MS KEELY GRAHAM: Deanne Tadros is a Senior Legal Officer with the New South Wales Ministry of Health. She manages NSW Health's clinical negligence and coronial practice through its external legal panel and also conducts litigation. She advises on all medico-legal issues, such as consent, privacy and guardianship. Deanne has acted on behalf of the Ministry seeking judicial orders or guidance on medical treatment decisions on behalf of public health organisations, including cases relating to withdrawal of treatment at the end of life and cases relating to providing treatment to minors when parents object. Prior to joining the Ministry of Health Deanne represented public health organisations and medical practitioners in coronial inquests and clinical negligence litigation. Deanne commenced her career as a Registered Nurse working predominantly in Emergency.

MS DEANNE TADROS: Thank you for inviting me to present to you this evening.

Tonight I will provide an overview of Inquiries and Coronial Inquests that have significantly influenced the clinical governance framework of the public health system.

Legislative Framework

There are 2 key acts:

- Health Services Act
  establishes the public health system framework

- Health Administration Act
  Contains the provisions relating to RCA's and Quality and Assurance Groups

Both Acts have undergone significant amendments over the years to adapt to the evolution of the public health system.

I will start tonight by discussing an Inquiry that will be familiar to most of you. The Special Commission of Inquiry into Camden/Campbelltown Hospitals resulted in significant policy development and legislative amendments that form the foundations of Health's clinical governance framework.

In 2002 four nurses raised concerns to the Minister for Health about patient care and poor administration of the then Macarthur Health Service. The Minister referred the Complaint to the HCCC.

In 2003 the HCCC completed its report and noted numerous quality and assurance issues and examples of poor clinical care however no individual practitioners were held to account.

The Health Minister sacked the Commissioner and appointed Bret Walker SC to undertake an Inquiry into the allegations and the operation of the HCCC.

The Inquiry found

- The HCCC had not properly applied its Act to hold individuals to account. Mr Walker changed the definition of 'unsatisfactory professional conduct'
- In response to the allegations Mr Walker found that many of the adverse events or clinical incidents could have been better handled by improved hospital procedures, by more open discussions between professional colleagues and by fuller disclosure to patients and families

Mr Walker opined that a Root Cause Analysis was a useful tool in examining medical error. He recommended that teams conducting an RCA be provided with immunities and protections akin to those found in the HAA in relation to Quality Assurance Groups

Following on from the Walker Inquiry Health

- Implemented a new incident management system and developed a state-wide mandatory incident management policy so all incidents are managed in a systematic manner.
- Established clinical governance units in all Area Health Services
- Established the CEC to analyse information from a range of sources, to identify trends, causes and develop preventative strategies.
- Developed the open disclosure policy.

I had referred earlier to the Health Services Act. S122 (c) of this Act provides the Secretary with the power to inquire into the administration, management and services of public health organisations.

There is currently an Inquiry of this nature into the management and response of St Vincent's Hospital to the under dosage of chemotherapy to head and neck patients.

An Inquiry under the Act will have a Terms of Reference and timeframe for when a report must be completed. Generally there will be appropriate experts assigned to undertake the review. The terms of reference can be amended in order to capture and respond to additional issues that may be identified whilst the review is being undertaken.

Not only can the Inquiry be flexible to respond to emerging issues but it also enables the timely consideration of issues that may have the potential to impact on public health and safety.

The case of Jehan Nassif illustrates the effectiveness of a S122 Inquiry.

The case concerned an 18 year old girl, Jehan Nasif who died from meningococcal disease. Her death was widely reported in the media and there was concern in the community as to whether the response and management by the Hospital was appropriate.

Although the matter was referred to the Coroner, an Inquest was unlikely to occur for at least one year. In the interim, given some of the concerns related to the Guidelines for early clinical and public health management of a meningococcal disease, an Inquiry was conducted to determine if the public health and hospital response was appropriate.

By way of background, Sydney South West Public Health Unit was notified of a confirmed case of meningococcal disease on 15 August 2006. The man's contacts were identified and given information about the disease and offered antibiotic clearance in accordance with the Guidelines.

One of these contacts was Jehan Nassif's boyfriend, who had just returned from a holiday with the affected person on 14 August 2006. Jehan and her boyfriend had engaged in intimate kissing on the evening of 14 August. The boyfriend, who was a potential carrier of the disease, was not offered antibiotic clearance until contacted by the Hospital on 15 August.

One of the concerns raised by the Jehan's boyfriend related to the hospital staff's failure to take adequate notice of his concerns that their intimate kissing placed Jehan at risk of contracting the disease.

The terms of reference for the Inquiry were discussed with the Nassif family, however based on legal advice they declined to participate in the Inquiry. The Inquiry was conducted by two infectious disease experts, one located in another state, as well as a barrister.

The Inquiry reviewed the current literature and consulted with relevant staff members in the public health unit and at the Hospital. The Inquiry were satisfied that the response of the Hospital and the Public Health Unit were appropriate. The Inquiry did however recommend amendments and clarification to a number of NSW Health Department protocols and fact sheets to indicate intimate kissing is a risk factor.

The Inquiry provided reassurance that the existing Guidelines were appropriate to protect the health and safety of the public.

The Coronial Findings were handed down in December 2007. There were no recommendations made in relation to amending the Guidelines, however the Coroner believed information provided by the public health officials to contacts of index cases of meningococcal diseases should be improved.

Several high profile Inquests followed the Nasif Inquest each identifying a series of individual error and systemic issues which contributed to the death. However it was the case of Vanessa Anderson which resulted in significant community concern about the state of the NSW Health system.

Unfortunately most of us are aware of the tragic circumstances that led to the death of Vanessa Anderson.

Vanessa was playing in a golf tournament when she was struck on the head by a golf ball. She was transported to Hornsby Hospital where a scan confirmed a depressed fracture of her skull. She was then transferred to RNSH.

The Coroner noted in his findings "if we had sat down and planned the worst possible scenario for Vanessa it could not have been done better".

The system issues can be summarised as follows:

- Indecision as to whether to admit Vanessa or transfer her to the Children's Hospital
- Failure to communicate to the VMO that Vanessa was admitted under his care.
- A shortage of neurosurgery registrars on call due to training courses in Melbourne.
- The neurosurgical fellow was performing registrar duties, he was tired and overburdened with work. He considered but did not provide anti-convulsants
- The neurosurgical registrar at the time had only worked in neurosurgery for 2 weeks and it was the intern's first day on the unit
- Record taking and clinical notes were deficient or non-existent
- Ignorance of protocols
- Failure to consult with senior staff
- Failure to conduct neurological examinations.

The Coroner observed that these are systemic issues that have existed for a number of years and regrettably all rose to the surface in this particular case.

An RCA was conducted by the Hospital and extensive education, training and policy development had been undertaken both at a local and state-wide level since the date of the incident. The Coroner acknowledged that when an adverse incident occurred there is usually an internal review (RCA) and recommendations made and implemented. The challenge for Health was to approach identified problems holistically.

The Coroner suggested a full and open Inquiry into the delivery of health services in NSW. This suggestion led to the most comprehensive inquiry into the public health service that had ever been undertaken.

SCI Garling

Mr Garling was tasked to review the acute care services of the public health system. Mr Garling found NSW Health to have one of the better Health care systems in the world but noted even the best health system is not immune from crisis and that the public health system had entered one now.

On the brink:

- Increased numbers of elderly patients with complex medical conditions led to longer hospital stays
- The young are presenting to ED's in numbers greater than anticipated . Of them a significant proportion may have mental health problems, along with drug and alcohol dependence
- Demographic change mean that Aust has an aging population which will require proportionally more care as the age groups survive through their 70s into their 80s.
- The skilled workforce are not evenly distributed amongst the population.
- The cost of treatment is rising along side the number of patients

Garling made 130 recommendations to improve the public health system. In his view the key to health's future was to establish 'team based, multidisciplinary care'.

He recommended the establishment of 'four pillars' to become the source of expertise for the Health system.

Clinical based programs were developed in response to the Garling recommendations such as Hand Hygiene – which focuses on infection control, and Between the Flags which provides a standardised system for

clinicians to recognise and respond to patients who are clinically deteriorating. These programs are now embedded into core business.

Government Reform

Further and significant health system reform occurred following the election of the coalition government in 2011. The Minister built upon the recommendations of Garling by streamlining the role of the Department, which would be renamed the Ministry of Health, and devolved major functions to the LHD and to the Health pillars. The reforms are intended to allow decisions to be made as close to the patient as possible.

A number of functions were transferred to the 'pillars' with the CEC now retaining full responsibility for system quality and safety providing leadership in clinical governance to the LHDs, and with the Agency for Clinical Innovation playing a key role in supporting clinical governance through its clinical taskforces.

The provision of safe and high quality health care in NSW requires effective clinical governance structures and processes. It is appropriate that Inquiries and Inquests test the effectiveness of this framework and suggest improvements to ensure the system evolves. As noted by Mr Garling 'Safety and quality is, and should be at the very heart of the NSW Public Health service'.