

SPECIAL COMMISSION OF INQUIRY  
INTO ACUTE CARE SERVICES IN NSW HOSPITALS

Before Mr Peter Garling SC, Commissioner

At Bourke Street Health Service Centre  
234 Bourke Street, Goulburn

On Wednesday, 16 April 2008, at 10.10am

Counsel Assisting: Mr Terence Tobin QC,

Senior Legal Officer: Clare Miller  
Legal Officer: Jarrod Whitbourn

1 THE COMMISSIONER: Good morning, ladies and gentlemen.  
2 This is the sitting of the Special Commission of Inquiry  
3 into Acute Care Services in New South Wales Public  
4 Hospitals. It is a public hearing and I will just give a  
5 formal direction to that effect.  
6

7 Having directed on 6 February 2008 that it is  
8 desirable by reason of the content of the terms of  
9 reference and the nature of the Inquiry that all hearings  
10 take place in private, I now direct that the hearing this  
11 morning at Goulburn, on Wednesday, 16 April 2008, is to  
12 take place in public.  
13

14 It will be necessary for anybody who wishes to give  
15 evidence to take an oath or make an affirmation to tell the  
16 truth, thereby they become witnesses in the Inquiry. It  
17 obliges each witness to tell me the truth, and it also  
18 gives those witnesses such protection as the statute  
19 permits against defamation and other adverse action.  
20

21 The terms of reference that constitute my Inquiry have  
22 been made public and I would be interested to hear from  
23 witnesses who have matters relevant to those terms of  
24 reference that they want to tell me about, but it is also  
25 of interest to me to learn from individuals and from  
26 members of the health service what solutions they might be  
27 able to suggest to some of the problems that they identify.  
28

29 In broad terms, we allocate about 20 minutes to each  
30 witness. I would like any witness to keep that in mind.  
31 We will start first with Mr Johnson.  
32

33 <ROBERT CHARLES JOHNSON, affirmed: [10.13am]

34  
35 THE COMMISSIONER: Q. Would you give the Inquiry your  
36 full name, please?

37 A. My name is Robert Charles Johnson.  
38

39 Q. Mr Johnson, I see from your badge that you are an  
40 official visitor at Goulburn Base Hospital.

41 A. Yes, sir.  
42

43 Q. What does that mean?

44 A. I don't know. They gave it to me at the door when I  
45 came in.  
46

47 Q. It's not a position?

1 A. No, sir, no.

2

3 Q. It's just a security rating?

4 A. Yes.

5

6 Q. You used to work for the Ambulance Service?

7 A. I was a New South Wales ambulance officer.

8

9 Q. For how long?

10 A. For about six years I was actually in the Ambulance  
11 Service.

12

13 Q. What would you like to tell me about, Mr Johnson?

14 A. I would like to read the statement that I have made  
15 and then submit it to the Commission.

16

17 Q. All right.

18 A. This should take me about six minutes. My name is  
19 Robert Johnson and I am a resident of Goulburn. I trained  
20 and worked as a New South Wales ambulance officer. I am  
21 also a registered assistant in nursing. Altogether I have  
22 served 14 years in the New South Wales health and hospital  
23 system.

24

25 Between the years 1988 until 1996, I was employed by  
26 Ryde Hospital in New South Wales. I was engaged to drive  
27 their ambulance and for general duties. During my period  
28 of service, I also worked as a wardsman and a technical  
29 aide in the physiotherapy department.

30

31 I was initially assigned to work in the hospital  
32 geriatric rehabilitation unit which was located on another  
33 hospital campus away from the general Ryde Hospital. I  
34 moved between the two. My duties were to drive from 8am to  
35 10am and from 2pm to 4pm for the hospital's day-care  
36 centre, and between 10am to 2pm for the actual  
37 rehabilitation unit.

38

39 Employed in the day-care centre were five staff plus  
40 the use of their two drivers. There was one registered  
41 nurse, one occupational therapist, two assistant  
42 occupational therapists and one cook - a total of seven  
43 staff. We two drivers went out into the community and  
44 returned with the clients for the day-care centre. These  
45 folks were mainly elderly post-operative, post-cerebral  
46 accident patients, and a few who suffered from dementia,  
47 who lived in their own homes. I sometimes encountered the

1 same folk in the local supermarket doing their shopping or  
2 in the car park getting in and out of their motor cars.

3  
4 During the five working days, from my memory, we had  
5 sometimes up to 20 clients per day and as few as four or  
6 five. However, at all times, the staffing levels remained  
7 at seven. I observed the registered nurse and the  
8 occupational therapist in charge sitting all day at their  
9 desks facing out through a window with their backs to the  
10 clients and moving papers and files backwards and forwards  
11 in front of themselves.

12  
13 The two assistants sat at a large table with the  
14 clients and showed them how to do handiwork, cutting out,  
15 knitting, basket-weaving, et cetera. The cook remained in  
16 the kitchen and served morning tea, lunch and afternoon  
17 tea. Both drivers were in and out during the day. During  
18 periods of the registered nurse's absence, the occupational  
19 therapist in charge would not allow the day's work to start  
20 until she was assured by the hospital's administration that  
21 a nurse from the nursing agency was engaged and on the way.

22  
23 On one occasion, a young male nurse, who was on a  
24 working holiday from Israel and who normally was an Israeli  
25 Army soldier, appeared for duty. On the day he worked, we  
26 happened to be taking the clients on a picnic outing. He  
27 expressed his great surprise to me that any organisation  
28 could afford to pay somebody on agency rates to go on a  
29 picnic. He told me that he had done nothing during the day  
30 apart from taking two clients to the toilet. This was not  
31 an isolated incident.

32  
33 The other four hours of the day, we two drivers spent  
34 in the actual unit itself. The unit director was a doctor.  
35 Under his direct control was his full-time secretary, a  
36 full-time clerk and a registered nurse, who was referred to  
37 as the community nurse. I reported to her. During the  
38 years I worked under this lady's direction, I witnessed  
39 that she never wore a uniform; rather she wore expensive  
40 frocks and shoes with heels. She also drove the unit  
41 vehicle to and from her home, explaining that she sometimes  
42 had to call upon a client en route.

43  
44 I never observed her to perform any kind of nursing  
45 duties, although, on one occasion, I saw her cutting a  
46 client's toenails. She claimed to occasionally accompany  
47 the director of the unit on home visits to do a patient's

1 assessment; however, it seemed to me that she was always at  
2 her desk or sitting in the tea room.

3  
4 In her office that I was in and out of during the day,  
5 she had a filing cabinet with patient files in it. At the  
6 beginning of the day, these files were spread out on her  
7 desk and she appeared to be studying them. At the end of  
8 the day, she replaced the files into the filing cabinet.  
9 Also she had an exercise book, a ruler and a biro pen.  
10 During my time there, the director's clerk claimed that  
11 these files and the filing cabinet rightly belonged in her  
12 office.

13  
14 Caught between the two women, the director seemed  
15 unable to make any decision and tensions ran high in the  
16 unit with people taking sides and lending support to one or  
17 the other. The clerk decided to take matters into her own  
18 hands. Over a weekend, she and her husband entered the  
19 unit and removed the filing cabinet and the files from the  
20 community nurse's office into her own office, where her  
21 door remained locked at all times when she was absent. She  
22 also held the only key.

23  
24 With the files gone, the community nurse was left with  
25 the exercise book, her ruler and the biro pen. She worked  
26 on this book all day ruling and writing. When I asked her  
27 what she was doing, she replied in the most aggressive  
28 manner, "My stats." I presume she meant statistics;  
29 however, I never mentioned this matter again.

30  
31 When I commenced work in the unit, I was told that  
32 every four weeks I was entitled to a rostered day off. It  
33 is still my understanding that in order to qualify for this  
34 rostered day off, one had to work an equivalent amount of  
35 hours in order to achieve this day off. I never worked one  
36 extra minute, nor was I ever asked to; yet every four weeks  
37 I was given a day off. Indeed one therapist in charge  
38 saved up her days off and went skiing.

39  
40 During my term of employment, I watched on the media  
41 and read about a judgment handed down on an anaesthetist  
42 employed in the operating theatres at Ryde Hospital. In  
43 his finding, the judge found that, on many occasions, the  
44 nursing staff in the theatre had tried to get the hospital  
45 administration to take action to remove this man who was  
46 badly drug addicted. The administration failed to take any  
47 action and the inevitable happened - a patient arrested in

1 the operating theatre and he was incapable of any action.  
2 Despite the best efforts of the nurses, the patient died.  
3 The anaesthetist was found guilty.

4  
5 I was called upon to work as a wardman at Ryde  
6 Hospital. My duties were often in the casualty department  
7 and I reported to the sister in charge there. On many  
8 occasions, when the casualty department was bursting at the  
9 seams, I witnessed two doctors who were employed at the  
10 hospital in administrative roles walk backwards and forth  
11 amongst these patients and never even acknowledge them, let  
12 alone do anything practical to ease the burden.

13  
14 In conclusion, I submit these examples to the  
15 Commission truthfully as I recall them and in the sincere  
16 hope that the waste and mismanagement that I witnessed  
17 will cease to occur in New South Wales hospitals; further  
18 that legislation be enacted that compels hospital  
19 administrators to act on complaints lodged with them - they  
20 should have no discretion to act, not act, or simply ignore  
21 and do nothing - and further, the person making the  
22 complaint should be protected and not turned into a  
23 scapegoat as whistleblowers run such a grave risk of doing  
24 in 2008, to the point that a person has to wait until they  
25 are my age and safely retired before being game enough to  
26 speak their truth. I wish this Commission success.

27  
28 Q. Thank you, Mr Johnson. Do you mind if I ask you a  
29 couple of questions?

30 A. No, sir. Please do.

31  
32 Q. I am interested in your talking about complaints.  
33 What sort of complaints are you there referring to? Is it  
34 a complaint by a patient about a doctor or is it complaint  
35 by staff of the hospital about other staff? What sort of  
36 complaints are you referring to?

37 A. Both those matters. I'm referring to if a visitor, or  
38 indeed a patient, feels that they have been mistreated or  
39 ill-treated in any way at all, that person should have the  
40 right to go to the hospital administration or to their  
41 appointed person. That person should be compelled by  
42 legislation to act within a time frame and the other person  
43 should be given an explanation of what the outcome is.

44  
45 I am also referring to staff like myself. I was in a  
46 very, very junior position in a hospital. Nobody would pay  
47 much attention to me. Indeed, I wasn't game to speak about

1 events that I witnessed - many events - during my career,  
2 my term of employment. The danger was that if I went to  
3 the administration and lodged a complaint, I would feel  
4 sure in my own heart that nothing would be done about it  
5 unless it suited their particular interests at that time.  
6 They might make an issue of it if that suited their  
7 purpose. It wouldn't matter how serious the complaint was,  
8 it would be trivialised.

9

10 Q. Have you been back to Ryde or the other area there  
11 since you have left your employment?

12 A. No, sir, I haven't.

13

14 Q. So you're not able to say whether the sort of thing  
15 you were observing is still there or not?

16 A. No, sir, I'm not.

17

18 Q. Have you spoken to anyone who is still there to be  
19 able to say whether it still exists there or not?

20 A. No, sir. I could not say that. Once I left, I never  
21 went back or kept in contact with anybody.

22

23 Q. I understand that. Mr Johnson, thank you very much  
24 for coming and telling me that. If I take that document  
25 from you and give it to my staff, we will then have a  
26 written record, thank you, of what you have told us.

27 A. And thank you for the opportunity, sir.

28

29 <THE WITNESS WITHDREW

30

31 THE COMMISSIONER: Is Mrs Slater present?

32

33 <JEANELLE MARGARET SLATER, sworn: [10.26am]

34

35 THE COMMISSIONER: Q. Would you give the Inquiry your  
36 full name, please?

37 A. Jeanelle Margaret Slater.

38

39 Q. Mrs Slater, I understand you want to draw some matters  
40 to my attention?

41 A. I do.

42

43 Q. What would you like to tell me?

44 A. I just wanted to talk about the maternity situation.  
45 I understand it's not acute care, but it is --

46

47 Q. It probably does fall within acute care, so don't

1 trouble yourself about that.

2 A. Okay. I just want to talk from my own perspective as  
3 a parent. I have four children, the first of which was  
4 born eight years ago within the hospital system in another  
5 State. Then I had two boys here within New South Wales,  
6 and my fourth I have had at home. I wanted to talk about  
7 the comparisons between them and --

8

9 Q. Which hospitals in New South Wales?

10 A. Bowral.

11

12 Q. For both your boys?

13 A. Both my boys were born and Bowral and then this one  
14 was born at home with a midwife at home. I would have had  
15 a home birth with both of the boys but the cost was  
16 prohibitive. It was still prohibitive, but I really felt  
17 like I could not go back into the system to have another  
18 baby. I didn't feel the need and I didn't want to fight  
19 for what I wanted again, which I find is something you have  
20 to do within the system. I did not feel quite safe within  
21 the system.

22

23 Having the baby at home was a much more pleasant  
24 experience. Certainly I know it was much cheaper for the  
25 health system for me to have my baby at home. Even having  
26 a baby at home, we had to fight for certain things like  
27 anti-D - anti-D is difficult to source here in Goulburn -  
28 and different things like that.

29

30 Q. Was your most recent birth here in Goulburn?

31 A. Yes, it was, yes.

32

33 Q. Can you tell me this, did you have any antenatal care?

34 A. Yes, I did.

35

36 Q. Was that through the public hospital system --

37 A. No, that was the private midwife.

38

39 Q. -- or through a general practitioner, or through a  
40 midwife?

41 A. A private midwife, yes.

42

43 Q. And that was, what, fairly regular visits?

44 A. Yes.

45

46 Q. Of the midwife to you or you to the midwife?

47 A. No, the midwife came to me.

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Q. When you say "a private midwife", was that someone you found by word of mouth or --

A. Yes, it was by word of mouth through the playgroup that I'm associated with. There are a few mothers there who have had home births and I was referred through that way.

Q. Someone - perhaps the midwife, or someone else - must have assessed you at an early stage of this pregnancy as being low-risk birth or suitable for having a birth at home. Is there any such assessment process?

A. Only the relationship is pretty much how she bases that assessment. For instance, my membranes started to leak on the Thursday before my baby was born. Had I been going to a birth centre, I would not have been able to birth in the birth centre; I would have had to birth in the hospital, because of a prolonged rupture of the membrane. Yet there were no complications, there was no hassles - there was nothing like that. So probably with all of my births I would not have qualified - except for my first because we didn't know - for a community midwife program as it stands. Yet, there were no complications, no problems whatsoever at all, and that comes through having a relationship with the person who is there to attend the birth and having that trust.

Q. You had a midwife who looked after you the whole way through and being present at the birth?

A. Yes, and she's still present.

Q. She comes and sees you now and looks after you postnatally?

A. That's right.

Q. It has been suggested to the Inquiry at various places that a case-load model of midwifery care which is similar to that but the birth doesn't take place at home, it takes place in a birthing centre, is an advantageous and a good model of care. Do you have a view about that?

I appreciate you have a view that birthing at home is a pretty good experience.

A. Yes.

Q. Since I'm looking at public hospitals and models of care in public hospitals, what's your view about that? Would that have been better?

1 A. We really need to - I think we either need to pay me  
2 to have the birth that I want to have, so in some way the  
3 government - I can recoup my funds that I've had to pay out  
4 to pay for my own birth, or offer those same - the Medicare  
5 provider numbers to midwives in order for them to provide a  
6 care that's not cost prohibitive, because it was cost  
7 prohibitive with the last two.

8  
9 I think we should be able to have the birth of our  
10 choice, but that is also another option, to have  
11 predominantly midwifery care within our public health  
12 system rather than an obstetrics model which is clearly -  
13 you know, it's very much the obstetrics model that's  
14 successful depending on the particular obstetrician.

15  
16 We have a 35 per cent episiotomy rate here in Goulburn  
17 which is way above what's acceptable and that is obviously  
18 coming through from the care that's on offer, certainly, a  
19 midwife program where predominantly midwives managed  
20 80 per cent of women who are perfectly healthy during their  
21 pregnancy and their birth, where I think at the moment we  
22 see less than 20 per cent of women actually give birth in  
23 the normal physiological manner, which doesn't equate to  
24 how it should be.

25  
26 Q. Is there anything more you would like to add to what  
27 you've said?

28 A. I don't think so.

29  
30 Q. All right. Thank you very much for coming in and  
31 telling me that.

32 A. Thank you.

33  
34 <THE WITNESS WITHDREW

35  
36 THE COMMISSIONER: Is Ms Matheson present? Come forward,  
37 madam.

38  
39 <ELIZABETH MYEE MATHESON, sworn: [10.33am]

40  
41 THE COMMISSIONER: Q. Would you mind giving the Inquiry  
42 your full name?

43 A. Elizabeth Myee Matheson.

44  
45 Q. Ms Matheson, what would you like to draw to my  
46 attention?

47 A. I'm here to talk about the maternity services that are

1 also offered in New South Wales. I think I have a fairly  
2 unique story to tell because I went and stayed in Holland  
3 for the birth of my first two children and returned to  
4 Australia where my third child was born in Goulburn Base  
5 and we've just given birth to our fourth child at home as a  
6 choice, so I've got a pretty good comparison to see pretty  
7 clearly the effects of different care during birth.

8  
9 You may be aware that in Holland they have and have  
10 had for a long time a significantly higher home birthing  
11 system. When I was there - we returned in '98 anyway and  
12 at that point there was still 80 to 90 per cent of children  
13 born at home through the system of care that was there. I  
14 didn't choose to go to Holland and birth my children at  
15 home. It's just that my husband is Dutch and the system  
16 gave me that choice while I was there. It was obviously  
17 very normal to birth at home there. I can only say that I  
18 had wonderful birth experiences there.

19  
20 After that, coming back here, we had our third child  
21 in 2000 and I just presumed that I could go to Goulburn  
22 Base Hospital and give birth in the same way that I had  
23 with the first two, which was just that I would be in  
24 control of getting the baby out of my body, if that's a  
25 polite way to say it, but unfortunately I found that the  
26 intervention was so dramatic from the first time that you  
27 went and from when I arrived there to give birth that the  
28 birth was longer, it was a lot more painful, my husband  
29 certainly had a much less enjoyable time, to the point  
30 where he flatly refused when we fell pregnant; he said,  
31 "There's no way I'm letting you go back up to  
32 Goulburn Base."

33  
34 I found that there was no real interest in my past at  
35 all. In fact, 10 minutes before my daughter was born the  
36 obstetrician asked me if this was my first child, so at  
37 that point he hadn't even seen the notes to see if it was a  
38 first - you know, what --

39  
40 Q. Had you had antenatal care at the hospital prior to  
41 your birth at Goulburn Base?

42 A. I attended the antenatal clinic there several times.  
43 Each time I actually saw a different midwife and two  
44 different obstetricians and I was told that there was a  
45 tour I could take through the hospital, which never  
46 eventuated because I couldn't make the first date, so in  
47 comparison to in Holland, I had had - they have compulsory

1 antenatal classes with a fully qualified physiotherapist  
2 for eight or nine weeks beforehand and having attended  
3 those classes, and my husband as well, that gave me all the  
4 information, that I had no fear at all of what was going to  
5 happen, that there was going to be anything wrong.

6  
7 The antenatal classes at Goulburn, I wouldn't even  
8 call them that. There were no classes, there were no  
9 classes running at the time, but I attended the clinic  
10 where I could see a midwife which, as I say, was a  
11 different one every time. I arrived in Goulburn Base  
12 Hospital. I didn't even know which way to sort of walk  
13 through the hospital. That was the standard of information  
14 that was given to me. I was also under the impression --

15  
16 Q. This is the year 2000?

17 A. 2000, that's right, yes. I was also under the  
18 impression that there was a lot of - that I could choose.  
19 I birth very quickly and I had no complications whatsoever  
20 with the first two and like I said before, I presumed that  
21 I could just go to Goulburn Base and birth in a room, but I  
22 found that the midwives didn't tend to leave me be to do my  
23 own thing. I had to wear an apparatus to gauge the baby's  
24 heartbeat which --

25  
26 Q. A foetal heart monitor?

27 A. Yes, which I found just an encumbrance during the  
28 labour period. I remember my husband and the little  
29 student nurse that was with us constantly having to walk  
30 around. The couple of times that I was examined by the  
31 obstetrician I found very painful, which I had never  
32 experienced before with the care from the midwives that  
33 I've had. As I said, he came in with a group of students,  
34 it ended up being about 10 minutes before my daughter was  
35 born, but at that stage he had no idea that my first births  
36 were four-and-a-half hour and two-and-a-half hour lengths.  
37 He hadn't even bothered to notice that.

38  
39 For some reason he'd noticed a hiccough in the foetal  
40 heart monitor and had asked me to lie up on the bed which  
41 was also - I just am always standing and always walking  
42 whenever I give birth, so even in the middle of a  
43 contraction, to have to lie down I felt was getting in the  
44 way of the natural process.

45  
46 I actually suddenly saw him heading towards my pelvic  
47 area with something, I didn't know what it was and was told

1 that it was a monitor that was to be placed in the baby's  
2 head and if I didn't let him do it that I would have to  
3 sign a paper so that I wouldn't sue him afterwards, because  
4 if the cord was stuck around the baby's throat that I would  
5 sue him and at that point I sort of asked my husband and  
6 the student nurse what they thought. I mean, the baby was  
7 born 10 minutes later, so this is in the throes of a time  
8 when you can't think straight and I feel that you're very  
9 vulnerable and you're not able at that point in time to  
10 make those sorts of decisions, but there was certainly -  
11 there had never been any indication - I hadn't even been  
12 told that this sort of thing might happen. It hadn't been  
13 explained to me in any way.

14  
15 I allowed him to put the foetal monitor into the  
16 baby's head which I could only describe as the most painful  
17 experience I've ever been through, even in comparison to  
18 the births themselves. It just didn't come close. The  
19 baby being born within 10 minutes after that I think is a  
20 fair indication that that's why it was very painful, but  
21 also that it was a completely unnecessary treatment.

22  
23 At the same time my waters had broken at our home at  
24 Woodhouse Lea, which is about 20 minutes outside of  
25 Goulburn, early in the morning, much the same as the other  
26 two births and before he had put the foetal monitor into  
27 the baby's head, suddenly an anaesthetist turned up and I  
28 was told that I was being given a pethidine shot because my  
29 waters had broken and there was a risk of infection. The  
30 anaesthetist tried, but the contractions were coming so  
31 quick that the baby was actually born before he could get -  
32 he had the little thing in that they inject --

33  
34 Q. The cannula.

35 A. The cannula. He had the cannula in, but the  
36 contractions were coming so quickly by that point that  
37 thank goodness he didn't have a chance to put the pethidine  
38 in and I tried to ask that that was not given and  
39 unfortunately they seemed to just presume that there was a  
40 risk of infection and that was what was going to happen; so  
41 I wasn't happy about that either. After the baby was born,  
42 he returned one time to see me in the room.

43  
44 Q. Is that the anaesthetist or the obstetrician?

45 A. The obstetrician, after the birth of the baby. There  
46 was a student midwife and a midwife at the birth and he  
47 walked into the room.

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Q. The obstetrician wasn't at the birth?  
A. No. No. Thank goodness he'd left. He was doing his rounds. He returned back to the room and said to my husband, "So the cord wasn't around the baby's neck?" That's good." And left. That was the extent of my experience - that was the extent of his sort of time with me in the birth room. We very quickly went home that same afternoon at two o'clock because I don't enjoy hospitals at the best of times and having had the two other births at home, I was keen to get there where I felt safe and I could actually enjoy my baby without having to take in everything else that was going on in the hospital.

We went home and I had two visits from the midwife after that because I'd also requested not to have the injection of vitamin K. When I was in Holland, we were able to give drops of vitamin K. I requested that and I wasn't allowed to do that. They came out to administer the drops of vitamin K which I had actually administered myself in Holland for the first 10 days. That was part of the system there.

Now that I look back and having heard - us mothers when we give birth and have children love to talk about it: it becomes our life. I've heard many stories from different people and I've become very careful about trying to tell my point of view because I find most Australian women just expect a negative birth experience and can't believe that I'm so lucky, they say, that I'm able to birth naturally with no complications, but I see that as more a consequence of being educated well before the first two births and being given the opportunity to birth in the natural way that is how it's supposed to go and that the birth in Goulburn Hospital was just a high intervention there that complicated things and made the birth longer and also a lot more difficult.

Q. So the interventions that fall under the description "high interventions" were these, if I understand your account correctly: one, the application of a foetal heart monitor around your stomach.

A. Without having that being told at an earlier time, yes.

Q. Two, the application of a foetal scalp monitor?

A. Yes.

1  
2 Q. Three, the insertion of a cannula into your wrist in  
3 advance of being given pethidine --  
4 A. Yes.  
5  
6 Q. -- which was unable to be delivered?  
7 A. Yes.  
8  
9 Q. Four, on two separate occasions an examination of you  
10 by an obstetrician which caused you a degree of discomfort  
11 and pain?  
12 A. Yes.  
13  
14 Q. And five, being required, because of a stated concern  
15 about the foetal heart, to lie on the bed rather than to be  
16 free to walk around or sit or kneel or --  
17 A. That's right, or stand.  
18  
19 Q. -- or stand --  
20 A. That's correct.  
21  
22 Q. -- or take a position that you chose.  
23 A. Yes. Also, I was required to put my legs up in the  
24 stirrup position and that's not how I like to birth.  
25 That's not how it goes naturally. I've just had our fourth  
26 child at home with the midwife that the previous lady spoke  
27 of and it all went smoothly. I don't consider the pain  
28 that - you expect a certain degree of pain during  
29 childbirth, but because I had the right support and I think  
30 the right experience, that it's quite - I can talk about  
31 three of my birth experiences as a wonderful, enriching  
32 time and unfortunately when my daughter was born at  
33 Goulburn Base, I can only say that I was left feeling very  
34 angry, frustrated, victimised. I've described it to my  
35 husband.  
36  
37 Q. Why do you describe it as "victimised"?  
38 A. Because I felt like there was no-one there who  
39 actually gave me the chance to speak for myself. I felt  
40 like I was handled as the next cow or the next sheep coming  
41 through the system. They didn't seem to be even interested  
42 in my previous birthing experience that indicated that I  
43 would be able to birth naturally and I'd indicated I wanted  
44 it drug free and that seemed to just all be washed away in  
45 the daily process of mothers giving birth in the hospital  
46 system.  
47

1           On reflection, I look back, I have photographs of the  
2 groups of women that I gave birth with in Holland and there  
3 was not one with a complication. There was one lady who  
4 had a Downs Syndrome child born. There were 15 in the  
5 first class all birthed at home and 18 in the second class  
6 and two of those births in hospital because one of them was  
7 having twins and the other one had something wrong with her  
8 pelvis and was required to go to hospital as well.

9  
10           My memory of that experience is a room full of ladies  
11 with little babies months later telling about a wonderful  
12 experience. It was talked about with happiness and joy and  
13 I feel like it enhances your sense of womanhood and gives  
14 you and your husband strength to be better people in life,  
15 compared to the stories we hear in Australia,  
16 unfortunately, from our friends who have had breech births,  
17 who have had Caesareans, who have had episiotomies, who are  
18 stitched.

19  
20           I have heard very few stories recounted from ladies  
21 and friends in Australia that have a positive birth  
22 experience and I feel so strongly that it could be possible  
23 with a simple change of emphasis, if you like, on how birth  
24 is seen. It seems to me like if you want things to go  
25 wrong, go to the hospital. They seem to almost be afraid  
26 themselves that woman can naturally give birth without  
27 needing drugs or intervention or a specialist standing  
28 there.

29  
30           I felt like in my birth that all I really needed was  
31 my husband and the student nurse there, but the student  
32 nurse obviously didn't have any real - any qualifications  
33 as of yet to be of any standing. I felt like it was very -  
34 that there was not much choice for me anyway and I went  
35 into it thinking like it would just be a simple matter of  
36 going in and giving birth, but I found that that was not  
37 possible because the environment seems to need you to do  
38 things with drugs and tools and monitors.

39  
40           Q. I understand that point of view. Thank you very much  
41 for coming and telling me about that.

42           A. Thank you.

43  
44           <THE WITNESS WITHDREW

45  
46           THE COMMISSIONER: Is Mrs Vaughan present? Come forward,  
47 madam.

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<ZOE VAUGHAN, affirmed: [10.49am]

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

A. My name is Mrs Zoe Vaughan.

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

A. Again, the maternity services. I have a first-born son who is now 10 months old and when me and my husband fell pregnant, I wanted to look at all of the options available to me within this area. Sorry, I'm a bit nervous sort of sitting here looking at everyone. I've grown up in this area, so I know it quite well. I also know that at Goulburn Base Hospital a lot of the stories or recounts that I've heard have been like was mentioned, negative in relation to birth. I saw it as something very different. I saw birth as a natural experience, something that can be positive.

Because of those beliefs that me and my husband held, we went in search of birth options that were available to us. We looked at Goulburn Base Hospital's statistics and records. We drew attention to the fact that at Goulburn Base there's a 35 per cent episiotomy rate compared to John Hunter where there's a 5 per cent rate, which is quite an alarming difference, and having my first child, you know, it was obviously quite scary to have those differences in the statistics and they're there in black and white.

My husband and I chose to have a private midwife and deliver our baby at home, which was our wish, and we wanted to have a drug-free nurturing environment to bring our baby in. You know, all through your pregnancy you eat the right things, you do the right exercises, you do everything positive for your child. I didn't see the point in going into the labour and then having an epidural or something else, like, to introduce drugs into your child just before it's born; so that was our view.

We also looked at a private obstetrician as an option which is funded, so women have the choice of having a private obstetrician and having an elective Caesar, but women aren't given the choice to have a funded private midwife and have a natural birth which --

1 Q. Funded by the Medicare system?

2 A. Yes, to give women the choice to be in charge of their  
3 own body and their own birth experience rather than being  
4 dictated by funds, which it is in a lot of cases. Since  
5 having Zac, as mothers do, you chat and discuss your birth  
6 and what happened and so on and I've had numbers and  
7 numbers of women say, "I wish that we had the option of  
8 having a private midwife." This is usually after having  
9 their first child or second or third, or whatever, and  
10 having the experiences that they have had at Goulburn Base  
11 Hospital, because, you know, it is seen as a medical  
12 procedure rather than a natural process.  
13

14 Q. It's not surprising that a hospital would apply a  
15 medical model, though, is it?

16 A. No, it's not surprising, but in saying that, other  
17 countries, like Holland and England, provide funded  
18 midwifery to women so that women can choose their own  
19 process of birth rather than being dictated by the hospital  
20 system. You know, me and my husband chose a midwife  
21 because it is one-on-one care; that is, through the whole  
22 pregnancy, your birth and afterwards, you have one-on-one  
23 continuity of care with this one person, as opposed to the  
24 hospital system where you get who you get on the day and  
25 you get to choose your obstetrician, whether they be there  
26 or not.  
27

28 In saying that, I feel like I had a positive  
29 experience because of being educated and doing the  
30 research, whereas lots of women just don't know that there  
31 is that option out there and if a slight change was made to  
32 the system so that women were given these options to choose  
33 their own process of birth, with funding, so that like they  
34 can choose their own private obstetrician, they could  
35 choose their own private midwife, I think that would  
36 improve the hospital system and improve these negative  
37 outcomes from the recounts that I'm told happens a lot  
38 through lack of communication between, you know, midwives  
39 changing shifts or the obstetrician not actually being  
40 there. Yes.  
41

42 Q. I can understand from your own perspective that you  
43 may exercise a choice to have your baby at home.

44 A. Yes.  
45

46 Q. I understand your complaint that the  
47 Commonwealth Government's Medicare system doesn't permit a



1 Q. You're presently employed at the Goulburn Base  
2 Hospital?  
3 A. Yes.  
4  
5 Q. How long have you been employed there?  
6 A. I've been employed at the Goulburn Base for 24 years  
7 and four years in health before that at Westmead.  
8  
9 Q. What would you like to draw to my attention?  
10 A. I also have a role as one of the delegate advisers for  
11 Greater Southern for dietetics. I was party to a written  
12 submission that our group, the New South Wales Nutrition  
13 and Dieticians adviser, has made to the Commission - to  
14 you. I just wanted to add perhaps a few things from a more  
15 local perspective. This submission - perhaps you haven't  
16 got to it yet - was around the issue of malnutrition within  
17 hospital patients and the hospital population.  
18  
19 Q. I should say we've received 350 submissions and --  
20 A. You haven't quite got to them yet.  
21  
22 Q. -- I haven't read them all yet.  
23 A. Yes. From a rural perspective and a local  
24 perspective, I believe that we probably have similar levels  
25 of malnutrition within our patient groups that we look  
26 after. They're quoting numbers like 51 per cent of  
27 patients within the hospital population have some degree of  
28 malnutrition.  
29  
30 Q. I was just going to ask when you use the term  
31 "malnutrition", that covers a range from being slightly  
32 undernourished to extremely undernourished?  
33 A. Slightly undernourished to the point of being  
34 extremely undernourished.  
35  
36 Q. "Malnutrition" would include somebody who is 3 or  
37 4 per cent undernourished --  
38 A. To the people who are in extremis sometimes.  
39  
40 Q. Yes, I understand.  
41 A. In the rural setting perhaps we have even more risk  
42 because we actually have quite lower levels of staffing of  
43 professionals and in general, we don't have the support  
44 staff in the rural sites. For example, I myself have  
45 responsibility for some 158 beds, plus the community and  
46 other roles.  
47

1 Q. Where are those beds?

2 A. They're all within the Goulburn Base Hospital,  
3 Bourke Street here, Kenmore Hospital, the Chisholm Ross and  
4 also Crookwell District Hospital, so officially --

5

6 Q. Do you include Yass as well in your --

7 A. No, Yass has their own part-time dietician, so I'm not  
8 involved there. Surveillance is difficult. As a  
9 profession, we also have a competing agenda from the  
10 Department of Health. So whenever services - and they  
11 expand in rural areas. For example, oncology services have  
12 expanded in recent times where we're providing chemotherapy  
13 and therefore, support to those patients, so the services  
14 expand and people like myself just have to embrace that or  
15 make a decision about what you don't do and that's a  
16 difficult thing to do at times.

17

18 Also, the Department of Health has competing agendas  
19 as far as the recognition of hospital malnutrition on one  
20 side and needing to do something about that, to dealing  
21 with the greater problem of obesity and wanting us to  
22 concentrate our efforts there. When you're limited to,  
23 like, one person doing this whole area and the whole  
24 cluster of what was the Southern Tablelands cluster, the  
25 staffing we have is 1.2 for what I do. I have a 0.2  
26 position as well that assists me.

27

28 A lot of hospitals have very limited dietetic cover.  
29 Goulburn Base Hospital has probably the only diet aide that  
30 I am aware of in the eastern sector of Greater Southern  
31 Area Health. Therefore, we don't have support staff who  
32 can assist people in doing menus and doing surveillance and  
33 doing those sorts of tasks because none of the hospitals  
34 have full-time dietetic services attached to them.

35

36 Looking at nutrition status falls then to the nursing  
37 staff. There are certainly issues with that - the skills,  
38 the time they have, the staffing, the communication issues.  
39 Malnutrition is something that is often missed, or even the  
40 basic monitoring. I did a quality exercise recently where  
41 we looked at patients whose weight was recorded in the  
42 hospital. Only 25 per cent of people actually had that  
43 very basic measurement done when they were in hospital.

44

45 We also have as part of the nursing admission form a  
46 very basic nutrition screening tool and that was only  
47 completed for 50 per cent of the patients that had come

1 through. Even when they were completed, there wasn't --

2

3 Q. Just give me an example of what that tool is?

4 A. It is a tool that has some very short questions: have  
5 you lost weight in the last so many weeks, how much weight  
6 have you lost? It is scored with a points system. Anyone  
7 over 3 should be referred to a dietitian. It is just a  
8 basic tool of weight loss. That will at least identify  
9 those patients who may have an issue if they are to be  
10 admitted into the system. I see there is probably even a  
11 greater potential for malnutrition with our patients and --

12

13 Q. Sorry, when did you do this project, roughly?

14 A. That was done earlier this year and last year.

15

16 Q. With the results where you have only 50 per cent  
17 approximately of the relevant questions being answered,  
18 what process is there, if any, for you to then take that up  
19 with the relevant people who should have been filling forms  
20 in?

21 A. We have already raised it. I have discussed it  
22 informally with the director of nursing at the Base. It is  
23 an issue that I want to look at in a certain context. The  
24 quality program will involve looking at patients when they  
25 come into the system and through it to see where and if we  
26 can make any difference. The whole project has not been  
27 reported on yet, but that would be the first place. I can  
28 understand that it is not an easy task. Nurses have an  
29 awful lot to do, but that is one of those things that is  
30 often not completed. Whether that is a priority --

31

32 Q. Do you think it may be because the nurses who are  
33 filling in those forms don't understand the significance of  
34 the questions and therefore regard them as less important  
35 than you do?

36 A. Less important than other things, yes. I think there  
37 is certainly the issue of the importance of it, and also  
38 even the ability to get patients weighed at times. At the  
39 Base, we have one ward which has a weigh check. If you  
40 have a person who can't walk, the only place you can weigh  
41 them is on that floor or you have to bring the scales down.  
42 Obviously there will be an issue there. So there are  
43 issues beyond the time thing. The availability of the  
44 scales, the fact that you have to take the scales to the  
45 patient or the patient to the scales, these things all  
46 impact.

47

1 It is probably both things - that process is in play,  
2 and also just the level of nutrition intake. That is a  
3 real issue in that we don't seem to value that nutrition  
4 and adequate nutrition is a basic right for every single  
5 person who comes into a hospital. It is not just people  
6 who are diabetic and need their diet adjusted. Every  
7 person who comes in has the right to have the right food.  
8 That is not always happening.

9  
10 There is an issue about equity of service across the  
11 State. People in a smaller rural site possibly are not  
12 getting their needs looked at as effectively as, say, they  
13 would in a bigger hospital where there are more staff and  
14 more professional staff.

15  
16 Q. But at some of the smaller sites, the preparation and  
17 service of food is more flexible, isn't it?

18 A. Certainly. The other issue at the moment, and I was  
19 going to get to that, is that we don't have, across the  
20 State, standards of nutritional care that are endorsed by  
21 the Department of Health. There has been a process in  
22 place, and I was actually part of that process, where from  
23 2003, we got together and we were meeting to determine what  
24 the hospital menu should provide for everyone.

25  
26 The process fell apart. The department did not end up  
27 endorsing it, and we still have the situation where you  
28 can't actually ask what should you be feeding a patient in  
29 that bed, in that hospital, and what should be available?  
30 There is not actually an official answer to that yet.

31  
32 Q. The process that you're referring to, though,  
33 produced, did it not, a good deal of debate, if not  
34 disagreement, amongst your professional colleagues as to  
35 what was appropriate?

36 A. The professional colleagues were in agreeance and the  
37 document was actually endorsed by the Dietitians  
38 Association of Australia.

39  
40 Q. When was that?

41 A. 2006 was the last time we had meetings about that. It  
42 had gone to them for comments. The comments were  
43 incorporated from the DAA. In fact, the document was also  
44 endorsed by the Institute of Hospital Catering. They also  
45 supported the document. The DAA and the hospital caterers  
46 wanted a meal plan included. The difference was we had  
47 scientific, evidence-supported recommendations about how

1 much protein a person should have, or milk, or whatever it  
2 might have been through the day that a diet must provide.  
3 No-one was arguing about that because it was supported by  
4 evidence. Where it came unstuck was with the principles of  
5 putting that science into the practical sense of a meal  
6 plan.

7  
8 Q. A menu or a meal plan?

9 A. A menu, or a meal plan basically. Then if we are  
10 looking at the Health Support scene people could take that  
11 and interpret it to a menu that might go across the whole  
12 State, as perhaps will happen, or to the local catering  
13 officer at Delegate or Bombala to say, "This is what I am  
14 supposed to feed the patients and these are the standards  
15 I must meet." That is where it fell apart.

16  
17 The food service side of things were looking at the  
18 dollar. If we were saying that people had to have  
19 nourishing mid-meals, they could see there was a cost  
20 involved in that. They wanted to be able to say, "You have  
21 given us the numbers. We will come up with a meal plan.  
22 We will come up with the food that meets that." The issue  
23 was we couldn't really quite see how that could happen if  
24 you didn't have clinicians, and not just dietitians,  
25 involved in saying, "Well, people have to have choice."

26  
27 You can meet that set of nutritional standards.  
28 The silliest case would be to say, "Here are six cans of  
29 tube feeding - the complete feed, six cans - just drink  
30 that for the day." You could do it in a similar fashion  
31 and say, "Here is this menu; one menu fits all. It has  
32 everything in it"; but you have not taken into account  
33 patient's needs, the fact that they eat small amounts. It  
34 was more a question of having the ability to have a tool  
35 you could use to interpret that actually recognised patient  
36 need at least to a degree, so that is where it fell apart.

37  
38 Q. Does that mean that, as we stand at the moment, so far  
39 as you know, there has not been developed a tool or process  
40 or formulation, or whatever term you want to give it, which  
41 converts the recognised level of nutritional standard into  
42 a menu?

43 A. No, not that it has been agreed on and --

44  
45 Q. Am I right in what I have said to you?

46 A. Yes. Most recently, on about 4 April, the Department  
47 of Health, along with Health Support, had a workshop

1 looking at the clinical interface between food service,  
2 Health Support and clinical things. That was a facilitated  
3 workshop. Actually Health Support were the people who came  
4 on board to say, "We really need to get this on track."  
5

6 One of the recommendations from that workshop - and we  
7 have not seen it yet - will be that the standards have to  
8 be revisited. We have to have agreeance across the State  
9 on what is an acceptable food service. Not just the  
10 numbers of grams of protein, fat and carbohydrate, but what  
11 we value as clinicians, the choice, the range of food, how  
12 it will be provided, all of these things need to be there  
13 because we need to be able to measure quality service  
14 against what is being providing in health support.  
15 That was basically just a reminder. A lot of this stuff is  
16 in the other submissions.  
17

18 In the rural sense, even in Greater Southern, there  
19 has been a little bit of resistance to the transition over  
20 to Health Support that will happen on 1 July. That doesn't  
21 mean that, all of a sudden, we will be getting our food  
22 from anywhere else. They will just transition the  
23 management and the food will come from wherever it is  
24 coming now.  
25

26 I agree with you; there are some sites that do very  
27 well, like your small hospitals with one cook who looks  
28 after everyone well. But there are also a lot of places  
29 where dinner at those sites is packet soup and a slice of  
30 bread and no option for a hot meal or a salad if that  
31 happened to be what you wanted. If you have catering staff  
32 that are perhaps taking their own approach to things,  
33 because we don't have any governance of this issue, it is  
34 very difficult to do anything about it. There is quite a  
35 difference between what you can get in different hospitals  
36 as well.  
37

38 I go to meetings and they'll repeatedly say, "I do  
39 this for my patients." One then asks, "How do you get that  
40 for your patient?" It becomes an individual matter for  
41 the catering manager as opposed to saying, "This is the  
42 basic standard and this is what should happen." That is  
43 obviously an issue across the State, thank you.  
44

45 Q. Thank you very much, Ms Lace.  
46

47 <THE WITNESS WITHDREW

1 <DAVID WHITE, sworn: [11.11am]

2

3 THE COMMISSIONER: Q. Would you give the Inquiry your  
4 full name, please?

5 A. My name is David White.

6

7 Q. And your occupation?

8 A. I am an electoral officer grade for Katrina  
9 Hodgkinson, who is the member of parliament for the  
10 electorate of Burri nju ck.

11

12 Q. Can you tell me what local government areas the  
13 electorate of Burri nju ck covers?

14 A. I hope I don't miss any out. Starting at the top:  
15 Cowra, Weddin Shire, then Lachlan, Boorowa, Young,  
16 Cootamundra, Gundagai, Yass, Harden. I hope I have them  
17 all.

18

19 Q. Thank you. What would you like to say?

20 A. I have a statement here from Katrina, which she has  
21 asked me to read to the Inquiry.

22

23 Q. If it is a written statement and it is not yours, it  
24 would be good if you handed it in. We don't need you to  
25 read it out. It is very good of Ms Hodgkinson to prepare  
26 this for us and I acknowledge her assistance. If she were  
27 here, I would no doubt ask her some questions about it.  
28 Are you able to answer some questions about it or is it  
29 really a matter for her?

30 A. I can't answer questions on Katrina's behalf; however,  
31 I have been an electoral officer for her for eight years  
32 and I deal with people and every issue that comes through  
33 our office.

34

35 Q. From the people that you have seen, what would you  
36 like to tell me about?

37 A. My concern, Commissioner, is that patients in rural  
38 areas are having increasing difficulty in accessing health  
39 services because of the structure of the health system in  
40 these rural areas.

41

42 Q. What do you mean by that?

43 A. Increasingly the service has been centralised. It  
44 works basically from what is referred to as the hub and  
45 spoke model. You have a large service hospital which  
46 provides everything. Then you have smaller hospitals  
47 outlying such as, say, Crookwell, Yass, those sorts of

1 places. The services available in the local community are  
2 continually being reduced with patients being required to  
3 travel into larger areas. That places considerable  
4 hardship on families, financially and emotionally.  
5 Patients get better quicker if they are in a supported  
6 environment with their families.

7  
8 I can talk from my own personal experience. I became  
9 a grandfather about two weeks ago. My daughter had to go  
10 to Canberra to have her baby.

11  
12 Q. From which area?

13 A. From Yass. I live in Yass. It is in the statement,  
14 but last year there were 154 babies born to residents of  
15 the Yass Valley, none of which were actually born in Yass  
16 because the health service had closed the maternity ward.  
17 The support that is given to --

18  
19 Q. Sorry, Yass to Canberra for your daughter would have  
20 been, what, an hour or so?

21 A. It is an hour and 20 minutes, depending on how fast  
22 you drive and what the traffic is like and all those sorts  
23 of things.

24  
25 We have a lot of complaints from constituents about  
26 the travel support that is provided to them through the  
27 IPTAAS, the isolated patients transport accommodation and  
28 assistance scheme. This has fairly recently been reduced  
29 to 100 kilometres each way. That means that people in Yass  
30 and the Yass area do not get any assistance because whilst  
31 they fall within the distance criteria, they are then  
32 required to make a personal contribution and that negates  
33 any assistance they get.

34  
35 If you have to travel to and from between Yass and  
36 Canberra or even further from smaller surrounding districts  
37 to visit a person in hospital or to obtain treatment, you  
38 get no assistance. With the price of petrol these days,  
39 that is extremely expensive.

40  
41 Q. I understand the difficulties of transport. Mr White,  
42 thank you very much for coming.

43 A. Thank you.

44  
45 <THE WITNESS WITHDREW

46  
47

1 <JOHN LESLIE WARBURTON, sworn: [11.16am]

2

3 THE COMMISSIONER: Q. Would you give the Inquiry your  
4 full name, please?

5 A. My name is John Leslie Warburton. I live at  
6 102 Sloane Street, Goulburn.

7

8 Q. Mr Warburton, I understand that you have been a  
9 patient at Goulburn Hospital?

10 A. I'd like to talk as a patient.

11

12 Q. What would you like to tell me about?

13 A. I would like start off by saying that the way I walk  
14 has nothing to do with my illness at Goulburn Base  
15 Hospital. This goes back quite a number of years when I  
16 had vertebrae collapse in my neck, causing problems with  
17 the nerves.

18

19 My trip to the Goulburn Base Hospital began when I  
20 returned from overseas, where I was living for some time  
21 back in the years previous to 2006. I arrived back at  
22 Goulburn and within the month that I came back, I  
23 deteriorated rather quickly. It climaxed on 2 May 2006,  
24 when I fell over trying to get into the shower. I couldn't  
25 get up. I couldn't roll over. I just had to slither on my  
26 back to get to my cell phone to ring an ambulance. I was  
27 taken to the acute care centre at Goulburn Base Hospital.

28

29 I have nothing but admiration, first off, for the  
30 ambulance officers, the casualty department, and I ended up  
31 in the acute care. Can I tell the doctor's name?

32

33 Q. Yes, of course.

34 A. It is thanks to Dr Renton and all the nursing staff  
35 and their professionalism, their expertise, their  
36 compassion and their thoroughness that I am here today.

37

38 Q. When you said "acute care", did you go through the  
39 emergency department at Goulburn Base?

40 A. But in an ambulance, yes.

41

42 Q. But then you went to the intensive care unit?

43 A. That's right.

44

45 Q. I was diagnosed as having complete renal failure.  
46 I think I weighed around approximately 140 kilos at that  
47 stage. My normal weight is about 80. I was full of fluid.

1 That is why I couldn't get up or anything. I had complete  
2 renal failure. I had septicaemia. I had a germ in my  
3 blood which I picked up overseas somewhere which probably  
4 started everything off, plus everything in the liver was  
5 pretty well bugged, and I was very touch and go for the  
6 first night. It was Dr Renton and the staff at the acute  
7 care who pulled me through.

8  
9 I have nothing but admiration for my treatment at the  
10 time I was in acute care - that was two weeks - and then  
11 the further treatment in the third floor at the Goulburn  
12 Base hospital. I was in hospital for a total of nine  
13 months before I was released.

14  
15 Q. You came down to this site, did you, for some period  
16 of that time?

17 A. Yes. I was here for the last two weeks. I was on  
18 rehabilitation to get well again. Everywhere I went - it  
19 did not matter whether it was the ward, the third floor  
20 ward, here, anywhere - I have no complaints whatsoever. I  
21 don't think you could get better treatment. It wouldn't  
22 matter if it was a five-star hospital in the middle of the  
23 United States or somewhere like that.

24  
25 Q. That is a very good story, Mr Warburton.

26 A. Also I'd like to mention the fact that I spent a lot  
27 of time overseas. I was married over there to a lovely  
28 lady and Dr Renton went out of his way to write a medical  
29 report plus a request which we emailed to the Australian  
30 Embassy in Manila. The embassy called my wife in and gave  
31 her an emergency visa to say she could be by my side. She  
32 was in Goulburn about three weeks after I was admitted.  
33 The normal process to get a tourist visa to Australia - it  
34 is very hard to get over there - could take anything up to  
35 six months. My wife got one within two weeks.

36  
37 Q. You have given me and the staff of the Inquiry a typed  
38 document?

39 A. When I left the hospital I was given that to take with  
40 me. If I had a relapse anywhere, I had the history of what  
41 treatment they gave me. Also I would like to say that the  
42 doctors in the hospital liaised with my personal GP,  
43 Dr Falk. I go for regular check-ups every quarter and he  
44 checks my progress all the time. I am pleased to say  
45 that every time I go to see the doctor he knows me better -  
46 every time.

47

1 Q. Do you mind carrying that personal medical record with  
2 you? Is that a problem for you?

3 A. No. I don't carry it around town, but if I travel  
4 anywhere, I always take it with me, yes.

5  
6 Q. If you go to your doctor, do you take it with you?  
7 A. No, because my doctor has all my records.

8  
9 Q. He knows all about it?

10 A. Dr Hutchins is another doctor I'd like to mention, and  
11 also the interns. I don't know what they call them,  
12 whether they are trainee doctors or intern doctors, but I  
13 had no problems with any of the staff. The lady mentioned  
14 the food. I didn't find any problems at all with the food  
15 that I got. All the staff, from the wardsmen right through  
16 to the Dr Renton himself, they were tremendous.

17  
18 Q. Mr Warburton, thank you very much. Please feel free  
19 to take that record with you, but thanks for coming and  
20 reporting your experience. I very much appreciate that.

21 A. Thank you very much.

22  
23 <THE WITNESS WITHDREW  
24

25 THE COMMISSIONER: We might take a short 20-minute break  
26 to give the Inquiry staff a break and we will return, if  
27 necessary, in 20 minutes.

28  
29 SHORT ADJOURNMENT  
30

31 THE COMMISSIONER: I propose to resume the hearing for a  
32 moment. I am told by my staff that we have heard from all  
33 the witnesses who have come forward, so it is appropriate  
34 that I formally close the hearing. In doing so, I want to,  
35 firstly, express my gratitude to the witnesses who did come  
36 to give evidence. I found their evidence to be of value  
37 and interesting; secondly, I express my gratitude to the  
38 staff of the Goulburn Base Hospital and the Greater  
39 Southern Area Health Service who facilitated the hearing  
40 this morning.

41  
42 I will now adjourn the public hearings of the Special  
43 Commission of Inquiry to resume at 9.30 tomorrow morning at  
44 Liverpool Hospital.

45  
46 AT 11.56AM THE COMMISSION ADJOURNED ACCORDINGLY  
47

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