can I ask you one question? You said you were discharged home but before you were discharged, no observations had been done since early in the morning?

A. At 6.30 that morning.

Q. Before you were discharged, were you examined that day by a doctor?

A. No.

Q. Not at all?

A. No.

Q. When was the last examination by a doctor before you were discharged?

A. The doctor had come that morning in their routine walk about, and told me I could leave that day. I don't think that he checked my wound. I really can't remember that now.

Q. You were certainly visited by a doctor?

A. Yes, I think so.

Q. Have you made a complaint to the Health Care Complaints Commission?

A. I rang the hospital and made a complaint there. I haven't done anything else.

Q. We might have one of the staff speak to you when you have finished and get some details from you about that?

A. Thank you.

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<KATALYN VISOLIT, sworn: [2.06pm]

THE COMMISSIONER: Q. Would you mind giving me your full name?

A. Katalyn Visolit. I am a member of the Bathurst area. I am also an ex-employee of Bathurst council as a town planning clerk; 10 years experience from Queensland when I moved here. Unfortunately I fell into an illness which would be classed as acute, subsequently, an ambulance trip eventuated into the hospital.

Q. Let me ask you a couple of questions to set the scene. You were at home when you fell ill?

A. Correct.

Q. And someone rang an ambulance for you?

A. Correct, my carer.

Q. About when was that? Would month and what year are we talking about?

A. My illness is a long-term illness.

Q. But the particular incident we are talking about.

A. It happened on 11 July 2004, and I'm still waiting on further assistance.

Q. You were taken to the emergency department?

A. Correct. I was evaluated by the emergency doctor and admitted immediately. My stay in hospital was approximately one week long.

Q. Then you were discharged back to home?

A. I actually discharged myself for the reasons that I do not wish to name.

Q. You went home?

A. Yes, I wasn't satisfied. My sheets weren't change etc et cetera I discharged myself thinking I could provide better care with my carer for myself at that time.

Q. What is it about your experience you wanted to draw my attention to?

A. Several changes of doctors didn't result in anything satisfactory towards healing my problem. Hence my visit to Gerald Martin, our local MP, 17 January 2005 -- I have all the documentation here to show -- who, in turn, advised that the appropriate avenues for me to take would be to

1 contact would be to contact Westmead Hospital and get in
2 contact with the Department of Entomology, namely Steven
3 Boyages and Cameron Dodds. I had some telephone as well as
4 written conversation with the said gentleman. I took his
5 advice over the phone. However, there was a letter
6 exchanged for a period of five months, me trying to get
7 into Westmead.

8
9 Q. For treatment?

10 A. Correct, which eventuated. The whole process started
11 on 17 January. About mid-May I received a letter to say
12 "We can't do anything for you, go back to your GP". The GP
13 was the person who told me to further look into the matter
14 and to seek help from Mr Gerald Martin, and subsequently in
15 that time my infection went to a secondary infection, and
16 with minimal medical knowledge, one thing I do know is that
17 after secondary infection you have only amputation. You
18 can imagine the fear I experienced.

19
20 Q. What is it, in particular, if anything about your
21 admission to Bathurst Hospital in 2004 that you think I
22 ought to know about?

23 A. The incident of discharging myself resulted because
24 the nature of my illness, at that point, the doctors
25 weren't sure if it was infectious or not. Hence I was put
26 into an isolation ward. It was approximately quarter past
27 11 at night when I was sitting up in bed crying, because
28 the nature of the illness is very similar to a third degree
29 burn. I had bandaged body all over, which was changed
30 three times a day.

31
32 A nurse that I had never met previously had come into
33 the room at quarter past 11 also, and saw me sitting in bed
34 crying from the pain, and asked me what the problem was. I
35 cut it short and I explained to her, and because my illness
36 is such a rare incident, and I have spoken to the
37 Department of Agriculture manager in NSW as well, and also
38 the Federal health minister's office. She had some
39 disbelief, and quite often this particular illness, if you
40 read any literature written on the illness itself,
41 determines that quite often it's misdiagnosed and thought
42 of as a mental issue, if not properly diagnosed. We didn't
43 have anyone in this town to diagnose it properly. I am a
44 law student. Hence, I have research abilities and the will
45 to survive. Each though it hurt, I never stopped going to
46 the library and ordering books from Sydney.

1 Q. I understand all of that. I just want to try and
2 understand, because I am looking at acute care services in
3 public hospitals, what it was. You have only had one
4 admission to Bathurst Hospital?
5 A. Correct.
6
7 Q. I can understand there is not enough medical expertise
8 in the community to diagnose your problem.
9 A. What was the reason for it?
10
11 Q. I am interested to learn from you, to see if I can get
12 it clear, you had an incident with a nurse late one evening
13 at Bathurst Hospital. Your condition wasn't diagnosed at
14 that stage.
15 A. It was actually diagnosed by the only dermatologist in
16 the greater area in Orange, Dr Derek Davies, who diagnosed
17 me, and subsequently the other doctors were trying to look
18 up literature so they could understand it better. My
19 discharging myself from the hospital resulted because the
20 nurse, who entered my room at 11.15 that evening and found
21 me crying, subsequently told me that I did not belong in
22 this hospital, I belonged in Bloomfield mental institution.
23 I took offence.
24
25 Q. Yes, I can understand that. Your complaint is that
26 the particular nurse didn't treat you properly because she
27 didn't accept your medical diagnosis but rather asserted,
28 incorrectly, that it wasn't a medical problem but a mental
29 health problem?
30 A. Correct.
31
32 Q. As a consequence of which you took the view you didn't
33 want to stay there and so you left; is that correct?
34 A. Correct. Ever since then I am still currently being
35 treated with a number of medications and I am also
36 receiving trauma counselling.
37
38 Q. You are not being treated at the hospital?
39 A. No, I have a fear of returning to that hospital, even
40 though there is another minor day surgery that I require,
41 but I am too scared to go back there.
42
43 Q. Are you being treated in the community with a general
44 practitioner or specialist?
45 A. Yes.
46
47 Q. General practitioner?

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A. Yes.

Q. Thank you for telling me about that?

A. Thanks for your time.

<THE WITNESS WITHDREW

THE COMMISSIONER: That concludes the public hearings of this Commission at Bathurst. It's necessary that I take evidence from two witnesses in a private hearing. The only people who will be present at the private hearing, in addition to me, the commission staff and the reporter, I will have to ask everybody else to leave, so I can take evidence in private.

(At 2.23pm the Commission adjourned into closed session)

(At 3.29pm the Commission resumed the public hearing)

THE COMMISSIONER: We will now adjourn this hearing in Bathurst and resume tomorrow in Orange.

AT 3.30PM THE COMMISSION WAS ADJOURNED TO TUESDAY, 18 MARCH 2008 IN ORANGE