Special Commission of Inquiry

into Healthcare Funding

Before: The Commissioner,
Mr Richard Beasley SC

At Level 2, 121 Macquarie Street,
Sydney, New South Wales

Monday, 19 February 2024 at 10.00am

(Day 005)

Mr Ed Muston SC	(Senior Counsel Assisting)
Mr Ross Glover	(Counsel Assisting)
Mr Ian Fraser	(Counsel Assisting_
Mr Dan Fuller	(Counsel Assisting)
Dr Tamsin Waterhouse	(Counsel Assisting)

Also present:

Mr Lachlan Gyles SC with Ms Joanna Davidson for NSW Health
Mr Neale Dawson with Ms Laura Toose for NSW Nurses and Midwives' Association

1 THE COMMISSIONER: Good morning.
2
3 MR MUSTON: Commissioner, it might probably be an
4 opportune time to take some fresh appearances. Can
5 I announce the appearance of Mr Fuller who has joined us as
6 counsel assisting the Inquiry.
7
8 THE COMMISSIONER: I'm going to shut the door because it
9 is a bit loud for me to hear.
10
11 MR MUSTON: Mr Fuller has joined the team as counsel
12 assisting. I think there are some other appearances, there
13 has been a slight changing of the guard for health for this
14 hearing block. I might allow them to announce their
15 appearances.
16
17 MR DAWSON: I appear with your leave for the New South
18 Wales Nurses and Midwives' Association. With me is
19 Ms Toose from the association.
20
21 MR GYLES: May it please you, I appear for NSW Health with
22 my learned friend Ms Davidson.
23
24 THE COMMISSIONER: Thank you, Mr Gyles.
25
26 MR MUSTON: The hearing block that we are about to embark
27 upon will deal principally with terms of reference E which
28 you are familiar with, the primary focus of it being
29 procurement and the existing procurement arrangements
30 within NSW Health.
31
32 We will then commence or take a little bit further the
33 building of a baseline in relation to term of reference H
34 in relation to innovation. But just starting with
35 procurement in terms of term of reference E, it's
36 undoubtedly a dry topic, but having regard to the scale of
37 the procurement system across NSW Health and its importance
38 to the smooth and efficient delivery of health care
39 state-wide, it is, on any view, very important. Towards
40 the end of the block we will be hearing some further
41 evidence about innovation, but we will come back to that.
42
43 It is important, I think, to make clear at this point
44 that this is not the only occasion we will be looking at
45 procurement. We will be focusing on it. But it is a topic
46 which will, of course, be picked up as we travel through
47 the regions and take evidence in hearing blocks at

1 different LHDs throughout the regions and equally at other
2 stages during the Inquiry when we might be focusing on
3 another topic or another term of reference. Of course, the
4 witnesses who are called may have something important and
5 useful to contribute in relation to other terms of
6 reference, including procurement, and so we will continue
7 to collect evidence in relation to all of these topics as
8 we go.
9
10 Similarly, the evidence that is called during this
11 hearing block may stray into some other terms of reference
12 and we will gather some potentially useful information in
13 relation to them along the way. But for present purposes,
14 I think we can proceed on the basis that the focus, at
15 least for this week, will be procurement.
16
17 Can I start, then, by tendering the hearing bundle,
18 which I think you should have a copy of.
19
20 THE COMMISSIONER: I'm sure I do.
21
22 MR MUSTON: I will hand up a copy of the index of exhibits
23 just to ensure we're all talking about the same thing.
24
25 THE COMMISSIONER: Yes, I have that, yes.
26
27 MR MUSTON: The documents listed there as B.001 to B.022
28 are a number of statements, then B.023 and following are
29 documents predominantly being those referred to in the
30 statements but also some additional documents which have
31 been gathered from summons material and the like and are
32 perceived to be relevant to the work of the Inquiry.
33
34 Can I point out at this point that there is a separate
35 confidential bundle, or a bundle in relation to which some
36 discussions are under way as between the Inquiry team and
37 health about confidentiality orders and the like, that's
38 not amongst the documents that are listed there but will be
39 forthcoming shortly, once those discussions have reached
40 their conclusion.
41
42 THE COMMISSIONER: So is all of this tendered in one go?
43
44 MR MUSTON: In one go.
45
46 THE COMMISSIONER: With the exhibit number on the left
47 side?

1
2 MR MUSTON: Yes. Save as to one further matter, which is
3 the document listed at B.049. I think a copy of that
4 document appears amongst the documents which are in --
5
6 THE COMMISSIONER: This is annexure J to the statement of
7 Nicholas Howson?
8
9 MR MUSTON: I believe so, yes. The issue in relation to
10 item B.049 is some discussion under way about the possible
11 need for some further redaction, and so at this stage,
12 whilst those discussions are ongoing, we should perhaps
13 not --
14
15 THE COMMISSIONER: That's not part of the tender at the
16 moment.
17
18 MR MUSTON: Certainly not part of any public tender at
19 this stage. But again --
20
21 THE COMMISSIONER: Why don't we just make it not part of
22 the tender for now?
23
24 MR MUSTON: I'm content to proceed on that basis. In the
25 background, we will deal with that and let you know where
26 we get to.
27
28 THE COMMISSIONER: Yes.
29
30 MR MUSTON: Can I outline very briefly the structure of
31 the evidence that we will be hearing this week and next.
32
33 Today we will be hearing from four nurses working in
34 different LHDs across the system who will give evidence
35 their experience of the existing procurement arrangements
36 and the way they impact on their important work. We
37 anticipate that will take most of today and perhaps drift
38 into tomorrow.
39
40 Tomorrow we're going to hear from Paul Dale, who is
41 the director of policy at the Medical Technology
42 Association of Australia. The members of that organisation
43 are obviously important as a source of innovation but also
44 are able to discuss procurement arrangements from the
45 perspective of a supplier to the system, which, of course,
46 is not unimportant.
47

1 We'll also, I anticipate, be commencing our
2 examination of procurement policies as they are applied
3 across several LHDs. The way we intend to do that is to
4 move through the procurement chain at each of the LHDs from
5 someone who is involved day-to-day on the ground with the
6 procurement activities, move through to someone at a more
7 senior level, who is a manager of procurement or equivalent
8 position within the LHD, and then, in two cases, we will be
9 hearing this week from the chief executives of the LHDs to
10 get a sense of how procurement is working, at least from
11 their perspective. The three LHDs that we're looking at
12 during this hearing block are Illawarra Shoalhaven, Sydney,
13 and South Western Sydney.
14
15 You will see at item B.001 in the tender list there is
16 a statement from Margot Mains, the CE of Illawarra
17 Shoalhaven LHD. She is unable to give evidence during this
18 hearing block. We are tendering her statement and we will
19 address the issues that are touched on in that statement,
20 if she is called at a later stage in the Inquiry, but the
21 other two LHDs, so Sydney and South Western Sydney, we will
22 be hearing from the chief executives of each of them.
23
24 We will then move from that, as we progress up the
25 procurement chain, to hear some evidence from the chief
26 executive of HealthShare, which is the pillar primarily
27 responsible for general procurement within the health
28 system.
29
30 That evidence will touch on how they envisage the
31 system operating, we'll look at several large reforms which
32 are under way and we will test with them - I should have
33 added the CE from HealthShare and also the chief
34 procurement officer from NSW Health. They are the two
35 people within executive and administrative level who deal
36 with procurement.
37
38 As I said a moment ago, we will hear about some large
39 reforms which are under way but also test with them any
40 issues which are identified during the evidence given by
41 those who are engaged in procurement activities at the
42 coalface over the coming days.
43
44 Pivot then to a look at procurement from a technology
45 and IT procurement. That's dealt with by a separate
46 pillar, eHealth. The way in which we're going to propose
47 to deal with that is to call evidence from two of the chief

1 information officers from two different LHDs, South Western
2 Sydney and Southern, to get their experiences of the way in
3 which procurement and technology is dealt with within their
4 LHDs and the way in which they interact with eHealth, being
5 the pillar principally responsible for technology and
6 technology-based procurement, and the policies that
7 surround that.
8
9 We will then, consistent with the theme, move from
10 them to hear some evidence from a Dr Zoran Bolevich, who is
11 the chief executive of eHealth.
12
13 Then finally we will move to, probably next week, hear
14 some evidence from Adjunct Professor Jean-Frederic
15 Levesque, who is the deputy secretary and chief executive
16 of clinical innovation and research within the ministry and
17 of the ACI, which is where we'll start to develop our
18 baseline or build on our baseline around innovation and the
19 way in which innovation is identified and, where
20 appropriate, scaled up within the system.
21
22 I think that leaves only for me to indicate that
23 Mr Fuller is going to be taking the evidence from the
24 nurses today and I will leave it to him to call them in the
25 order that he sees most appropriate.
26
27 THE COMMISSIONER: Thank you. Yes, Mr Fuller.
28
29 MR FULLER: Thank you, Commissioner. I call Kylie
30 Tastula.
31
32 **<KYLIE TASTULA, affirmed: [10.12am]**
33
34 THE COMMISSIONER: Listen carefully to Mr Fuller's
35 questions and then - Mr Gyles wants to --
36
37 MR GYLES: Might I say something before we start?
38 I appreciate, Commissioner, you are not dealing with
39 objections to evidence but can I raise one matter in
40 relation to paragraph 28 of the statement.
41
42 THE COMMISSIONER: Yes.
43
44 MR GYLES: Obviously hearsay --
45
46 THE COMMISSIONER: You might have to keep your voice up
47

1 MR GYLES: I'm sorry. If your Honour sees paragraph 28 --
2
3 THE COMMISSIONER: I don't know about "your Honour".
4 "I have heard reports", that bit?
5
6 MR GYLES: Sorry?
7
8 THE CHIEF COMMISSIONER: Is it "I've heard reports".
9
10 MR GYLES: Yes, and the final sentence. This isn't just
11 a matter of form, particularly in relation to the last
12 sentence there is quite a bit to that and it's not really
13 very - if that becomes an important issue, that really
14 needs to be dealt with by the appropriate people.
15 Essentially my objection is that this won't really give you
16 very much assistance, Commissioner, on these topics.
17
18 THE COMMISSIONER: Let's see how it goes. I appreciate
19 that the way it is drafted in the statement - well, you
20 wouldn't be able to make a finding on it, in any event, so
21 I understand where you are coming from. Let's just see
22 where it goes. If it causes you any difficulty, you need
23 to call some evidence, all of that sort of thing, that will
24 be accommodated.
25
26 MR GYLES: Thank you very much.
27
28 **<EXAMINATION BY MR FULLER:**
29
30 MR FULLER: Q. Would you state your full name, please?
31 A. Kylie Tastula.
32
33 Q. Your occupation?
34 A. I'm a nurse practitioner.
35
36 Q. You are employed substantively in the Sydney Local
37 Health District; is that correct?
38 A. Yes, I am.
39
40 Q. You have made a statement to assist the Commission?
41 A. Yes, I have.
42
43 Q. Can I ask that you be given a hard copy of that
44 statement and can the operator bring up document number
45 [SCI.0003.0001.0009]?
46 A. Thank you.
47

1 Q. Would you just have a look through that statement and
2 confirm that that is the statement that you made on
3 12 February 2024?
4 A. It looks like my statement, yes.
5
6 Q. It has 30 paragraphs in the version that you have
7 there?
8 A. Correct, yes.
9
10 Q. I'm just going to ask you some questions about the
11 matters that you have raised in that statement. It is true
12 and correct to the best of your knowledge and belief; is
13 that right?
14 A. That is correct.
15
16 Q. You have been a registered nurse since 1997; that's
17 right?
18 A. I have, yes.
19
20 Q. And a nurse practitioner since 2021?
21 A. Correct, yes.
22
23 Q. Can you just describe your role as a nurse
24 practitioner?
25 A. So a nurse practitioner means I've got an additional
26 endorsement on my registration that sort of gives me an
27 extended scope of practice, so I can prescribe medications,
28 I can authorise investigations, and I can refer on to other
29 clinicians.
30
31 Q. What were the requirements to get that additional
32 endorsement as a nurse practitioner?
33 A. I completed a masters of nurse practitioner at Sydney
34 Uni and then you have to complete 5,000 hours of advanced
35 practice with a clinical supervisor.
36
37 Q. Between 2011 and 2021, you were a clinical nurse
38 consultant; is that right?
39 A. I was, correct. Yes.
40
41 Q. Just describe the difference in that role compared
42 with your current role as a nurse practitioner?
43 A. So the current role, I have the additional
44 endorsement, so I'm allowed to prescribe and act a lot more
45 autonomously than what I did as a clinical nurse
46 consultant. So as a CNC I worked collaboratively within
47 the team; now I can work a bit more autonomously but still

1 within the same team.
2
3 Q. When you refer to acting "more autonomously", can you
4 give some examples of what that involves?
5 A. So my job, I run the stroke team at RPA, so a lot of
6 what I can do now as an NP is I can diagnose when people
7 come through and I can then order the treatment for that
8 patient, so the hyperacute therapies, I can do that without
9 requiring a medical person to sign that off.
10
11 Q. Sorry, what therapies were those?
12 A. That would be IV thrombolysis for acute stroke or
13 endovascular clot retrieval.
14
15 Q. Would I be right in thinking that your area of
16 specialty is stroke care?
17 A. Neurosciences, correct, yes, stroke predominantly.
18
19 Q. You were also chair of the Stroke Network for the
20 Agency for Clinical Innovation from 2007 to 2023; is that
21 right?
22 A. 2017 to 2023; correct, yes.
23
24 Q. Can you just describe what that role involved?
25 A. The Agency for Clinical Innovations is one of the
26 pillars of the Ministry of Health and they sort of run the
27 disease networks, so the Stroke Network had a co-chair that
28 was medical and a nursing co-chair, and we basically run
29 that - we run the network in terms of clinical
30 collaborations, rolling out models of care, looking at
31 different things that are implemented and looking at gaps
32 in current practice and acting as sort of the clinical
33 experts in that area for the stream.
34
35 Q. So was it a sort of advisory role?
36 A. It was, yes.
37
38 Q. You have said in paragraph 8 of your statement that
39 your role on the ACI Stroke Network gave you a state-wide
40 perspective and understanding of some of the challenges
41 associated with procurement. Can you just explain how your
42 role gave you that understanding?
43 A. So as the co-chair you deal with anything that comes
44 across the state that affects stroke. So we sort of worked
45 collaboratively together as a network across the state, but
46 my role sort of made me the clinical expert where a lot of
47 the nurses would come to me and ask for advice, and when we

1 would roll out education, we would roll out research, we
2 would roll out implementation projects, we would then see
3 what it was like in all the different LHDs and different
4 hospitals.
5
6 Q. So is that nurses from across the state in different
7 LHDs and hospitals --
8 A. Correct, yes.
9
10 Q. -- would come to you?
11 A. Yes, nurses and other clinicians, yes.
12
13 Q. Including in relation to procurement issues; is that
14 right
15 A. Yes.
16
17 Q. Were you still working as a clinical nurse consultant
18 or nurse practitioner at this time when you were a chair --
19 A. Correct, so I still had my full-time job; this was
20 additional to it, yes.
21
22 Q. I see. Then in paragraph 7 of your statement, you
23 have described being on other state and national
24 committees, and I won't go through them all, but do you
25 have any oversight or awareness of procurement issues as
26 part of those roles?
27 A. So in terms of procurement, probably not necessarily;
28 it would just be general conversation that you would have
29 with the people who were on those different networks.
30
31 Q. And just in your day-to-day role now as a nurse
32 practitioner, what is your level of involvement in
33 procurement issues and matters?
34 A. So I guess with my union hat on, I do get people that
35 come and talk to me about issues that they have, but I also
36 have an oversight around my service so I do know what's
37 involved in terms of whether we need to order equipment,
38 whether we need to order anything, so I do spend time doing
39 that sort of stuff.
40
41 Q. Just focusing on that operational part of your role,
42 do you, for example, approve procurement?
43 A. No.
44
45 Q. In your statement you have raised three main
46 procurement issues that you said you wanted to highlight.
47 Can I just make sure at a high level that I understand

1 those issues and then we'll go into them in more detail.
2
3 The first issue you have identified, is this right, is
4 a lack of consistency between LHDs, agencies and facilities
5 in relation to how stock and equipment is ordered; that's
6 the first issue?
7 A. Correct, yes.
8
9 Q. The second issue is a lack of consistency in relation
10 to the approval and sign-off processes and requirements; is
11 that right?
12 A. Correct, yes.
13
14 Q. And am I right in thinking that that issue is related
15 to the first issue but you see it as discrete?
16 A. Yes, yes.
17
18 Q. The third issue is a lack of consistency in the
19 products procured at different sites to do the same thing;
20 is that basically right?
21 A. Correct, yes.
22
23 Q. Starting with the first issue, and I think you start
24 with this in paragraph 12 of your statement, in
25 paragraph 12, you talk about, I think, the first and second
26 issues together but let's just start with the first issue.
27 You refer to there being different processes for how
28 different types of stock or equipment are to be obtained.
29 Can you just elaborate on or explain at a general level
30 what that issue is from your perspective?
31 A. So I guess in order to purchase anything within
32 a hospital, depending on what you're purchasing is
33 a different sign-off process. So if you are to organise
34 syringes and general equipment that you need to look after
35 a patient, that's done through one process, which is now
36 DeliverEase.
37
38 If you want to organise, order to buy a pen to
39 document whatever you are doing, that's a different process
40 again, and then if you want to organise for me to document
41 my neuro obs, for example, that's a different process
42 again, and all of them involve different ordering and
43 different sign-off processes.
44
45 Q. It might be helpful to go through a couple of examples
46 that you have given in your statement about that. The
47 first example is in relation to what you have called Power

1 BI software?
2 A. Yes.
3
4 Q. Can you just elaborate on what that software actually
5 does and is used for?
6 A. So as part of the Agency for Clinical Innovation we
7 were looking at trying to benchmark our processes across
8 the state for stroke, so looking at our KPIs, so that way
9 we could work out how a hospital is performing. So we set
10 up these databases called RISE, so sites are allowed to
11 upload data into this database and then it makes
12 a dashboard and the reports are run and they're generated
13 through this software, I think it is called a visualisation
14 tool, that's called Power BI.
15
16 We all had a free licence to use that initially and
17 then you had to purchase a licence for Power BI, and
18 because a lot of our sites were all using the same thing,
19 we sort of asked each other how you went about purchasing
20 said software and it seemed to be a different process at
21 every single site that I spoke to and everyone had
22 a different sign-off for how to buy this licence
23
24 Q. Just going through that in a bit more detail, so the
25 actual visualisation and benchmarking, is that done at the
26 LHD level or at the ACI level?
27 A. So the data is collected by ACI. So we all capture
28 our own data and then we submit to ACI whichever data we
29 want to submit to depending on what your site is.
30
31 Q. And when you said "we" just then, you mean the LHD
32 captures its own data, submits it to ACI?
33 A. Correct. So the individual clinicians for each stroke
34 service, we all capture our own data and then we submit
35 whichever data we want to ACI in terms of this RISE
36 database.
37
38 Q. Can you just give us some examples of what sort of
39 data you are submitting to ACI?
40 A. So we're looking at benchmarks. So we're looking at
41 all of our things like door to needle time, which is the
42 time someone is triaged for stroke to the time they're
43 given IV thrombolysis, which is an international KPI. We
44 look at things like the swallow screen, which is another
45 international KPI. There are different clinical indicators
46 to show that you are providing good stroke care, and
47 I guess the only way you know how you're performing is to

1 benchmark it to other like services.
2
3 So the rural network initially set this up, so they
4 set it up so they could benchmark amongst themselves, and
5 then the metro sites are slowly getting on board, with the
6 idea that it's going to go towards the national task force
7 that has just been established.
8
9 Q. The LHDs collect the data, submit it to ACI. Does
10 that process require the use of Power BI?
11 A. No. So it depends on how you collect data on your own
12 site. So everyone collects data in different ways. So we
13 upload it via Excel spreadsheet.
14
15 Q. So who is it who's using Power BI?
16 A. The RISE database, so that's used through ACI, so all
17 of the data that we submit is then collated into the RISE
18 database, and Power BI is the tool that's used to show what
19 that data looks like and the benchmarking.
20
21 Q. So who was it who required the licences to use
22 Power BI?
23 A. So us individual sites, to use the - to see the
24 reports and to see our dashboards, needed Power BI to be
25 able to look at it.
26
27 Q. When you refer to a "site", is that --
28 A. RPA is a site, yeah.
29
30 Q. I see. So you both provide data to ACI for the
31 benchmarking --
32 A. Correct.
33
34 Q. -- and then if you at RPA want to see your own
35 results of the benchmarking, you need the Power BI
36 software; is that right?
37 A. Not to see my own results because I have my own
38 results on site because I collect my own data, but it's so
39 I can benchmark to a like facility. So, for example, if
40 I wanted to benchmark to North Shore, the Power BI tool
41 would then enable us to benchmark against different sites,
42 and so we could see a report, so you could see all of
43 New South Wales, who submit data, the Power BI would show
44 you those reports on a dashboard.
45
46 Q. So both ACI wants Power BI and the individual sites
47 want Power BI?

1 A. Correct, yes.
2
3 Q. How did it come about that you needed to buy a licence
4 to Power BI rather than using the free version, do you
5 know?
6 A. I think the free version just ran out. I think it was
7 only for a limited time and then it expired.
8
9 Q. Are you aware of the approximate cost of the licence?
10 A. I never got the approval through, so no.
11
12 Q. So you didn't have the responsibility --
13 A. No.
14
15 Q. -- for procuring?
16 A. I did, but I never got it passed, no-one could work
17 out how to help me.
18
19 Q. So you haven't managed to procure that software?
20 A. No.
21
22 Q. And you didn't even get to the point of knowing how
23 much it would cost you; is that right?
24 A. No.
25
26 Q. Was it you who held the delegation that would enable
27 you to acquire that software at the LHD level?
28 A. I wouldn't be able to sign it off but I'd be the one
29 that would have to put through the purchase.
30
31 Q. Would that depend on how much the licence would cost?
32 A. Correct, yes.
33
34 Q. So you were engaged at an early stage of the process
35 trying to work out how to procure it, in effect?
36 A. Yes.
37
38 Q. And if it had cost more than your financial
39 delegation, it would have had to go to someone else; is
40 that right?
41 A. So I have no financial delegation, so it would be my
42 manager who would then have to sign it off, yes, but
43 depending on the cost, whether they could delegate it or it
44 would go higher.
45
46 THE COMMISSIONER: Q. Can I just ask, in paragraph 16,
47 the last sentence, you say:

1
2 *I found out that the process for purchasing*
3 *the software was different at every*
4 *hospital.*
5
6 Is that hospitals within the same LHD or hospitals in
7 different LHDs?
8 A. Hospitals in different LHDs, so across New South
9 Wales.
10
11 Q. Why weren't you able to purchase the licence?
12 A. No-one could ever work out how to do it for me. Every
13 time I asked, it was a submission through SARA, which is
14 our search and request anything form, and it never got
15 anywhere.
16
17 Q. So they couldn't work out how to buy it?
18 A. I'm assuming --
19
20 Q. It wasn't an issue of cost or was it?
21 A. No, I'm assuming it's still on a wait list somewhere
22 to be worked out.
23
24 Q. So someone else has to make a decision about whether
25 it should be bought or not?
26 A. Yeah. Yeah. As far as I know.
27
28 Q. Is it essential for you?
29 A. It will become essential, yes. Yeah.
30
31 MR FULLER: Q. Why will it become essential?
32 A. There was a national task force set up last year
33 that's looking at national targets for stroke KPIs, and
34 a lot of that will be read via Power BI so we can benchmark
35 across the country.
36
37 Q. Can you describe from the start the process that you
38 went through you to attempt to acquire this software?
39 A. So initially, so before SARA, we have, on our intranet
40 site, an IT section, and all of the different softwares and
41 hardware that you might need is - you can get that through
42 there and there's quotes. So I tried that, but Power BI
43 didn't come up as an option.
44
45 So I then started ringing other people to work out how
46 they did it and they gave me how they did it at other
47 hospitals and I tried that, that didn't work. I did an S1

1 form, which is what we used to have to do to order
2 anything, and then I put in a request through SARA, just
3 asking for the purchase of Power BI and I never got
4 a response back.
5
6 Q. When did you start trying to do this?
7 A. It was probably last year.
8
9 THE COMMISSIONER: Q. The benefit of having this
10 software and being able to see how other hospitals are
11 performing is what? That you have international benchmarks
12 for the treatment of people that have suffered a stroke and
13 you can see, at your hospital, whether you're doing better
14 or worse than other hospitals? And I presume if they have
15 aspects where their KPIs - they're faster or they're doing
16 better than you, you can contact them and say, "What are
17 you doing that's different from us"; is that it?
18 A. That's exactly correct. Everything about stroke is
19 very time dependent. So the better your times are, the
20 better is the outcome for the patient. So if there was
21 a better performing site, then you could go to them and ask
22 for advice.
23
24 Q. Equally, if there was a very poorly performing site,
25 you could ring up and offer some - have a discussion about
26 it?
27 A. That's exactly right, yes.
28
29 MR FULLER: Q. You have referred to the SARA software.
30 That's an acronym or an initialism for "search and request
31 anything"; is that right?
32 A. Yes, correct, yes.
33
34 Q. When was that introduced, from your perspective?
35 A. Within the last two years, I'm - I wouldn't know off
36 the top of my head exactly.
37
38 Q. Does that currently sit alongside the S1 form process
39 that you described?
40 A. Yes, so I think some things use an S1; some things use
41 SARA.
42
43 Q. Do you know which uses which?
44 A. No, that's - I wouldn't have a clue what used what.
45 I just asked someone at that point.
46
47 Q. In terms of the SARA process, can you just describe

1 what you did with that system?
2 A. So SARA is anything for us, so it is how we apply for
3 our annual leave, how we apply for ADOs, and how we apply
4 for some procurement things so - and that's how we get IT
5 help. So you just put in a general inquiry and then
6 someone at the other end answers you at some point.
7
8 Q. So it's not a system for actually placing an order; it
9 is a sort of inquiry system - is that right?
10 A. So I think this was meant to have been - to make
11 a purchase. Yeah, but it's different to what you would use
12 for other procurement.
13
14 Q. Do you know if that's a Sydney LHD specific thing or
15 not?
16 A. No, SARA is a state-wide thing.
17
18 THE COMMISSIONER: Do we know what the cost of this
19 software licence is?
20
21 MR FULLER: I think the witness didn't know the answer.
22
23 THE WITNESS: No.
24
25 THE COMMISSIONER: Okay.
26
27 MR FULLER: Q. You've said in paragraph 20 of your
28 statement that the SARA system does not provide any
29 guidance as to how you obtain quotes and so on. As far as
30 you can see, there's no sort of user guide for the system?
31 A. No, there's sort of a "help" button but it tells you
32 just to go to a general inquiry.
33
34 Q. Is that a general inquiry email address or something
35 like that?
36 A. No, it's - it is an online form so you just submit the
37 online inquiry.
38
39 Q. Do you know who it goes to?
40 A. No.
41
42 Q. And I take it you submitted an inquiry about trying to
43 acquire this software?
44 A. Yes.
45
46 Q. And you haven't received a response; is that right?
47 A. No.

1
2 Q. No feedback at all in relation to it?
3 A. No.
4
5 Q. When would you have submitted this inquiry, do you
6 remember?
7 A. Last year some time. Yeah.
8
9 Q. About when?
10 A. Probably about July/August of last year.
11
12 Q. Do you know whether there are any contacts within, for
13 example, a Sydney local health district's procurement team
14 who you could contact and ask about these sorts of issues?
15 A. I don't know.
16
17 Q. Did you attempt to speak to anyone else about this
18 issue other than putting an inquiry through the SARA
19 system?
20 A. No. I probably gave up at that point.
21
22 Q. In paragraph 21, you have mentioned the issue in your
23 mind that other stroke services don't use SARA; is that
24 right?
25 A. For this purpose, yeah. So everyone had a different
26 process. Some would do S1, some did SARA, some did their
27 local IT.
28
29 Q. Is the issue with that that you're identifying that
30 there was no-one else you spoke to who could give you
31 guidance about how to place the order using the SARA
32 system?
33 A. Correct.
34
35 Q. And the guidance people could give you was based on
36 their own experiences?
37 A. Yes.
38
39 Q. Which were different from what was available to you in
40 Sydney Local Health District; is that right?
41 A. Yes.
42
43 Q. In paragraph 22, I think you've summarised the issue
44 by saying that most stroke service staff use the same
45 software in the same way and the cost is the same but the
46 process to obtain it is different. Are there any
47 particular changes that you think could be made to address

1 that issue?
2 A. I guess I just think it should be pretty much
3 standardised across the state. That would make things
4 a lot easier. But I also think if it's software that's
5 used for an actual clinical reason I don't understand why
6 we have to apply for it every time. I think I have used,
7 at some point, simple things like Adobe, PDF, it's not
8 actually standard on a computer so we have to try to
9 purchase that as well. I just think the standardisation
10 should be a lot better.
11
12 Q. When you say "we", you mean Sydney Local Health
13 District?
14 A. Yes - or whoever the "we" is. I think everyone would
15 need to use a PDF at some point.
16
17 Q. So if you have to access that from your laptop, you
18 can't necessarily do that?
19 A. Yep.
20
21 Q. You may have to procure that software?
22 A. Correct, yes.
23
24 Q. You have given a second example, which I might just go
25 through quickly with you, relating to software for a CT
26 machine. This is in paragraph 23 of your statement. Can
27 you just explain what that software is, what it does?
28 A. Yes. So Rapid software, so when someone has an acute
29 stroke, they come into hospital and they get what we call
30 a trifecta of CT scans, so they all get a non-contrast CT,
31 a CT angio and a CT perfusion.
32
33 The Rapid software maps the CT perfusion and gives us
34 maps that show us how much of that tissue is core and dead
35 tissue already and how much of it's penumbra, which would
36 be salvageable tissue, and that then leads us on to say
37 which patients would be eligible for endovascular clot
38 retrieval, for example.
39
40 Q. The particular post-processing software you're talking
41 about in paragraph 23, is that software that does all of
42 those things?
43 A. It is only relevant to the CT perfusion scan, so it
44 does maps. So anyone who has had a stroke, you have an
45 area of tissue that might already be dead, which is what we
46 call the core, and then you have the salvageable tissue,
47 which is the penumbra, and the perfusion software, whatever

1 brand it might be, maps that out for us and tells us the
2 exact volumes that would be.
3
4 Q. Do you see that part of the software as being
5 essential to the clinical work you're doing for stroke --
6 A. It is essential for criteria to be eligible for clot
7 retrieval.
8
9 Q. Can you just elaborate on that a little bit?
10 A. So endovascular clot retrieval, so if someone has an
11 acute stroke, if they have a large vessel occlusion, so one
12 of the big vessels might be blocked, if they present in
13 under six hours they don't need a perfusion scan, but
14 anyone between six and 24 hours needs a perfusion scan for
15 us to show that there's enough salvageable tissue to make
16 the treatment beneficial for the patient.
17
18 Q. You've said that each facility had to negotiate
19 directly with the supplier to obtain that software.
20 A. Yes.
21
22 Q. That's the supplier of the software or the machine or
23 both?
24 A. The supplier of the software. So the software doesn't
25 come with the machine. So the Rapid software we had to
26 purchase from the private company itself.
27
28 Q. Is it a different supplier of the software - sorry,
29 the supplier of the software is different from the supplier
30 of the machine?
31 A. Correct, yes.
32
33 Q. Were you involved in negotiating for that software?
34 A. In a way, yes, I was, yes.
35
36 Q. In what way?
37 A. So my team had to negotiate for that software, yes.
38 So one of our interventional neuroradiologists did the
39 negotiating, and I helped in terms of the clinical things,
40 yes.
41
42 Q. What specifically did you help with?
43 A. So we - so RPA is a referral centre for endovascular
44 clot retrieval, so we took patients from a lot of other New
45 South Wales hospitals, so we - clinically I worked with the
46 other hospitals, as well as ours, to try to get this Rapid
47 software deployed in the hospitals where we needed it, and

1 then teaching the staff how to use it.
2
3 Q. Are you aware of the price range of this software?
4 A. Not off the top of my head, no, but I think it was
5 like - no.
6
7 Q. Would it be under $10,000?
8 A. No, no, above that.
9
10 Q. 100,000?
11 A. I was - between 50 and 100 I think, yes.
12
13 Q. In relation to this issue that you've identified,
14 again, are there any changes that you think could be made
15 to address or improve it?
16 A. So in terms of getting the software, so we purchased
17 the software for our district, our district signed it off,
18 there was no problems with that. But it was then we had to
19 go and try and get it in other hospitals, so we had to
20 negotiate for Western New South Wales, for them to get the
21 software. It had to go through multiple steps to get
22 executive to actually sign it off, and given it's not
23 exactly the - it's not cheap, a lot of districts were very
24 delayed in getting that. But I think it was also the
25 clinicians' time in having to negotiate different things,
26 where, when Telestroke was established, they negotiated the
27 price for all 23 sites, so then they got a better deal than
28 the sites who individually negotiated those prices.
29
30 Q. Is this software that would be required for a CT
31 service at any location in New South Wales?
32 A. Only for those who treat hyperacute stroke, yes.
33
34 Q. Do you know how many approximately there would be
35 across New South Wales?
36 A. About 40.
37
38 Q. Forty?
39 A. Yes.
40
41 Q. In paragraph 25 --
42
43 THE COMMISSIONER: Q. Just before we leave paragraph 24,
44 "the need for individual facilities to do this meant
45 different prices were paid by different facilities". First
46 of all, the facilities we're talking about are facilities
47 that provide stroke services?

1 A. Correct, yes.
2
3 Q. And the different prices paid by different
4 facilities - do you know, I think you mentioned the range
5 of price of the software, but do you know what the
6 differences were that were being paid between different
7 facilities?
8 A. I don't know what each hospital signed off for, no.
9
10 Q. And some facilities had this approved quickly and
11 others waited years. Are these, first of all, facilities
12 within the same LHD?
13 A. No. So we negotiated for all of our LHD, so we got it
14 for the two sites, yeah.
15
16 Q. The reason that some were approved quickly and others
17 waited years - first of all, years, how many years are we
18 talking?
19 A. I think some sites only got it in the last 18 months,
20 and so we got it in about 2016.
21
22 Q. And do you know what the reason for that was, the
23 difference in timing?
24 A. The priority of stroke within the district, I guess.
25
26 Q. Sorry, when you say, "I guess", does that mean you
27 know that's the reason or are you speculating?
28 A. That's what I've been told.
29
30 MR FULLER: Q. Are you able to elaborate on which LHDs,
31 or give some examples of LHDs that got the services, the
32 software much later than Sydney LHD; for example, the last
33 18 months, which LHD were you referring to?
34 A. Western Sydney.
35
36 Q. And when you said that you're aware of different
37 prices being paid, how are you aware of that?
38 A. So through ACI, when Telestroke was being rolled out.
39 Because they negotiated a price for the 23 sites. So it
40 came as part of Telestroke.
41
42 Q. Can you just elaborate on that? What's the
43 relationship between Telestroke and this CT software?
44 A. So because Telestroke is an assessment tool for
45 hospitals that don't have neurologists on site, so via
46 telehealth they will assess, so someone at Bathurst,
47 because there is no neurologist on site there, the patients

1 will present to hospital, the same as I run a stroke call
2 at RPA, these will be done virtually, and so as part of
3 that, Telestroke mandated certain things had to be in place
4 and Rapid software was one of the things, so they
5 negotiated the prices.
6
7 Q. So did that give you an idea of the amounts that have
8 been paid at other LHDs for the Rapid software?
9 A. Yeah, for the deployment of that through Telestroke,
10 yeah, because they got it at their price.
11
12 Q. That was through your positions in the ACI; is that
13 right?
14 A. Yes.
15
16 Q. In paragraph 25, just looking at the second sentence,
17 the first part of it says clinicians must be consulted
18 appropriately for procurement. Can you just explain,
19 firstly, what you see as appropriate consultation with
20 clinicians?
21 A. So I think given - well, this is post-processing
22 software that impacts clinical decisions as to who is
23 eligible for treatment or who isn't, I think that people
24 who are part of that decision-making should actually be
25 spoken to about what the appropriate software would be.
26
27 Q. And in this particular case, there wasn't an issue
28 about the appropriateness of the software; is that right?
29 A. No, because we did all the negotiating, yes.
30
31 Q. So it was about the process for procuring?
32 A. Correct. Yes.
33
34 Q. But then you go on to say that, in your view, the task
35 of procuring should be done by non-clinical staff who
36 consult with the clinicians as appropriate; is that right?
37 A. Yeah.
38
39 Q. That's your view. Can you just explain why that's
40 your view?
41 A. Well, I guess I think I'm there to provide clinical
42 care for a patient, not necessarily to be negotiating
43 contracts and prices and things like that. Whilst
44 I understand that it might be part of the job, I do think
45 clinicians' time is probably better spent being clinical.
46
47 Q. I think you mentioned that it was a clinician who was

1 involved in negotiating for this Rapid software; is that
2 right?
3 A. Yes.
4
5 Q. Do you have any oversight of how much time that
6 clinician would have spent doing that?
7 A. It would have been a fair amount of time, over - over
8 a couple of months negotiating, yes.
9
10 THE COMMISSIONER: Q. Is that why you, in the first
11 sentence of paragraph 25, are talking about the amount of
12 time being unreasonable?
13 A. Yes.
14
15 Q. Is that what you're referring to?
16 A. Yes.
17
18 MR FULLER: Q. In terms of your time having oversight of
19 this issue, can you estimate how long you would have spent?
20 A. No, I wouldn't be able to estimate now, no. Sorry.
21
22 Q. I might move on to the second issue that you've
23 raised, which is about a lack of consistency in approval
24 requirements and processes.
25 A. Yes.
26
27 Q. Can you just again explain at a high level how you -
28 what you see that issue as being?
29 A. So I guess it's the different processes for every
30 different thing that you have to order within a hospital.
31 So if I want to order a pen, I need to put an order in
32 through COS and that involves a certain amount of sign-off.
33
34 If I want to order a syringe, it needs to be done
35 through DeliverEase, which is a different sign-off, and
36 then if I want to order neuro obs charts, then that's
37 another different process again and it's a different
38 sign-off process for that. So each individual thing
39 requires a completely different process in how to order it.
40
41 Q. And that process includes different approval
42 individuals and mechanisms; is that right?
43 A. Correct, yes.
44
45 Q. In paragraph 13, you say there needs to be a clear and
46 consistent delegation framework for decision-making, as
47 well as a degree of trust. I take it there is

1 a delegations manual or some other kind of document that
2 sets out the delegations for the LHD; is that right?
3 A. If there is I wouldn't know where it was.
4
5 Q. So that's not a document that you have seen --
6 A. Not that I have, no.
7
8 Q. -- if it exists? And why do you say there's
9 a delegation framework lacking in clarity and consistency?
10 Is it partly because you have no visibility of what the
11 delegations might be? Is that right?
12 A. I think it's also, I think, if you're a nurse unit
13 manager on a ward, you're responsible for the budget on
14 that particular ward, but you're only allowed to sign off
15 $50 worth of any equipment or anything at any one time.
16 I just think if they're responsible for an entire budget
17 they should be surely responsible to sign off things that
18 are required on that ward.
19
20 Q. And I take it that issue also relates to the issue of
21 trust that you have raised; is that right?
22 A. Yes.
23
24 Q. So the issue of trust is to do with the level of
25 financial authority that's given to clinicians who
26 otherwise have large clinical responsibilities; is that
27 a fair summary?
28 A. Correct, yeah.
29
30 Q. Are you able to give a specific example of this being
31 an issue - that is, the level of financial authority that
32 a manager has to sign off on?
33 A. Well, I guess if it was me, for example, we use this
34 thing called "My Stroke Journey" that we give to patients,
35 so it's written by the National Stroke Foundation, and it
36 is a booklet we order through the National Stroke
37 Foundation. For me to get that, I have to sign off an S1,
38 and then I think it has to go through multiple people
39 before that actually gets approved for me to be able to
40 order that purchase. So it can take a week, depending on
41 who is signing it off, to how long it actually gets through
42 that process.
43
44 THE COMMISSIONER: Q. Sorry, it is my fault but I just
45 missed what the purchase was - of what?
46 A. It is called "My Stroke Journey". It's a book that we
47 give to all our patients who have had a stroke and it sort

1 of goes through their process. It is used by all
2 clinicians but it's written by the National Stroke
3 Foundation, so it is not an order through NSW Health as
4 such.
5
6 MR FULLER: Q. The actual process of informing patients
7 about their stroke and what needs to be done, is that
8 something that you have oversight or responsibility for
9 as --
10 A. Correct, yes.
11
12 Q. -- nurse practitioner in the service?
13 A. Yes.
14
15 Q. You also say, I think related to this point, that the
16 need to seek financial approval from multiple levels can
17 slow down the process and adversely impact staff and
18 patients. Is that something you have experienced
19 personally?
20 A. Yes.
21
22 Q. Can you give an example of that?
23 A. So when you look at endovascular clot retrieval, so
24 I have been in that angio suite where I have heard them
25 asking for a certain device and there hasn't been any
26 available, or they - at one point there was no lignocaine
27 available, we had to go to another department to find
28 lignocaine.
29
30 Q. And are you able - I suppose that's one example. Are
31 there any other examples that you can give of having to
32 borrow stock from other units or facilities?
33 A. So the borrowing of stock happens a lot. A lot of it
34 is because they only want specialised equipment on certain
35 wards, which is a cost thing, which makes complete sense,
36 so I think they're borrowed on a regular basis.
37
38 But if you run out of stock - so if you put an order
39 in through DeliverEase, is the example now, so if you order
40 fluids through DeliverEase, you don't actually know whether
41 there's any stock in a warehouse. So prior to Christmas
42 they ordered the stock to get them through the Christmas
43 period but they didn't know that there was a backlog, so
44 then, all of a sudden, all of this stock just appeared on
45 a ward. Whereas you might have the opposite, you order
46 a certain particular thing and there's no stores but you
47 don't get told that, you just - things don't turn up.

1
2 Q. Just so I understand it, that's a different issue from
3 delays being caused by lengthy approval processes; is that
4 right?
5 A. Sorry, correct, yes.
6
7 Q. I'll come back to that issue. Just on the issue of
8 delays because of approval processes, do you have any other
9 examples in your experience of that happening?
10 A. Not for me because I don't do a lot of ordering, yes.
11
12 Q. On the second issue that you raised about DeliverEase
13 and lacking visibility of stock orders and levels, firstly,
14 can you describe what DeliverEase is from your perspective?
15 A. So DeliverEase is a new system for ordering everyday
16 equipment that's used. So every ward, their stock level
17 was assessed, so there's a minimum and a maximum that can
18 be ordered, so then that doesn't need to be signed off by
19 multiple levels, that's automatically approved and that's
20 reviewed every six months. But you don't know what's
21 available in the warehouse, so you might put your order in
22 and it might not be available but you don't get told that;
23 you just have to hope that it turns up.
24
25 Q. So it's a new software system; is that right?
26 A. Yes, it's a barcode, yes.
27
28 Q. Barcode on individual medical consumable items; is
29 that right?
30 A. Correct, yes.
31
32 Q. And is the idea that they are scanned in or out when
33 they come in or when they are used?
34 A. No, to order them. So you scan to order them. So you
35 don't scan them in or out to say you're using them.
36
37 Q. Using DeliverEase, is it - sorry, are you directly
38 involved in using the deliveEASE system?
39 A. No.
40
41 Q. Have you received any training in relation to it?
42 A. No, not outside the general conversation - NO, not
43 outside general education, yes.
44
45 Q. I'll just come to this now. In paragraph 30 of your
46 statement, you say that you understand deliverEASE has been
47 rolled out, however, "we are yet to see all the benefits of

1 this system". Firstly, can you describe any benefits of
2 the system that you have seen in your role?
3 A. So I guess the stock levels, so the minimum and
4 maximum, means it doesn't have to be signed off by multiple
5 people, so the wards have the ability to order the stores
6 that they need without it being signed off multiple times
7
8 Q. When you say you're yet to see all the benefits of the
9 system, what further benefits are you expecting to see?
10 A. I would hope there would be less clinician time having
11 to spend ordering equipment.
12
13 THE COMMISSIONER: Q. Just so I understand what you're
14 saying, when stock is down to a certain level, DeliverEase
15 enables people to order more stock without having to get
16 that approved?
17 A. Correct, yes.
18
19 MR FULLER: Q. And I take it you have not yet seen, in
20 your role, the benefit of less clinician time being
21 involved?
22 A. No, well, it's still the NUMs and the educators who
23 are doing all the ordering.
24
25 Q. Sorry, just repeat that?
26 A. It's the NUMs and the educators doing a lot of the
27 ordering still.
28
29 Q. Nurse unit managers and --
30 A. The clinical nurse educators, yes.
31
32 Q. Just coming back to the issues with approval, does
33 SARA assist in any way with obtaining approvals?
34 A. No, because SARA, once you put your request in, you
35 don't know what it's up to.
36
37 Q. So there's no way within SARA of seeing the progress
38 of your request as you have given the example earlier?
39 A. No.
40
41 Q. I take it you would agree that there is a need for
42 appropriate governance and oversight of procurement
43 decisions and - sorry, yes?
44 A. Yes.
45
46 Q. And there are good reasons for limiting financial
47 delegations to particular roles and individuals; is that

1 right?
2 A. Correct, yes.
3
4 Q. But you think a balance needs to be struck in a
5 different way; is that right?
6 A. I also think there probably shouldn't be a different
7 process for each different thing.
8
9 Q. I'll just come to the third issue that you've raised,
10 which we have touched on already, and that is inconsistency
11 in products at different sites to do the same thing?
12 A. Yes.
13
14 Q. Can you just elaborate on that issue from your
15 perspective?
16 A. So I guess with my clinician hat on, so endovascular
17 clot retrieval, they're transferred in from any other site,
18 they can come into RPA. If medical retrieval pick
19 a patient up and they have to put in an art line, for
20 example, to monitor blood pressure, they will set it up
21 with their equipment. They then come to RPA and we have to
22 change all of those lines because the equipment isn't
23 compatible with our equipment at RPA.
24
25 Q. This is the example you've given in paragraph 27 of
26 your statement; is that right?
27 A. Correct, yes.
28
29 Q. So when you say "art line", that's an arterial line?
30 A. Yeah, so it's an invasive line that measures blood
31 pressure, sorry.
32
33 Q. Thank you. So this is, I take it, an actual example
34 not a hypothetical example --
35 A. Correct, yes.
36
37 Q. -- you've given in paragraph 27. When you say it
38 makes transfers difficult, that's patient transfers; is
39 that right?
40 A. Yes.
41
42 Q. Is there any good reason that you can think of based
43 on your clinical education and experience for different
44 facilities to have different arterial lines?
45 A. No. It's all based on the equipment that we have at
46 each site, yeah.
47

1 Q. So if different sites have different equipment, they
2 may require different arterial lines?
3 A. Correct, yes.
4
5 Q. Other than history, is there a good reason that you
6 can see for different sites to have different equipment?
7 A. No.
8
9 THE COMMISSIONER: Q. I get this at a big picture level,
10 but when you're saying - so in paragraph 26 you're talking
11 about a lack of consistency, even between facilities, or
12 they might be hospitals within the same LHD, and could that
13 be Sydney LHD that you're talking about?
14 A. It could be, yes.
15
16 Q. And then you say in 27:
17
18 *... for example, arterial lines could have*
19 *a different set up in different facilities*
20 *and the Ambulance Service or Medical*
21 *Retrieval Service ...*
22
23 What is "a different set up"? What does that mean?
24 A. So it comes attached to a bag to keep it patent all
25 the time, and then the line that goes down to actually go
26 into the machine, to measure the blood pressure, that
27 connects to the patient, that has to be changed between
28 each site.
29
30 Q. Because the bit that's on it doesn't fit in the
31 machine --
32 A. Correct, yeah.
33
34 Q. -- at the RPA?
35 A. That's exactly right, yeah.
36
37 Q. I imagine that is something that sounds like might
38 have been raised as something that should be fixed?
39 A. It's been the case for as long as I know, but yes.
40
41 Q. Over many years?
42 A. Yes.
43
44 Q. And why don't we have consistency for something that
45 sounds pretty basic?
46 A. I think it's again down to the equipment. It's down
47 to the equipment, what everyone has. So when we used - so

1 when the IV pumps were changed, I think in 2010, there was
2 a rollout across the state, so we all actually have the
3 same equipment for that. But it hasn't been done for
4 anything else.
5
6 MR FULLER: Q. Is this equipment that needs to be
7 replaced on a regular basis or not?
8 A. It wouldn't be replaced on a regular basis, no.
9
10 Q. Do you have any idea of how often it would need to be
11 replaced?
12 A. Our monitoring equipment I think I have seen replaced
13 once in the 20 years I've been at RPA. It is not a regular
14 event.
15
16 THE COMMISSIONER: Q. Sorry, can I also just ask: in
17 paragraph 27 when it says that this could also mean the
18 patient has to have two changes of their arterial line,
19 I take it it doesn't mean two invasions into the patient
20 itself?
21 A. No.
22
23 Q. It's changing the connector?
24 A. It's changing the line, yes, correct.
25
26 THE COMMISSIONER: Sorry for my imprecise medical
27 terminology but "connector" will do.
28
29 MR FULLER: Q. Is there an issue you see from a clinical
30 perspective, and if so, what is it?
31 A. Is there - sorry?
32
33 Q. Is there an issue with having to take the time to
34 change the connectors from a clinical perspective?
35 A. Well, you're opening up a line that you shouldn't be
36 opening up all the time, so that is an infection control
37 risk. You also risk losing the line when you're pulling -
38 changing the line all the time.
39
40 Q. Sorry, you risk losing?
41 A. You risk losing the line if you're constantly changing
42 it
43
44 THE COMMISSIONER: Q. When you say "risk losing the
45 line", what does that mean?
46 A. So the invasive parts are the part that's actually in
47 the artery --

1
2 Q. I see because of movement --
3 A. Yeah, if you didn't do it properly. Correct, yes.
4
5 Q. And the other thing I think you mentioned was there's
6 some - couldn't put a percentage on it but some slight
7 increase in infection increase?
8 A. Correct, yeah. It's also a waste of time when we're
9 trying to do something very quickly, in an acute stroke.
10
11 MR FULLER: Q. Just to elaborate on that, I take it
12 these transfers are happening in urgent circumstances; is
13 that right?
14 A. They are, yes. Yeah.
15
16 THE COMMISSIONER: Q. Time is of the essence in the
17 treatment of all stroke patients; correct?
18 A. Correct, yes.
19
20 MR FULLER: Q. You have also in paragraph 29 talked
21 again about doctors asking for a device or a piece of
22 equipment, only to be told that the facility has run out.
23 How do you think - and you've raised this in the context of
24 consistency of products as well as the issues about
25 approval processes that we discussed earlier. How do you
26 think consistency of products and processes would help with
27 that issue of things running out?
28 A. In terms of if it was consistent across the state?
29
30 Q. Yes.
31 A. I don't know if it would help in terms of that.
32 I think the consistency would help in terms of staff being
33 adaptable, moving from site to site.
34
35 THE COMMISSIONER: Q. That running out of stock, though,
36 is that what DeliverEase is partly meant to guard against?
37 A. DeliverEase only does smaller things. So in terms of
38 endovascular clot retrieval, it doesn't do the devices
39 because they're a lot more expensive.
40
41 MR FULLER: Q. When you have referred to devices and
42 equipment running out in paragraph 29, can you give an
43 example of some --
44 A. The devices I'd be talking about are the catheters
45 actually used for endovascular clot retrieval, yeah.
46
47 THE COMMISSIONER: Q. That's not something that's

1 ordered through DeliverEase?
2 A. No.
3
4 Q. Because it's above a certain --
5 A. It's quite expensive, yes.
6
7 MR FULLER: Q. Are you aware of whether DeliverEase is
8 going to be expanded in Sydney Local Health District beyond
9 medical consumables?
10 A. I have no idea.
11
12 Q. Are there any other changes that you think would be
13 useful to address this issue of product consistency?
14 A. So I think I'm a bit hesitant but the rollout for the
15 IV pumps I think was really good in that it is consistent
16 across the state. So if my patient is getting thrombolised
17 at Concord and the pump comes across, it's the same pump so
18 everyone knows how to use it.
19
20 There are certain things that clinicians are very
21 particular about and would like to keep their own devices
22 but I think it would make things a lot easier for the
23 bigger things like using a hoist, using equipment would be
24 a lot easier for people moving across the state for agency
25 casual if it was consistent everywhere.
26
27 MR FULLER: Thank you. Those are my questions,
28 Commissioner.
29
30 THE COMMISSIONER: Q. In 29 you say:
31
32 *I have lost count of how many times I have*
33 *heard doctors asking for a device or*
34 *a piece of equipment only to be told that*
35 *the facility has run out.*
36
37 Presumably there's someone that has responsibility for
38 making sure you don't run out of catheters. Who is that,
39 for example, at RPA? There's a person designated or --
40 A. I don't think there is a person designated for it.
41 Yep. It's the nurses who are in there.
42
43 Q. So that might be a problem. Otherwise, it's an
44 oversight?
45 A. Correct.
46
47 Q. By people?

1 A. Yep.
2
3 MR FULLER: That's all, thank you, Commissioner.
4
5 THE COMMISSIONER: Mr Gyles or anyone else? Do you want
6 to ask any questions? Seek leave to ask any questions?
7
8 MR GYLES: Yes.
9
10 **<EXAMINATION BY MR GYLES**:
11
12 MR GYLES: Q. Dealing first of all with the issue
13 about --
14
15 THE COMMISSIONER: Sorry, this is Mr Gyles for NSW Health.
16
17 MR GYLES: Q. Good morning.
18 A. Morning.
19
20 Q. Dealing with the issue you raise about arterial lines
21 concerning the use of different equipment at different
22 hospitals, including sometimes within the same LHD, the
23 equipment - in terms of procurement, this is not so much an
24 issue of procurement but, rather, an issue of the selection
25 of the equipment, isn't it? So the particular hospital or
26 LHD is choosing a particular piece of equipment to use for
27 that service that is required?
28 A. Mmm-hmm yes.
29
30 Q. And your issue is that a greater level of
31 standardisation of selection of equipment, will lead to
32 the - or obviate some of the difficulties you've identified
33 with patients who have to be transferred between
34 facilities?
35 A. Yes.
36
37 Q. So that particular issue you've raised isn't so much
38 that there is a difficulty getting equipment; it's really
39 a question of achieving standardisation, which would
40 involve getting the individual hospitals to agree with each
41 other that there's a particular piece of equipment that
42 they would use that is standard across the system?
43 A. Correct, yes.
44
45 THE COMMISSIONER: But they would then have to procure it.
46
47 MR GYLES: They would then have to procure it but I don't

1 think this witness's issue is with the particular
2 procurement of the equipment; it is a concern about the
3 lack of standardisation of the equipment.
4
5 THE WITNESS: I guess if it was procured across the state,
6 then it would probably be cheaper for each individual site,
7 as well, if everyone did it together.
8
9 MR GYLES: Q. Obviously, and that's, as you would
10 understand it, one of the ideas of having the shared
11 services, that you achieve those economies?
12 A. Yes.
13
14 Q. With procurement yourself, and I'm not being critical
15 of you at all, but dealing with your actual personal
16 experience of procurement, you tell us in paragraph 28 that
17 when you have personally escalated issues with procurement,
18 these have been resolved promptly. So your personal
19 experience is not unsatisfactory?
20 A. Correct.
21
22 Q. In terms of procurement generally within the Sydney
23 LHD, there is a procurement team, isn't there, who you can
24 go to if there is any particular procurement issue?
25 A. I'm not sure who they would be. There is a purchasing
26 CNC that I know of.
27
28 THE COMMISSIONER: Q. Who do you escalate issues to?
29 Who were you referring to? When you say, "whenever
30 I escalate issues", who do you go to?
31 A. I am probably cheeky and I will go straight to the
32 execs.
33
34 Q. The execs?
35 A. As in either our general manager or chief executive,
36 yeah.
37
38 MR GYLES: Q. So in terms of your --
39
40 THE COMMISSIONER: Q. You know them personally, do you,
41 and have a relationship with them?
42 A. Correct, yes. Which is why I don't tend to have
43 issues. Stroke is a very public service.
44
45 MR GYLES: Q. But in terms of what you have said about
46 getting reports from other people about the way things
47 might happen, essentially, that's information that has been

1 provided to you in a conversation with other people?
2 A. Or through my union with people making complaints,
3 yes.
4
5 Q. And if you've been in theatre or you've heard of
6 people expressing issues about a particular piece of
7 equipment which isn't available, you haven't drilled down
8 into why there might be a difficulty with that particular
9 piece of equipment at that time, in terms of availability,
10 have you?
11 A. I have - I've been told certain reasons, whether
12 they're true or not, I don't know because -- -
13
14 Q. Well, we all know that there have been significant
15 supply chain issues that have impacted the industry during
16 COVID, for example?
17 A. Yes.
18
19 THE COMMISSIONER: Q. Is that one of the reasons you
20 were referring to? What were the reasons you were
21 referring to?
22 A. No, it's mostly a staffing thing around people having
23 time to do it. Because it's clinicians --
24
25 Q. So, what, people are so busy taking care of human
26 beings who need care taken of them, that --
27 A. They don't have time, correct.
28
29 Q. -- ordering equipment gets missed?
30 A. Yeah, correct.
31
32 MR GYLES: Q. And you would agree that a system of
33 automatic ordering, if that was able to be achieved, and
34 the traceability of product into the storerooms, would be
35 obviously something that would be helpful?
36 A. Yes. Which I think is part of that h-trak, I think it
37 is called, which they're trying to introduce that into the
38 radiology department.
39
40 Q. That's part of this procurement program which is being
41 rolled out at the moment, and from your perspective, that
42 would be a significant benefit to have those sorts of --
43 A. I would hope so, yes.
44
45 Q. -- capabilities?
46 A. Mmm.
47

1 Q. And DeliverEase is a step down that road, with the
2 standardisation of ordering?
3 A. (Witness nods).
4
5 Q. As well as other initiatives that are being brought
6 in?
7 A. Yes. I guess DeliverEase, we still need to get to
8 that point, because I've still got CNCs who are counting
9 how many syringes are in a box.
10
11 Q. I'm sorry, I didn't hear that?
12 A. I've still got CNCs who are counting how many syringes
13 are in a box for DeliverEase at the moment, so I'm hoping
14 to getting to that point.
15
16 Q. In terms of the issue that you told the Commissioner
17 about relating to the software licence, that was in
18 relation to the benchmarking --
19 A. Power BI, yes.
20
21 Q. As you understood it, that was a licence that was
22 required at your hospital?
23 A. NSW Health.
24
25 Q. You understand that there had been a software licence
26 entered into by NSW Health, and it came to a time where
27 that - the free licence came to an end, and then it had to
28 be renewed?
29 A. (Witness nods).
30
31 Q. And are you aware that there is an information - an
32 ICT procurement team at the Sydney LHD?
33 A. Mmm.
34
35 Q. That being the information and communication
36 technology team?
37 A. (Witness nods).
38
39 Q. And when you came to deal with that particular licence
40 issue, I think you've said in July and August last year,
41 you interrogated or used the SARA system and you say you
42 made a request for information?
43 A. So I used the local intranet site first, which is the
44 ICT website, and there was nothing on there about Power BI.
45
46 Q. And you spoke to people in other hospitals?
47 A. Mmm-hmm.

1
2 Q. And you said that some were ordering it through SARA,
3 some through local IT, and some through the old-fashioned
4 S1 manner of ordering?
5 A. Yes, yes.
6
7 Q. And you understood that those hospitals were getting
8 these licences by use of those means?
9 A. Yes.
10
11 Q. So there was no problem getting this licence; it was
12 a matter of getting it done - getting the requisite
13 approval for the financing of it and then signing it off?
14 A. (Witness nods).
15
16 Q. And you attempted one of those methods, which was the
17 SARA system, and then you said you gave up after that?
18 A. I tried an S1 as well.
19
20 Q. Okay. But then, in July or August last year, you gave
21 up and you didn't progress that?
22 A. Correct.
23
24 Q. And you didn't escalate it to the ICT team at Sydney
25 LHD?
26 A. No. No-one knew what I was talking about when
27 I asked.
28
29 Q. Are you saying you did raise it --
30 A. So I asked locally within RPA, yes. Not - I didn't
31 escalate it formally.
32
33 Q. But you understand that there is a team of people, in
34 the Sydney LHD, with an expertise in information and
35 communications technology?
36 A. Yes.
37
38 Q. And they would be a team that - in the issue that you
39 were dealing with, which was getting the software licence,
40 that would be, you would imagine, something within their
41 remit?
42 A. They've never helped with purchasing of software
43 before, no.
44
45 Q. On this particular occasion, you knew that other
46 hospitals were getting these licences. You knew that they
47 were available. You believed they were important. And

1 what I'm really suggesting to you - and no doubt you were
2 very busy and had many other priorities, but what I'm
3 suggesting to you is that there was a means by which this
4 could have been escalated within the system, which was by
5 the Sydney LHD ICT, who could have taken that issue up?
6 A. Quite possibly, yes, I had just spent enough time on
7 it at that point, so it went to the end of a "to do" list.
8
9 MR GYLES: Thank you very much. Thank you, Commissioner.
10
11 THE COMMISSIONER: Q. Can I just ask something further.
12 In your statement in paragraph 4, you tell us you have
13 worked at Sydney LHD since 2009 in neurosciences. Then in
14 5 you tell us essentially, no doubt in very summary form,
15 what you do as a nurse practitioner, and you talk about
16 outpatients' clinics, but in relation to that aspect of
17 your expertise and scope of practice dealing with
18 diagnostic interventions, et cetera, is there a particular
19 part of the RPA, is there a stroke section, is there
20 a particular area that you work in, is it the ED or --
21 A. Neurosciences, so I go wherever a stroke comes or a
22 clot retrieval --
23
24 Q. Everywhere. So someone with a stroke might be taken
25 into emergency, for example
26 A. Correct. So I spent a lot of time in emergency, a lot
27 of time in radiology, or the stroke unit.
28
29 Q. Going forward to what you have said in paragraph 29
30 about - if something emerges out of this, anyone can have
31 leave to ask a question. In paragraph 29 where you've
32 said, "I have lost count of how many times I have heard
33 doctors asking for a device or a piece of equipment only to
34 be told that the facility has run out", I assume, first of
35 all, you're talking about your experience at the RPA?
36 A. Yep.
37
38 Q. That's the first thing. Then, as a piece of
39 equipment, I think you nominated catheters as an example of
40 something that sometimes aren't available?
41 A. Yeah.
42
43 Q. They are needed often in stroke care, stroke
44 management?
45 A. So anyone who has endovascular clot retrieval needs
46 one, yes.
47

1 Q. And an example of a device would be what?
2 A. The same, the catheters used for that, yes.
3
4 Q. Using those terms interchangeably.
5 A. Yeah.
6
7 Q. And you may have answered this, but I just want to be
8 really clear. Is there someone within the ED or the
9 hospital that has responsibility for making sure, for
10 example, that you don't run out of catheters? Is there any
11 person that has that job or that's an aspect of their job?
12 A. So there would be different departments who would have
13 people responsible for that. Some that don't.
14
15 Q. What about the --
16 A. So radiology doesn't.
17
18 Q. -- emergency department?
19 A. So emergency does, radiology doesn't.
20
21 Q. So when you're talking about frequently having heard
22 doctors say, "I want a catheter" and someone says, "There
23 aren't any"?
24 A. That would be radiology.
25
26 Q. That's in radiology, and there's no-one responsible
27 there for making sure --
28 A. Not currently, no.
29
30 Q. So the clinicians are the ones who have to keep an eye
31 on stock levels there for things like, as an example,
32 catheters?
33 A. Correct, yes.
34
35 Q. So should something change about that? It doesn't
36 seem like it is very good that you've run out of catheters
37 if they're essential for helping people with strokes?
38 A. So I think they have had a brief signed off to get
39 someone to start doing stores.
40
41 THE COMMISSIONER: Did anything come out of that that
42 anyone wants to ask a question about?
43
44 MR GYLES: No, Commissioner.
45
46 MR DAWSON: I just have one or two questions.
47

1 THE COMMISSIONER: Sure, go ahead.
2
3 **<EXAMINATION BY MR DAWSON**:
4
5 MR DAWSON: Q. You indicated in response to a question
6 about DeliverEase that you still have clinical nurse
7 consultants counting syringes. Can you explain what that
8 means in process?
9 A. So they have to count the syringes to make sure that
10 that adds up to the same number that they've got in store
11 at that time. So they were counting all of the different
12 bits of equipment and making sure it adds up to the same
13 thing that was registered.
14
15 Q. So there's a level of stock that's meant to be
16 maintained and they can only order it when you fall below
17 that level of stock?
18 A. Correct, yes.
19
20 Q. And the only way to know if you have the level of
21 stock is to count them?
22 A. Yes.
23
24 Q. And is DeliverEase meant to overcome those problems?
25 A. So I've been told this is the initial parts of
26 DeliverEase and then once it's sort of got a routine and it
27 is regulated, then it doesn't happen anymore.
28
29 Q. Does it apply to all sorts of other stock apart from
30 just syringes: people have to count them to see if you are
31 at that base level?
32 A. Yes.
33
34 THE COMMISSIONER: Did anything come out of that,
35 Mr Gyles?
36
37 MR GYLES: No, thank you, Commissioner.
38
39 THE COMMISSIONER: Nothing further?
40
41 MR FULLER: Just two questions, arising from the questions
42 from Mr Gyles.
43
44 **<EXAMINATION BY MR FULLER**:
45
46 MR FULLER: Q. In response to Mr Gyles you said that you
47 asked someone at RPA about obtaining Power BI. Can you

1 just identify who you asked about --
2 A. So I asked the people I know who work in the IT
3 department, but they didn't know. They couldn't help me.
4
5 Q. And in terms of the central LHD ICT, I think you said
6 that they haven't assisted in procuring software in the
7 past. Did I understand that correctly?
8 A. Correct, yeah.
9
10 Q. Have you had personal experience of that?
11 A. So the other software that I've purchased there's
12 just - as I said, the intranet has quotes and you just
13 submit it with a quote. So it used to be an S1, you
14 submitted the quote and that was all you had to do.
15
16 Q. So that's why you inferred --
17 A. Yeah.
18
19 MR FULLER: I understand.
20
21 That's all, thank you, Commissioner. Might be witness
22 be excused.
23
24 THE COMMISSIONER: Yes, thank you very much for your time.
25 It's greatly appreciated. Thank you. You are free to go.
26
27 **<THE WITNESS WITHDREW**
28
29 MR FULLER: The next witness is Paul Haines. He is by
30 AVL. I just wonder if it might be a convenient time to
31 have the morning tea break while we set that up.
32
33 THE COMMISSIONER: Sure. We can do that. We will have
34 a break until 11 .35, then --
35
36 MR FULLER: Thank you, Commissioner.
37
38 THE COMMISSIONER: -- and come back with that witness.
39 Thanks.
40
41 **SHORT ADJOURNMENT**
42
43 THE COMMISSIONER: There is no need to stand when I walk
44 in or leave, just so people know. I know it is a habit.
45
46 All right. We have Mr Haines?
47

1 MR FULLER: Yes, thank you, Commissioner.
2
3 THE COMMISSIONER: Mr Haines, can you hear me?
4
5 THE WITNESS: I can, indeed.
6
7 THE COMMISSIONER: I'm Richard Beasley. I'm the
8 Commissioner for this Inquiry.
9
10 **<PAUL ANTHONY HAINES, affirmed: [11.36am]**
11
12 **<EXAMINATION BY MR FULLER:**
13
14 THE COMMISSIONER: Mr Haines, Mr Fuller is now going to
15 ask you some questions. Do you have a copy of your
16 statement with you?
17
18 THE WITNESS: I do, yes.
19
20 THE COMMISSIONER: Just listen carefully to the questions.
21
22 Go ahead, Mr Fuller.
23
24 MR FULLER: Thank you, Commissioner.
25
26 Q. Mr Haines, can you state your full name, please?
27 A. Yes, certainly. My full name is Paul Anthony Haines.
28
29 Q. And that's H-A-I-N-E-S; correct?
30 A. That's correct.
31
32 Q. You're employed substantively in the Southern NSW
33 Local Health District?
34 A. That's correct.
35
36 Q. And you've made a statement to assist the Commission,
37 which you've got a copy of; is that right?
38 A. That's correct.
39
40 Q. Where are you giving evidence from today, Mr Haines?
41 A. From my home, which is in the town of Yass in
42 New South Wales.
43
44 Q. You currently work in the emergency department at Yass
45 District Hospital; is that right?
46 A. That's correct.
47

1 Q. You've worked there since 2016?
2 A. That's correct.
3
4 Q. Since 2018, you've been a clinical nurse specialist;
5 is that right?
6 A. That's correct. Yes.
7
8 Q. Can you just explain what that role involves, please?
9 A. Yeah, certainly. So my role involves the mentorship,
10 training and support of junior colleagues and, also the
11 transition of nurses that actually want to work in the
12 emergency environment, so that might be nurses who are
13 currently working on our ward, who want to actually
14 progress to work in our emergency department. So it's very
15 much a sort of mentorship and support role.
16
17 MR GYLES: Can I raise one issue, which was - and there
18 is only one issue about the affidavit, which is
19 paragraph 19 --
20
21 THE COMMISSIONER: I don't think it is an affidavit.
22
23 MR GYLES: I'm sorry, the statement. The issue about 19
24 is obviously, if one looks at it, there are difficulties
25 with the evidence, but as a matter of substance, that's not
26 something that you will be looking into --
27
28 THE COMMISSIONER: Whether this place was built well or
29 not?
30
31 MR GYLES: Whether someone thought that it might go over
32 budget just doesn't matter. Again, that would be a pretty
33 complicated issue to deal with. So in my respectful
34 submission, Commissioner, you wouldn't allow that.
35
36 THE COMMISSIONER: I'm not going to be making any findings
37 about that.
38
39 MR GYLES: Yes, Commissioner, thank you.
40
41 MR FULLER: Q. Mr Haines, you work part-time for the ACT
42 Ambulance Service as a paramedic as well; is that right?
43 A. That's correct.
44
45 Q. What is your FTE at Yass District Hospital?
46 A. So my FTE at Yass is 0.42.
47

1 Q. That's full time equivalent?
2 A. Yes, so that is 16 hours a week.
3
4 Q. And has that been about the same during the period
5 that you have worked at Yass?
6 A. For the whole time I have worked at Yass it has been
7 roughly around about that.
8
9 Q. Thank you. I'm just going to ask you some questions
10 about the hospital itself, so that we get a bit of an
11 understanding of it. You've said in paragraph 5 of your
12 statement that the hospital has a four-bed ED and a 10-bed
13 inpatient unit; that's right?
14 A. That's correct.
15
16 Q. Is that all in one building?
17 A. That's correct.
18
19 Q. And how is the ED connected with the inpatient unit?
20 A. So essentially you can think of them as two very large
21 rooms divided by a double door.
22
23 Q. And is there a corridor in between them or just
24 directly connected?
25 A. Just a door - they're directly directed by a door,
26 yes.
27
28 Q. On average, how many beds would be occupied at a given
29 point in time?
30 A. I know that over the last year, it has increased
31 substantially, but in years gone by it would normally be
32 about five to six beds, and I'm not entirely sure of what
33 the figures are over the last year, but it is substantially
34 more than that.
35
36 Q. Is that five to six beds out of the 14 total in the
37 hospital?
38 A. No. So you could think of them as sort of almost
39 different departments. So we've got the emergency
40 department, which has four beds in it, then we have the
41 inpatient unit or the ward, which has 10 beds in it.
42
43 Q. Just as a general proposition, how busy is the ED at
44 Yass?
45 A. So the emergency department probably sees, on average,
46 I think between about 10 and 30 patients a day.
47

1 Q. How many was that, I'm sorry?
2 A. Between about 10 to 30, sometimes a little bit less,
3 sometimes a bit more.
4
5 Q. And you said that the patient numbers have increased
6 over the last year. Do you know why that is?
7 A. Yes, so I'm talking about the inpatient numbers on the
8 ward specifically. So I know that now we are having
9 patients transferred from other hospitals to our hospital
10 because we have the available beds there, which wasn't
11 something that was necessarily done before. But because we
12 have the vacant beds there, we often get patients sent from
13 other hospitals within the local health district for
14 discharge planning or further rehabilitation.
15
16 Q. Which other hospitals are those?
17 A. Namely, Queanbeyan hospital, which is just outside of
18 Canberra, and Goulburn hospital as well.
19
20 Q. Do you have employed doctors at Yass District
21 Hospital?
22 A. We do have employed doctors but they all tend to work
23 on a locum basis, though - although they don't have
24 a contract with the hospital, I don't believe, they may
25 have a contract with the local health district, so we have
26 a few regular doctors and then some who work less
27 regularly, but they don't have any sort of contractual
28 obligations to actually come to work at the hospital for
29 a set amount of hours as far as I'm aware.
30
31 Q. Focusing on the regular doctors, are they specialists
32 or are they general doctors?
33 A. Normally, they are GPs, so --
34
35 Q. GPs?
36 A. Yes.
37
38 Q. What's the staff profile of nurses at Yass?
39 A. So currently, we've actually recently had a bit of an
40 increase in the staffing profile because of the increased
41 workload, but what we have at the moment is one to two
42 nurses on the morning shift and evening shift, in the
43 emergency department, and two nurses on the ward in the
44 morning and the afternoon. That isn't set in stone.
45 Sometimes, the ED only has one nurse in it at a time.
46
47 THE COMMISSIONER: Q. Is the increased workload because

1 of the transfer of patients from the other hospitals you
2 mentioned to the Yass hospital?
3 A. Sorry, I didn't catch that. Can you say again?
4
5 Q. When you said "increased workload", is that because
6 you're receiving patients from the other hospitals you
7 mentioned?
8 A. I think that's a large part of it. But I also think
9 that the patient presentations to our hospital is
10 increasing as the township of Yass and the Yass valley
11 increases as well.
12
13 Q. Does that mean that, for example, the 10-bed ward - is
14 that usually at full occupancy?
15 A. It's - it hasn't been for the last few months because
16 we've actually had a cap on the amount of beds because we
17 can't get the staff to actually work in the hospital. But
18 for many months before that, it was certainly nearing
19 maximum occupancy.
20
21 Q. So, for example, now, how many patients are in that
22 10-bed ward at the moment?
23 A. I don't know. I haven't actually worked at the
24 hospital for the last week.
25
26 Q. But to the extent that it's not at full capacity,
27 that's relating to the ability of the hospital to get staff
28 there?
29 A. That's correct, yes. Yes.
30
31 MR FULLER: Q. The patients who have been transferred to
32 Yass, do you know whether they are patients who otherwise -
33 who are unable to access aged care facilities?
34 A. Yes, some of them will be. Some of them will be
35 patients who are waiting for aged care facilities, or they
36 might be patients who are actually awaiting various
37 assessments to access social care payments and what-not.
38
39 Q. Are those things that you know from your personal
40 experience?
41 A. I actually - I'm actually not in a good position to
42 comment on the ward because I don't work there. I'm an
43 emergency department clinical nurse specialist so I'd
44 rather not comment on that.
45
46 Q. Just focusing on the emergency department, you
47 mentioned, I think, a morning and evening shift; is that

1 right?
2 A. That's right.
3
4 Q. What are the shift times?
5 A. So we have the morning shift starts at 7 o'clock in
6 the morning and goes until 3.30, and the afternoon shift
7 starts at 1 o'clock in the afternoon and goes until half
8 past 9 at night, and then we have a night shift that starts
9 at 9 o'clock at night and goes until 7 o'clock in the
10 morning. We also, at times when we're at normal staffing
11 and we don't have the double staffing in the emergency
12 department, have a shift that goes between about 11 o'clock
13 in the afternoon *[sic]* and 7 o'clock in the evening.
14
15 Q. And how often would you have only one nurse rostered
16 on a shift in the ED?
17 A. Well, every night. We only have one nurse rostered on
18 a shift in the ED, but also our normal staffing before the
19 uplift, we would have a nurse rostered in the morning by
20 his or herself every morning, up until 11 o'clock.
21
22 Q. Have you yourself experienced working alone in the ED?
23 A. Oh, yes, very regularly.
24
25 Q. And when you're alone in the sense of being the only
26 nurse on the shift, is there always someone else in the ED,
27 another staff member?
28 A. Not necessarily in the ED, no. No. It depends. So
29 we normally will have nurses on the ward. If we have
30 a doctor working, then there can be a doctor in the ED.
31 But often we - sometimes we don't have doctors or often we
32 have doctors that work overnight and they won't stay in the
33 hospital overnight, they will stay in the local residence.
34 So during that time, I would normally be on my own.
35
36 Q. Taking the night shift as an example, would there be
37 occasions where you are the only clinician in the hospital
38 as a whole?
39 A. No. There would normally be a nurse on the ward -
40 a nurse or two on the ward.
41
42 Q. But the doors that separate the ward from the ED, do
43 those mean there might be occasions where you're in the ED
44 and not visible to someone else in the ward?
45 A. That's correct. Yes.
46
47 Q. Do you have 24-hour security at the hospital?

1 A. No, we don't.
2
3 Q. Do you have security at all?
4 A. No, we don't. I believe we have funding for a health
5 and security assistant but we have rarely actually managed
6 to attract anybody into that position. So it's very rare
7 that we would ever have security.
8
9 Q. And I take it there is no contract or agency security
10 either?
11 A. No.
12
13 Q. You refer later on in your statement - I don't need to
14 take you to it - to the hospital being in an isolated
15 location. Can you just explain what you mean by that?
16 A. Yeah. So the hospital is in the centre of Yass town,
17 which is a town of about 7,000 people, and when I say
18 "isolated", particularly with regard to security, I mean
19 with regards to access to security or police services if we
20 were to actually need them.
21
22 My understanding is that the police station shuts at
23 about 3 o'clock in the morning and then our local police
24 services would be either a highway patrol officer or
25 officers from Goulburn, which is about an hour drive.
26
27 Q. Have you personally had the occasion to call on police
28 after 3am in the morning?
29 A. I haven't personally.
30
31 Q. Are you aware of anyone else who has?
32 A. Yes, I am.
33
34 Q. And are you aware of how long that response took?
35 A. I can give you an example. So are you talking about
36 calling on the police in terms of using our duress alarm
37 system or are you talking about calling on the police in
38 terms of actually just picking up the phone and dialling
39 000?
40
41 Q. Let's start with just dialling 000. Do you have
42 experience of that?
43 A. Yes, we do, we do. And the response from the police
44 when dialling 000 has generally been reasonably good.
45 I can't tell you the exact time.
46
47 In terms of summoning the police with our duress

1 system, I can give you an example of when it has actually
2 accidentally been activated and the police turned up
3 approximately one and a half hours later.
4
5 Q. I'll come back to that in a bit more detail. You've
6 raised in your statement four issues relating to
7 procurement. I might just go through each of them in the
8 order that you've raised them, if that's okay.
9 A. Certainly.
10
11 Q. The first issue you've raised relates to stock
12 ordering. That starts at about paragraph 8 of your
13 statement. Do you see that?
14 A. Yes, yeah.
15
16 Q. Firstly, what do you mean by "stock"?
17 A. So in the hospital, we have obviously lots of
18 consumable items, so this could be anything from syringes,
19 needles, pads, consumables that we use to keep people alive
20 for various reasons - blood bottles. That's what I mean
21 with regards to stock.
22
23 Q. Are you including any sort of equipment when you are
24 talking about stock or is it mostly the medical consumables
25 that you are referring to?
26 A. Mostly the medical consumables is what I'm talking
27 about.
28
29 Q. Just thinking about your personal experience, what is
30 your involvement, if any, in the stock ordering process?
31 A. So my involvement is essentially when I identify that
32 a stock level is low, then I write it on a list to be
33 ordered.
34
35 Q. Do you have any authority to approve procurement of
36 stock?
37 A. No, no, I don't.
38
39 Q. So you're involved at the very first stage, if I can
40 put it that way?
41 A. That's right, yes.
42
43 Q. In paragraph 8 --
44
45 THE COMMISSIONER: Q. Who is responsible? Don't worry
46 about paragraph 8. If you notice you are low on
47 a particular consumable and you make a note, who is

1 responsible for ordering it at Yass hospital?
2 A. At the moment, we have what's called a clinical
3 support officer, so it is a member of staff who works,
4 I think, two to two and a half days per week who picks up
5 the stock list on a set day and tries to put the order
6 through.
7
8 THE COMMISSIONER: Thank you.
9
10 MR FULLER: Q. I might just come straight to that issue,
11 Mr Haines. You talk about this in paragraphs 9 to 11 of
12 your statement; is that right - the accountability for
13 maintaining stock levels?
14 A. That's correct, yeah.
15
16 Q. In paragraph 10 you refer to the clinical support
17 officer. Am I right in understanding from your answer just
18 then that there's just one clinical support officer who is
19 part-time?
20 A. There is. That's correct.
21
22 Q. You say that there's no identifiable staff member with
23 accountability for maintaining stock levels. Is that not
24 the clinical support officer?
25 A. Well, no, because the clinical support officer is
26 actually non-clinical in that sense. So they're not
27 a registered nurse. They don't even really know what a lot
28 of the stock that they're ordering actually is. So they
29 base their orders on what staff members have actually
30 written on the list. When I say that nobody's actually
31 accountable for it, it means that stock may or may not get
32 ordered and you might have multiple people ordering stock.
33
34 Q. And is that because it falls to the clinicians to
35 identify whether or not stock needs to be ordered?
36 A. That's right. That's correct.
37
38 Q. You say that this can lead to under-ordering or
39 over-ordering. Can you give an example of that?
40 A. Yeah, so often, what will happen, so a clinician will
41 identify that an item of stock is low and they will order
42 it, and then another clinician might, a day or so later,
43 also identify the same stock is low and order it again, and
44 then another day later, the same stock might be ordered
45 again, because nobody actually has responsibility for
46 ordering that stock level, in that we all do but nobody
47 does, so we don't know what anybody else has ordered and

1 nobody knows who is actually accountable for doing it. So
2 in this sense, you may - you often get gross over-ordering
3 or gross under-ordering of stock.
4
5 Q. Is it the case that all orders of stock go through the
6 clinical support officer?
7 A. They should do, but I'm not a hundred per cent sure
8 about that. In the past, it has certainly fallen to the
9 nurse manager. I guess it depends if the clinical support
10 officer is there or not.
11
12 Q. And maybe you partly just answered this, but is there
13 a reason why the clinical support officer wouldn't be in a
14 position to keep track of whether there has been a double
15 order of particular stock, for example?
16 A. Well, I suppose they would be to some extent, but
17 I guess there's a bit of a discrepancy because a clinical
18 support officer doesn't actually have the clinical
19 knowledge so they just kind of order what they've been told
20 to order.
21
22 Obviously if they pick up something glaringly obvious,
23 then commonsense would tell them to query it, but other
24 than that they don't really know what all the stock is that
25 they are ordering, so they don't really have the
26 understanding to know whether it is an over-order or an
27 under-order in that sense.
28
29 Q. Do you know whether there is a process for doing any
30 kind of stocktake, counting of stock in storerooms?
31 A. No, I don't. What I do know is that this has been
32 a problem since I've started and it's been something that
33 has been acknowledged as something that needs to be fixed
34 but nobody has ever really actually gotten round to do it.
35 I can tell you that a local member of staff on light duties
36 has actually taken it upon herself to try and do something
37 about this to have minimum stock ordering levels, so that's
38 an ongoing project.
39
40 Q. Can you just explain a bit about that project - you
41 refer to it in paragraph 8, I think.
42 A. Yeah, that's right. So we have a nurse who is on
43 light duties, for a physical reason, and she took it upon
44 herself to try and put some minimum and maximum stock
45 levels in place so we're not getting in a situation where
46 we're missing low stock or even too much stock, and she's
47 trying to sort of come - put together some sort of at least

1 a minimum level of stock that we should have in the hope
2 that the clinical support officer can go through the
3 storeroom, and actually look at how much stock that we've
4 got, compare it to an inventory of stock that we should
5 have, and then order more as needed.
6
7 Q. Do you know what specifically the nurse is doing to
8 try to achieve that?
9 A. Yeah, so I mean, she's going through the stock that we
10 have and then having a think about what we need and
11 obviously it's in the sense of trying to reduce waste.
12
13 Q. Can you think of any other changes or improvements in
14 the processes currently at Yass that could help to address
15 these issues?
16 A. My personal feeling is that there needs to be somebody
17 who is accountable for actually doing it, and I think that
18 there are multiple technological advances that we can use
19 to actually monitor how much stock that we're using, but
20 also how much stock that we have as well.
21
22 So I can tell you in the ambulance service in which
23 I work in the ACT, we actually have somebody whose job it
24 is to go around all of the stations with a van full of
25 stock, go and check the minimum stock levels and just
26 replenish them, but also he has a barcode thing that tells
27 him how much stock is needed and it's a fairly
28 straightforward process.
29
30 Q. Just on that example, is that a clinical person or
31 a non-clinical person?
32 A. Non-clinical person.
33
34 Q. And how is it that they are able to identify what is
35 an appropriate stock level? Is that determined by
36 a clinical person?
37 A. Well, I suppose - I don't know if they just have
38 specific training to understand what the stock is, but also
39 in terms of ambulance stock, we have much less stock, so
40 it's not the same as a hospital where we need a much
41 greater variety of stock.
42
43 Q. The first suggestion you had was having a person who
44 is accountable. Is it your view that that needs to be
45 a clinical person or not?
46 A. I think it does need to be a clinical person,
47 ultimately, yeah.

1
2 Q. And the second suggestion was that technological --
3
4 THE COMMISSIONER: Q. Why do you hold the view that it
5 should be a clinical person?
6 A. Because a lot of the time, the clinical support
7 officer actually doesn't really know what she's ordering.
8 Sometimes, the lists that we have for ordering stock are
9 very unclear about exactly what it is that you're ordering.
10 It's actually more in the description rather than what you
11 are seeing. So you really have to have somebody who
12 actually knows what the stock is.
13
14 For example, the clinical support officer is often
15 coming to myself and saying, "What actually is this? Do we
16 actually need it?" And I actually have to explain from
17 that point of view what it's for and why we need it and
18 what it actually is, particularly if the picture of the
19 item isn't very clear on the computer.
20
21 THE COMMISSIONER: Thank you.
22
23 MR FULLER: Q. Is one possible solution to have
24 a clinical person who identifies minimum and maximum stock
25 levels for particular consumable items and then
26 a non-clinical person, like the clinical support officer,
27 can then do the actual administrative task of working out
28 what needs to be ordered?
29 A. Potentially.
30
31 Q. And is that similar to what the nurse who you've
32 described in paragraph 8 is trying to achieve?
33 A. I believe so.
34
35 Q. Is that nurse's project - do you know if that has been
36 approved at high levels within the district or is it
37 something that they are doing of their own initiative?
38 A. No, no, it is not. It's just something that they have
39 done of their own volition locally.
40
41 Q. The second suggestion you had was about technological
42 advances. Can you just describe a bit more about what you
43 mean by that?
44 A. Yeah, so I understand that everything is barcoded and,
45 for example, in the ambulance service, what happens is that
46 all items are barcoded so the person goes along with the
47 barcode, goes to the tray where the items are supposed to

1 be kept, scans the barcode, it tells them how many there
2 should be in that tray, what they are, and if the stock is
3 understocked then he will or she will then replenish the
4 stock that we have.
5
6 Q. Do you have any knowledge of an initiative called
7 DeliverEase?
8 A. No.
9
10 Q. Can I come to the next issue that you raise, which is
11 in paragraph 12 about tracking expiry dates of stock. Can
12 you just describe what that issue is?
13 A. Yeah. So we have an awful lot of equipment in the
14 hospital, and most of it has an expiry date because it's
15 a medical consumable. Because a lot of these items do
16 expire but get used very seldomly, keeping a track of
17 expiry dates can be very difficult. In an ideal world, the
18 nurses would be checking the expiry dates regularly. In
19 reality, sometimes this just doesn't get done because of
20 workloads and whatever. What that does is that it actually
21 sometimes leaves us in a situation where we actually have
22 expired items that we can't use, which can obviously be
23 a patient safety concern.
24
25 Q. Do you have any examples of that happening in practice
26 that you have experienced?
27 A. Yes. So I personally have been in the mid of
28 a forensic blood analysis kit, which involves taking blood
29 from a patient who was involved in a motor vehicle
30 collision, and because this is something that we don't use
31 an awful lot at Yass hospital, they're kind of stored in
32 the back cupboard. Unfortunately the ones that we did have
33 were all expired which was a problem and meant a delay to
34 actually the collection of the blood sampling for that
35 patient.
36
37 Q. And what happened? What did you do to resolve that
38 issue?
39 A. I actually had to get another blood sampling - no,
40 I didn't, actually. I had to use - we have two different
41 kits and one of them is for blood and urine and one of them
42 is just for blood. I had to use the blood sampling
43 equipment from a blood and urine sample kit. So it didn't
44 really matter at the end of the day, but I'm not entirely
45 sure if that would hold up in court.
46
47 Q. Is the issue of coming across expired stock something

1 that is common in your experience?
2 A. Not common, I wouldn't say. I mean, we do do a pretty
3 good job of actually checking expiry dates. So with
4 regards to things expiring and then having to be thrown
5 away, then that is a problem. Us not having equipment
6 because it has expired tends to be less of a problem. So
7 could you just clarify what situation you are actually
8 referring to?
9
10 Q. I think you've answered my question. So you have to
11 dispose of equipment - sorry, of stock fairly regularly
12 because it has expired; is that right?
13 A. That's right. That's correct.
14
15 THE COMMISSIONER: Q. So it is more a waste issue than
16 anything else?
17 A. That's right, yeah.
18
19 MR FULLER: Q. You've talked about nurses keeping track
20 of expiry dates, but is there any systematic process for
21 doing that at the moment? At Yass?
22 A. Well, we do - we sort of allocate different staff
23 members different responsibilities with regards to tracking
24 expiry dates and what-not, but all of this is obviously
25 based on the staff member's ability to have the time to
26 actually do it. Obviously, we have no control over the
27 workload in the emergency department, so sometimes that
28 does go by the wayside because we just don't have the time
29 to do it.
30
31 Q. What is the current mechanism for recording the expiry
32 dates through that process?
33 A. So what we do is every month we - before the end of
34 the month, we actually make sure that all of the trolleys
35 are actually checked with regards to their expiry date for
36 the next month. So each member of staff is allocated
37 a specific piece of equipment to check and it's their
38 responsibility to check the expiry dates on those bits of
39 equipment before the end of the month.
40
41 Q. Is that recorded in some sort of document or do they
42 just --
43 A. It is, yeah. Yeah, we keep records of that.
44
45 Q. By hand or on a computerised system?
46 A. By hand, yeah.
47

1 Q. The next issue you raise is about the need for or
2 having to order things in bulk, at paragraph 14. Can you
3 just describe or elaborate on that issue?
4 A. Yeah. So a lot of the equipment that we - or some of
5 the equipment that we absolutely have to have, that it's
6 really, really important to have, we only need one or two
7 units of the items. And what I'm referring to really is
8 things such as specific airways for children, specific -
9 and connections for ventilators, all consumables that
10 actually have an expiry date as well. Hopefully, we never
11 have to use them, but we do have to have them just in case
12 we actually do need them.
13
14 The problem is that a lot of these consumables can
15 only be bought in large quantities, say between 50 and 200
16 units. So every time we buy them, we have to buy a minimum
17 of between 50 and 200 units to actually get just the two or
18 three units that we actually need. This is a bit of
19 a problem because it then leads to massive or gross amounts
20 of wastage of stock.
21
22 Q. How do you know about the number of units you have to
23 purchase in one order?
24 A. So when the units actually turn up, they come in boxes
25 of whatever they're in, 50 to 200, they will turn up on the
26 shelf and then I try to get them from the shelf or I have
27 to order a box at a time, and that's - yeah, that's the
28 minimum that I can order.
29
30 Q. In paragraph 14 you talk about disposal costs, for
31 example, for needles and syringes. Is that because of the
32 need to have a specialised disposal process for sharps, for
33 example?
34 A. Yeah, that's right. That's right. So I believe it
35 costs much more to dispose of sharps and needles, so
36 I think that's probably what I'm referring to there.
37
38 Q. I take it from your statement that there's no formal
39 mechanism for hospitals within your district to collaborate
40 on stock ordering; would that be right?
41 A. No, there isn't unfortunately. So one of the - from
42 my understanding, every hospital has its own cost code and
43 everything that is ordered to a hospital is actually
44 ordered against that cost code. What this actually means
45 is that hospitals are reluctant to share equipment,
46 particularly very expensive equipment, because that then
47 comes out of their own cost code. So, for example, some of

1 this equipment I refer to with regards to consumables, it
2 would obviously be much better for the health service if I
3 could borrow it from the local hospital, but that local
4 hospital has absolutely no prerogative to lend any of its
5 stuff because it comes out of their own cost code. So as
6 a result, we're actually wasting a lot of equipment, and
7 hence taxpayer money, because we can't collaborate together
8 and share the stock.
9
10 Q. How is it that you are aware of that issue?
11 A. Well, I understand a little bit about the ordering
12 process and I understand that every hospital has its own
13 individual cost code when it comes to ordering stock.
14
15 Q. Have you spoken to people at other hospitals about
16 that? What's the source of that --
17 A. Mainly my - my own nurse manager, so - who is actually
18 responsible for the finances.
19
20 Q. I take it you're not aware of any mechanism for
21 sharing costs between hospitals --
22 A. I'm not aware of any mechanisms, no.
23
24 Q. Other than what we've already talked about, where
25 you've given some suggestions for improvements in the
26 processes, do you have any other thoughts about what would
27 make for appropriate processes and procedures to address
28 some of the issues you've raised?
29 A. No, I think probably what I've alluded to with regards
30 to the sorting of the cost codes so we can actually
31 effectively share stock, would be a great cost saving
32 across the whole local health district. I think that would
33 probably be the best thing that we could do.
34
35 Q. Can I move on, then, to the next, larger issue that
36 you raise, which is about the hospital redevelopment,
37 starting in paragraph 18.
38 A. Yeah.
39
40 Q. Just identify what involvement, if any, you had in
41 either the consultation for that development or otherwise
42 through the hospital redevelopment process?
43 A. So I personally wasn't involved in the consultation
44 process. What I did do is chat to other members of staff
45 that were involved in that consultation process, and I had
46 some suggestions during the redevelopment as well with
47 regards to what they might think about changing to make our

1 care of patients safer and more effective.
2
3 Q. Just going through the issues that you've raised, in
4 paragraphs 20 to 22 you talk about concerns around the
5 observation of the mental health room and waiting area.
6 I take it from your answer just then that you weren't
7 involved in raising those concerns; is that right?
8 A. No, I wasn't involved in raising those concerns but
9 I am assured by staff members that went to the consultation
10 that these concerns were raised.
11
12 Q. Are you able to just elaborate on the issue that you
13 describe in paragraph 20 about sufficient observation of
14 a patient in the mental health room? What does that mean?
15 A. Yeah. So often patients that are - that come to us
16 with mental health concerns are often very thought
17 disordered; they can be a very high risk of hurting
18 themselves or other people, and during the consultation
19 they actually allocated one space as a mental health room,
20 and the reason it was allocated as a mental health room was
21 because it had two doors and that was for staff safety.
22
23 The problem with that area is that there are no
24 windows in the doors or there was no actual ways of
25 monitoring that patient as well. And bear in mind that
26 when you're one nurse working on your own, there's no way
27 that you can actually safely and adequately monitor
28 a patient who's in a room by themselves with a door shut,
29 with no cameras in the room as well. I mean, obviously
30 you've got other things to do with regards to treating
31 other patients and running the whole department. So there
32 was no sort of way that we could do that. But the opinion
33 of health infrastructure was that this would be the mental
34 health room, and the reason was because it had two doors.
35
36 Q. Was the mental health room ultimately implemented as
37 part of the development?
38 A. It was ultimately implemented, and - am I able to sort
39 of relay a story that actually happened as a result of that
40 implementation? Is that appropriate?
41
42 Q. Just firstly, was it implemented in the way that you
43 just described, with two doors and without windows in the
44 doors, as I understand it?
45 A. No, I mean, our only consultation advice was to not do
46 it, essentially, that it would probably be inappropriate as
47 a mental health room because we couldn't actually directly

1 view the patient.
2
3 Q. And so how has it actually been implemented now?
4 A. Well, we actually no longer use that room as a mental
5 health room because, sadly, we had a patient who managed to
6 strangle themselves in that room and almost died and
7 required resuscitation as a result of where the room was
8 and the lack of visualisation we had on the patient. So we
9 no longer use that room as a mental health room.
10
11 Q. Just to be clear, as far as you know, the room was
12 implemented in a way that health infrastructure - or in a
13 way that it had originally been designed?
14 A. That's correct.
15
16 Q. And when did the incident that you've just described
17 happen?
18 A. I believe it was within a few months of the renovation
19 being complete.
20
21 Q. When was the renovation completed?
22 A. I don't know off the top of my head, I'm sorry.
23
24 Q. Is that incident something that you heard about from
25 other nurses who were working there --
26 A. That's right.
27
28 Q. -- or did you experience it?
29 A. That's right.
30
31 THE COMMISSIONER: The work started in 2019, the statement
32 says, in paragraph 19.
33
34 MR FULLER: Q. Are you aware of whether there would be
35 ims+ records or something like that about that incident?
36 A. Yes, there definitely was, yeah, definitely.
37
38 Q. You say that you no longer use the mental health room
39 since then?
40 A. No.
41
42 Q. Do you know about how long it's been since that room
43 has been used?
44 A. Oh, so we do use it, but we don't use it for mental
45 health patients. So we use it for very, very low acuity
46 patients who are at no risk to themselves - or low risk to
47 themselves or, you know, not just for a mental health point

1 of view but physically as well. We encourage our staff not
2 to use it for anybody who's got anything wrong with them.
3
4 Q. And so, to the best of your knowledge, that might have
5 been two or three years ago that it was last used for that
6 purpose?
7 A. Yeah, that's right.
8
9 Q. You also raised in paragraph 20 an issue about line of
10 sight to the waiting room, where you say it's critical to
11 be able to observe patients while they're awaiting review.
12 Can you just explain why that's critical in your view?
13 A. Yeah, so when you're a triage nurse you actually have
14 responsibility for the ongoing monitoring of the patients
15 who are in the waiting room. So a patient will come into
16 the hospital, and dependent on their level of acuity they
17 will either be sent to the ED bed or they might go to
18 a chair or they might actually go back out to the waiting
19 room as well depending on space availability within the
20 department.
21
22 What this means is that often we have multiple
23 patients, sometimes many patients, in the waiting room that
24 are actually waiting to see a doctor. Obviously things can
25 change in a patient's condition as well and they do require
26 ongoing monitoring during that period whilst they are in
27 the waiting room, and we have actually no way of
28 necessarily doing that, particularly effectively, in the
29 current setup that we've got.
30
31 As a result of our recommendations, however, they did
32 actually put some cameras in the waiting room, so we can
33 actually observe our patients on cameras, which is probably
34 better than nothing.
35
36 Q. So the cameras were implemented as part of the
37 redevelopment process?
38 A. I believe so, yeah.
39
40 Q. Where do those cameras feed in to?
41 A. So there are multiple screens, so there's certainly
42 one in the triage room where the emergency nurse would sit,
43 and I don't know - there are other cameras but I don't know
44 if the waiting room feed goes to those screens, actually.
45 So I know that there's definitely a screen in the triage
46 room that can be seen, and also there's a screen in the
47 nurses' station as well, but I don't know if it has the

1 waiting room patients on it.
2
3 Q. You said that the cameras are better than nothing.
4 A. Mmm.
5
6 Q. Do you think they are as good as having the line of
7 sight that had been suggested originally as part of the
8 redevelopment?
9 A. No, definitely not.
10
11 Q. Why is that?
12 A. Well, the problem is that when you're actually
13 assessing a patient, then you've obviously got to be
14 focused on that patient. So when I'm in the triage room,
15 I'm with a patient and assessing the patient - I might be
16 examining an ankle or a wrist or I might be listening to
17 their chest or doing observations on them - I can't be
18 looking at the screen whilst I'm actually looking at the
19 patient as well.
20
21 The other thing is that I often have to leave that
22 room, given that there's only myself, sometimes, in that
23 department, and that means that actually nobody during that
24 period of time is actually looking at the patients. We're
25 very lucky at Yass hospital because our administration team
26 are actually very good and they will actually look at the
27 patients for us, they'll keep an eye on them and if they
28 have any concerns they'll let us know, but that's actually
29 not part of their job, they're not trained to do that and
30 there is no expectation that they would, either.
31
32 Q. When you are in the triage room, obviously, you are
33 focusing on the patient who you are trying to assess. Can
34 you just explain in your mind how having improved the line
35 of sight to the waiting room would avoid that issue, or
36 reduce it?
37 A. Well, what you actually see in most hospitals is the
38 triage nurse actually sits behind a glass screen, actually
39 looking out on to the waiting room, so you can actually see
40 all your patients all the time.
41
42 In sitting in the room that I actually sit, the door
43 is closed, I actually have no direct line of sight to any
44 of the patients that are sitting in the waiting room, so
45 I can't be assessing them as I'm actually doing my other
46 business as well, as I'm speaking to other patients who
47 might be - you know. So in other hospitals, what happens

1 is the triage nurse sits at the desk behind the glass
2 screen, where all the patients are in the waiting room, but
3 they're also assessing the patient who is actually behind
4 the glass screen and then the patients that are sitting in
5 the waiting room behind, so you've got that direct line of
6 sight all the time.
7
8 Q. That set-up that you have just described, have you
9 personally experienced or seen that in another hospital?
10 A. Yes. Yeah.
11
12 Q. Can you give an example of a hospital?
13 A. Yeah, I can. I can give you example of two, actually.
14 Canberra Hospital is set up that way, in the ACT, and North
15 Canberra Hospital is also set up that way in the ACT as
16 well.
17
18 Q. In paragraph 23 you've talked about asking for a wall
19 clock to be purchased as part of the redevelopment. Were
20 you told why that was not approved?
21 A. No, I wasn't.
22
23 Q. Has any clock been installed since the refurbishment
24 was completed?
25 A. Yeah, I just want to clarify this. So it's actually
26 not a wall clock that I wanted. So it was a timer,
27 actually, more than a wall clock. Sorry, I probably could
28 have been a little bit clearer on that point there. What
29 I actually wanted was a timer, so when we're managing
30 patients that are in cardiac arrest we can actually keep
31 very clear focus on when certain interventions need to be
32 done.
33
34 So for optimal outcomes, obviously, we need to be
35 doing certain things at certain points and it's very
36 difficult to keep track of what you're doing unless you
37 actually have a timer up on the wall, so in most hospitals
38 you would actually see that up there. So that's what
39 I asked for.
40
41 Q. And has a timer been installed since the redevelopment
42 was completed?
43 A. No. I was initially told that it shouldn't be
44 a problem, nut then I was told that there probably wouldn't
45 be the budget for it.
46
47 THE COMMISSIONER: Q. How much would you expect it to

1 cost, do you know?
2 A. I - no, I don't know how much they cost.
3
4 MR FULLER: Q. Have you raised this issue again since
5 you raised it for the first time during the redevelopment?
6 A. Yeah, I have. I haven't raised it formally through
7 ims+, but I've certainly spoken to my manager about the
8 issue, and the response was essentially the same.
9
10 Q. You have also raised - I won't go through them - some
11 issues about the quality of the refurbishment work. Can
12 I just ask you: what in this process of redevelopment do
13 you think could have been done better?
14 A. I suppose I'll just talk in general terms, because
15 I think the sense that I got from the builders that were
16 actually doing the work, that it would be a very, very
17 difficult project from the very beginning because there
18 would be lots of unforeseen problems and issues that would
19 actually arise as a result of the redevelopment and that,
20 you know, it would be something that perhaps should have
21 been thought about a little bit more with regards to
22 whether it was actually good value for money. Does that
23 kind of answer your question?
24
25 THE COMMISSIONER: Q. Just in terms of the building, the
26 building's very old, is it?
27 A. It is very old.
28
29 Q. Do you know how old?
30 A. No, I don't know how old.
31
32 Q. Is it like a 1950s style or earlier --
33 A. Oh, I think earlier than that, yeah.
34
35 MR FULLER: Q. Just in terms of the specific issues that
36 you raised, leaving aside your conversation with the
37 building contractors, would I be right in thinking, for
38 example, that you think there should have been more
39 engagement with feedback given by people who are actually
40 working in the hospital at the time? Is that --
41 A. Yeah, I felt so, and obviously I can only comment on
42 the clinical things, and I can't actually talk about
43 workmanship per se. Certainly from a clinical point of
44 view, there was a number of recommendations that we sort of
45 fed back with regards to line of sight and that kind of
46 thing that weren't implemented.
47

1 With regard to quality of work, what I can tell you is
2 that shortly after the redevelopment was finished, that we
3 had a large rainstorm and water was pouring through the
4 roof of the hospital.
5
6 Q. Can I now ask you about duress alarms, which is the
7 next issue you have raised from paragraph 26.
8 A. Sure.
9
10 Q. Just as a starting point, what is a duress alarm?
11 A. So a duress alarm is essentially - if you can imagine,
12 it's about the size of a credit card, a little bit thicker
13 than that, and what it is is it's meant to be a personal
14 alarm that each individual is issued at the beginning of
15 their shift, and what happens is if you find yourself under
16 duress or in a potentially violent situation or under
17 attack from a patient, then you activate this alarm and
18 what should happen is the other members of staff in the
19 building are actually sent a message to say that you've
20 actually activated your duress alarm.
21
22 The other thing that's supposed to happen is a company
23 from the city somewhere, I believe our local provider is
24 Canberra, will actually phone the hospital to see if we are
25 okay.
26
27 THE COMMISSIONER: Q. Is there a fixed alarm in the
28 building, in the hospital, like a --
29 A. Sorry, I didn't catch that.
30
31 Q. Is there a fixed alarm, on a wall?
32 A. There is, yeah. So we actually have fixed alarms on
33 the wall. There are - yeah, there's a number of fixed
34 duress alarms that we can actually push as well to activate
35 the system.
36
37 Q. So when you are talking about duress alarms in your
38 statement, you are referring to these personal alarms?
39 A. That's correct, yeah.
40
41 MR FULLER: Q. Just starting with the fixed duress
42 alarms, do they all activate the same system or notify the
43 same people, do you know?
44 A. I believe so.
45
46 Q. So all of the ones in the hospital would notify to the
47 same - sound an alarm to the same person or group of

1 people; is that right?
2 A. Or people, yeah, yes. Yes.
3
4 Q. What you were describing in terms of - in relation to
5 the credit card style of duress alarm is a personal duress
6 alarm; that's right?
7 A. That's correct, yep.
8
9 Q. Do you know the particular model of duress alarm at
10 Yass?
11 A. I don't, no.
12
13 Q. Have you experienced different types - sorry, have you
14 worked, other than as a paramedic, in any other hospitals
15 than Yass?
16 A. I have, yes.
17
18 Q. Have you experienced different types of duress alarms,
19 personal duress alarms?
20 A. I have, yeah.
21
22 Q. Which other hospitals have you worked in?
23 A. So most of my experience is actually from the UK, so
24 hospitals that I've worked in in London, they were the
25 other duress alarms that I have experienced.
26
27 Q. Have you worked in any other hospitals in New South
28 Wales?
29 A. No.
30
31 THE COMMISSIONER: Q. You started at Yass in 2016, you
32 say in your statement - am I right? Back in paragraph 4,
33 "I have worked in the ED since 2016"?
34 A. Yes, that's correct.
35
36 Q. And you say in 26:
37
38 *We have not had a functioning duress alarm*
39 *at [Yass District Hospital] in the 7 years*
40 *I have worked there.*
41
42 There were personal alarms available when you started in
43 2016; they just didn't work?
44 A. That's correct.
45
46 Q. So someone had made a decision that personal alarms
47 were necessary, for them to be there; correct?

1 A. That's correct.
2
3 Q. But they didn't work?
4 A. That's correct.
5
6 Q. And they haven't worked since?
7 A. That's correct.
8
9 MR FULLER: Q. When you say that they don't work, or
10 they're not functioning, can you just elaborate on what you
11 mean by that?
12 A. Yes. So we've had - obviously this has been an
13 ongoing saga for us at Yass hospital. The current alarms
14 that we actually have were brought in as a replacement or
15 an update on the alarms that we had that didn't work.
16 Unfortunately, these alarms also didn't work. When I say
17 that they didn't work, what I mean - (audio/video feed
18 dropped out due to storm) - of the alarms when you actually
19 activate them, just nothing actually happens.
20
21 Q. Sorry, Mr Haines, you just dropped --
22
23 THE COMMISSIONER: Q. When you were talking then, for
24 a very brief moment, everything went out here. It's our
25 problem, not yours. Usually, this building doesn't need
26 a storm to lose wi-fi or other things, but we're actually
27 having a storm here in Sydney. We missed a couple of words
28 so I might get Mr Fuller just to repeat the question and we
29 will go again.
30
31 MR FULLER: Q. When you said, Mr Haines - I think you
32 were elaborating on what you meant by them not working or
33 not functioning --
34 A. Yes.
35
36 Q. -- can you elaborate, please?
37 A. So we've had multiple problems with them. Some of the
38 alarms just don't activate when we've actually tried to
39 activate them. The other big problem that we've had is
40 being able to, if the alarm has actually activated,
41 locating where the actual person is that is under duress,
42 has been a problem as well. So often a patient will
43 perhaps go to a back corridor, and they activate their
44 duress alarm and it comes up as duress alarm in the
45 kitchen, or something like that. And this is to do with
46 the wi-fi that we've actually struggled with, and it seems
47 that no matter what they do, they don't really seem to be

1 able to resolve the problem.
2
3 We're now getting to the point where they actually
4 have very little battery life, and because so many of them
5 don't work, we actually don't have enough for the staff
6 members to actually each have a personal alarm.
7
8 Q. Can I just go through each of the issues that you've
9 just raised. So you have said that there are occasions
10 when they don't activate.
11 A. Yes.
12
13 Q. By that, do you mean that they don't notify anyone,
14 or --
15 A. That's right. That's right.
16
17 Q. At all?
18 A. That's right.
19
20 Q. How do you know that?
21 A. Well, we actually have started testing them fairly
22 regularly to see actually what doesn't work, and we
23 actually find that even now, and in the past what we've
24 done, we've a just tried to activate them and nothing
25 happens, so no signal is sent.
26
27 Q. Do you know if these alarms are working properly and
28 they are activated, do they notify everyone currently
29 working, all nurses and doctors currently working in the
30 hospital?
31 A. So what's meant to happen is they activate - what
32 they're meant to do is send a message to all - everybody
33 who is wearing a duress alarm, to say that a duress alarm
34 has been activated somewhere in the hospital. It is meant
35 to tell you what tag number has actually been activated and
36 where that person is so you can render assistance.
37
38 Q. So as far as you know, if it has been activated, it
39 should notify everyone wearing a duress alarm. In other
40 words, it's not grouped; is that right?
41 A. No; that's correct, yes. The other thing that is
42 meant to happen is it's meant to notify a monitoring and
43 surveillance company who are based in a local city, and the
44 process is that they're supposed to phone the hospital to
45 try to see if everything is okay, and if nobody answers the
46 phone, then they're supposed to call the police.
47

1 THE COMMISSIONER: Q. How are other staff notified? If
2 a nurse, for example, activates their duress alarm, how is
3 the GP or another nurse notified?
4 A. So they have their own personal duress alarms, and on
5 that duress alarm it actually starts beeping and says that
6 another duress alarm has been activated and where that
7 duress alarm is activated.
8
9 Q. Through them being linked as a system, is it?
10 A. Yes, that's right. I mean, presuming everything
11 works, of course, which it doesn't.
12
13 MR FULLER: Q. So if it's working properly, it's
14 supposed to notify both other staff wearing a duress alarm
15 and the company that you referred to; is that right?
16 A. That's correct.
17
18 Q. In this first scenario where you have said they just
19 don't activate, have you experienced that yourself?
20 A. Yes, I have.
21
22 Q. Does the duress alarm say anything?
23 A. No. It depends what their malfunction is. Sometimes
24 it just does absolutely nothing. Well, most of the time it
25 just does absolutely nothing, actually. Just nothing
26 happens.
27
28 Q. Have you experienced this in particular locations in
29 the hospital?
30 A. Various locations.
31
32 Q. And does it give you any sort of error message in that
33 scenario?
34 A. No.
35
36 Q. But did you say it has a little screen on it?
37 A. It has a screen on it, yeah.
38
39 Q. And so from the screen, it appears to be on, at least,
40 to have battery power; is that right?
41 A. Yeah. So part of the checking process that we're
42 supposed to go through every morning is actually check that
43 the system is functioning. So what we do is you run
44 through a very quick check process on it and it tells you
45 that the alarm is working and functioning.
46
47 Q. So this first scenario is one where you have done that

1 self-test at the beginning?
2 A. Yeah.
3
4 Q. It's indicated the alarm is working, but when you
5 attempt to activate it, it doesn't do anything?
6 A. Yeah, that's correct.
7
8 Q. As far as you can see?
9 A. Yeah.
10
11 Q. The second scenario you mentioned is where it doesn't
12 correctly identify the location of a person; is that right?
13 A. That's correct. Yeah.
14
15 Q. In that scenario, does it identify any location?
16 A. Yeah, sometimes it does. It normally identifies the
17 location, but the problem is it's often the wrong location,
18 and again that's due to the fact that they can't seem to
19 figure out the WAP system in the roof, it just can't seem
20 to locate where the duress alarms are, for some reason.
21
22 Q. Can I ask how wrong is the location? Is it a long way
23 away in some situations you've --
24 A. Yeah, look, we've been given different buildings. So
25 we have a kitchen that is actually a separate building that
26 it's supposed to work in as well and I've had somebody
27 activate a duress alarm within the hospital, in the ward,
28 and it said that they were actually in the kitchen, which
29 is a completely separate building.
30
31 Q. The third scenario, then, as I understand it, has to
32 do with limited battery life. Can you just elaborate on
33 that, please?
34 A. Yeah. I mean, my overall impression of these alarms
35 are that they're pretty cheap and now we're actually having
36 problems with the batteries failing very quickly, and as
37 a result, we actually have very few alarms left in the
38 hospital because they're all - they're all being repaired
39 or run out, batteries no longer viable.
40
41 Q. Is this what you're describing in paragraph 30 of your
42 statement, if you just want to have a look at that?
43 A. Yeah, that's right. That's right. So we actually
44 have - we have ordered some more duress alarms, and
45 I believe that the order went in some time ago - it might
46 even be over a year ago now - but we still haven't received
47 the duress alarms. I'm reliably told that they are sitting

1 on somebody's desk in Goulburn hospital but we are still
2 yet to receive these alarms. I don't know what the problem
3 is but we don't seem to be seeing them at Yass hospital for
4 some reason.
5
6 Q. Who told you that?
7 A. The nurse manager who's trying to follow that up.
8
9 Q. You've said in paragraph 30 you don't currently have
10 enough duress alarms for each staff member in the ED to
11 wear one. How many functioning duress alarms are there for
12 the ED at the moment?
13 A. This is actually not just for the ED. This is for all
14 of the hospital staff. So I can't tell you how many are
15 left, but I can tell you that we don't have enough for
16 every member of staff on a day shift to have a duress
17 alarm.
18
19 Q. On a given shift, how many staff would there be not
20 wearing a duress alarm?
21 A. I couldn't guess, but it would - it would be
22 a substantial amount.
23
24 Q. There would be one or more on every shift that you've
25 experienced?
26 A. Oh, more than one, yeah, yeah.
27
28 THE COMMISSIONER: Does the first sentence of paragraph 26
29 require some clarification, then? "Not had any"?
30
31 MR FULLER: Sorry, I missed that, Commissioner.
32
33 THE COMMISSIONER: The first sentence of paragraph 26
34 says:
35
36 *We have not had a functioning duress*
37 *alarm ...*
38
39 It sounds like there are some that are functioning or am
40 I misunderstanding that?
41
42 MR FULLER: Q. Perhaps, Mr Haines, if you can just
43 explain what you mean by "a functioning duress alarm" in
44 the first sentence of paragraph 26.
45
46 THE COMMISSIONER: Q. Do any of the alarms work, that
47 you know?

1 A. Some of the alarms - well, it depends what you
2 constitute "working", so some of them will activate and
3 some of them will tell you that somebody has actually
4 activated their duress alarm. If you're lucky, they'll
5 give you a correct location, but I wouldn't have said that
6 that's a particularly functioning duress system myself.
7
8 Q. There are various levels of functioning, are there?
9 A. There may be - there may be some that do work
10 properly, yeah.
11
12 Q. Can you shed any light about if personal duress alarms
13 have been some form of issue, either not working entirely
14 or only partially working, why this hasn't been resolved in
15 seven years? I imagine it's something that has been taken
16 up with management, has it?
17 A. Yeah, it is. So this has obviously been a drama for
18 a long, long time. I initially raised this with the
19 director of nursing. I had limited luck with that one.
20 I then raised it with the general manager through the union
21 and we had ongoing meetings and meetings and meetings,
22 after which nothing was resolved. I then --
23
24 Q. When you say "limited luck" - just pausing there -
25 when you say "limited luck" with the director of nursing,
26 what is the response that you know, from personal
27 knowledge, has been --
28 A. What I can tell you is that the issues weren't
29 resolved. So there --
30
31 Q. Is it a cost issue?
32 A. I don't know what the issue is. I can't, for the life
33 of me, fathom why I'm still talking about this seven years
34 later, but it seems that I am. I've raised it with
35 multiple people within the organisation. I've also raised
36 it with SafeWork NSW, and not had any luck on that one
37 either.
38
39 THE COMMISSIONER: All right. Thank you.
40
41 MR FULLER: Q. Mr Haines, when you do those self-tests
42 in the mornings that you've described in paragraph 30 or at
43 the start of a shift, do you know if there is a record of
44 whether, you know, the number of alarms that are or aren't
45 working?
46 A. Yeah, so when a staff member comes - starts a shift in
47 the morning, what they will do is they will take an alarm

1 and they will test it, and then it will tell you whether
2 the alarm is actually working or not. Then they will sign
3 out that alarm. If the alarm is not working, then what
4 they have to do is they have to put in a fault report and
5 then it gets sent away to somewhere to get fixed.
6
7 Q. And, I'm sorry, what report do they fill in?
8 A. So the - currently when they're doing is they're doing
9 a fault report, so that goes to the maintenance man and he
10 sends it off to wherever he sends it to get fixed.
11
12 Q. Is that an electronic form that they submit?
13 A. No, it's a book. It's a handwritten document.
14
15 Q. And how does that - who does that go to, sorry, the
16 maintenance people?
17 A. That goes to the maintenance man, and he then follows
18 up and sends the alarm off to whoever he sends it to to be
19 fixed.
20
21 Q. If an alarm doesn't work properly when it's self
22 tested - sorry, I'll start that again. You do a self test
23 in the morning, the alarm seems to be working. If you then
24 activate the alarm or attempt to, and it doesn't work, does
25 that get recorded somewhere?
26 A. Yeah, that's right. Well, that would be - ideally,
27 and I think that this probably doesn't happen as much as it
28 should, what you would ideally do is an ims+ in that
29 situation. However, I am aware that staff don't always do
30 ims+ when they probably should be.
31
32 Q. Do you know why that is?
33 A. My personal feeling is that people are so fed up with
34 trying to manage this duress system that they don't feel
35 like there is any point in struggling on with it anymore so
36 they don't bother about it.
37
38 Q. Is completing an ims+ report something that a staff
39 member would have to do during their ordinary work hours?
40 A. Yes, that's right. I mean, do you mean - are you
41 asking whether staff can claim overtime if it has to be
42 done out of hours?
43
44 Q. No. Can I put it this way. If a staff member has
45 a really busy shift, that might be a reason why they don't
46 fill in an ims+ report?
47 A. Oh, absolutely. Yeah, that's why they don't get done

1 most of the time, just due to workload.
2
3 Q. You also mentioned earlier that this current system
4 replaced a previous system; is that right?
5 A. That's right.
6
7 Q. When did that happen, do you remember?
8 A. Oh, I don't remember what year it was, but I remember
9 it was before COVID, so I'm thinking (indistinct -
10 audio/video feed froze) before that.
11
12 Q. I'm sorry, Mr Haines, you just froze recently --
13
14 THE COMMISSIONER: Q. You said it was before COVID?
15 A. Sorry, I was saying my understanding is it was before
16 COVID, so I think probably it would have been 2019, 2018,
17 maybe before that.
18
19 MR FULLER: Q. Did that previous system use a different
20 physical kind of personal duress alarm?
21 A. Yes, it did. It appeared to be some sort of pager
22 system that nurses were meant to wear a pager system and to
23 activate it somehow that way.
24
25 Q. You mentioned, finally on this issue, in paragraph 28,
26 being the chair of the health and safety committee at Yass
27 District Hospital.
28 A. Yes.
29
30 Q. How long have you been the chair of that committee?
31 A. Those committees have been running for about a year
32 and a half.
33
34 Q. A year and a half. And who else is on that committee?
35 A. So in that committee we have the director of nursing,
36 we have multiple staff representatives and also the work
37 health safety representative from the LHD.
38
39 Q. So someone from the LHD is on that committee?
40 A. Yeah, that's right. Yep.
41
42 Q. Do you know whether there is a reporting line from
43 that committee to anyone else within the LHD?
44 A. Yeah, my understanding is that the reporting line goes
45 right to the chief executive officer, at the different
46 tiers of the meetings.
47

1 Q. Do you recall whether issues relating to duress alarms
2 were being raised at the beginning when that committee was
3 first set up?
4 A. Yeah. Yeah, this is actually a standing item within
5 our meetings, so we kind of - every time we have a meeting
6 we discuss duress alarms and the progress that's actually
7 made to resolve the issues.
8
9 Q. Are you personally aware of any other steps that have
10 been taken to escalate these issues up into the local
11 health district?
12 A. I'm not aware of anything personally. What I can tell
13 you is early last year we actually had a director of
14 nursing who was very sympathetic to the concept of actually
15 having a working duress system, and she actually put in an
16 awful lot of effort to try and resolve this, and I believe,
17 unfortunately, it still wasn't resolved despite her best
18 attempts, but I do know that people at the executive level
19 are very, very aware of this issue.
20
21 Q. Can you, just to help us, explain why at Yass it's
22 important to have a functioning duress alarm system?
23 A. Well, it's really important because often we are quite
24 isolated in terms of our position. We are looking after
25 multiple different patients - they could be drug or alcohol
26 affected; they could be thought disordered; and also we
27 have limited numbers of staff, especially out of hours when
28 all the community health staff and managers go home.
29 You've often got three, sometimes four members of staff in
30 the whole building.
31
32 During the night shift, you've only got one nurse in
33 the ED working there. So that's somebody working in
34 isolation with very limited resources. So you actually
35 need to be able to get a distress signal to your colleagues
36 to let them know that you're struggling, if you are, and
37 also I think as I've explained, we have very little police
38 assistance.
39
40 THE COMMISSIONER: Q. The example you have given in
41 paragraph 31 of the locum nurse --
42 A. Yeah.
43
44 Q. -- to your knowledge, was that - as a locum nurse, was
45 she working in the ED or on the ward?
46 A. She was working in the ED.
47

1 Q. And does that mean she was on her own?
2 A. She was on her own, yeah.
3
4 Q. And I think it's implied, but the threats of violence
5 were from an ED patient, I take it?
6 A. That's correct. Yeah.
7
8 Q. Is there a record kept when a patient threatens
9 a clinician? Is there a record kept of that sort of thing?
10 A. Yes, there certainly was in this instance because
11 obviously this was a fairly significant incident for this
12 one member of staff, so she did an ims+ report as a result
13 of that. Unfortunately, her - not surprisingly, her duress
14 alarm didn't activate during this incident and no help was
15 rendered, so she certainly did do an ims+ as the result of
16 this.
17
18 Q. That's an example that you know about. Are there any
19 other instances that you know about, either because you've
20 done it or a staff member has told you, where, forgetting
21 testing, and it doesn't work, where a member of staff has
22 activated their - or attempted to activate their personal
23 duress alarm because they feel they need to and it hasn't
24 worked?
25 A. There are examples of that, yes. I haven't personally
26 but I've been told examples of - there have been times when
27 duress alarms have been activated and they haven't worked.
28
29 Q. So that's more than once, in any event?
30 A. Yes.
31
32 MR FULLER: Q. Mr Haines, you say that that nurse has
33 not returned to work due to this incident. How do you know
34 that?
35 A. Well, she actually - I actually spoke to her post this
36 incident and debriefed her about the incident and she told
37 me personally that she's actually not coming back to work
38 at Yass hospital because she feels so vulnerable, and that
39 was the straw that broke the camel's back. She also sent
40 an email to the executive team and detailed exactly why she
41 was never coming back to Yass hospital.
42
43 THE COMMISSIONER: Did everyone hear that?
44
45 MR FULLER: We just had a loud thunder strike.
46
47 THE COMMISSIONER: We just had a loud bang of thunder

1 here, but your answer was caught, in any event.
2
3 MR FULLER: Q. To your knowledge, is this issue about
4 not having functional duress alarms having an impact on
5 whether other nurses are willing to work at Yass hospital?
6 A. I couldn't say for sure yes or no, to be honest.
7 I couldn't give you a yes or no. I do know that the nurses
8 feel very vulnerable. In fact, because of this, we
9 actually took some industrial action some years ago because
10 the nurses felt so strongly about having a duress system
11 that actually works. We actually put a cap on the amount
12 of beds to actually get the executive team to come and meet
13 with us about the issue. So I know it is certainly
14 strongly felt. I don't know if nurses are not coming to
15 work at Yass because of it.
16
17 Q. Do you know what the outcome of that industrial action
18 was?
19 A. Yeah, so the outcome of that industrial action was
20 that we ended up getting work health - SafeWork NSW
21 involved.
22
23 Q. And what was the outcome, if any, of that?
24 A. Well, they actually did come to site and they agreed
25 that the duress system was insufficient and it wasn't
26 appropriate, and they issued a provisional improvement
27 notice to the local health district, which the local health
28 district thought they answered appropriately.
29
30 Unfortunately, we didn't feel the same way, as staff
31 members, because the duress system still didn't work, so we
32 asked WorkSafe New South Wales to come back to the site,
33 which they did. They agreed that the system hadn't been
34 adequately rectified, and they said that they were going to
35 issue another - a further provisional improvement notice to
36 the LHD to actually fix the duress system, but that
37 provisional improvement notice was never received and we
38 never had any further contact from SafeWork NSW, despite
39 multiple attempts to try and follow them up.
40
41 Q. You're aware of people trying to follow up SafeWork
42 about that; is that right?
43 A. I did personally and - as did the work health safety
44 officer from the nurses and midwives union of New South
45 Wales.
46
47 Q. And you're not aware of any response on that issue?

1 A. There was no response.
2
3 Q. Just before leaving duress alarms, you gave an example
4 early on in your evidence of activating a duress alarm and
5 I think the police not responding or no-one coming for
6 about one and a half hours. Did I understand that
7 correctly?
8 A. That's right.
9
10 Q. Can you just elaborate on - is there anything more to
11 say about that example?
12 A. Well, my feeling is that our duress system is so -
13 such a crude system, in that it often gets activated
14 accidentally. There also was a function called "man down"
15 on it. Whenever the duress alarm was actually laid flat,
16 it was assuming that you had been knocked to the floor or
17 you were dead and activated as well.
18
19 So as a result of that, there was lots of false
20 activations and I think that there were probably also some
21 false activations of the police as well, and I get the
22 sense that - and this is just me speculating - that perhaps
23 the police were getting a little bit fed up of false
24 activations, so when the alarm did actually activate in
25 circumstances that we actually needed police, then it was
26 taken less seriously than perhaps it should have done.
27
28 Q. What was the response to those false alarms?
29 A. Well, it depends what actually happened. So as
30 I said, the process is normally that the company will call
31 us on a phone in the hospital to see if we're okay. If we
32 don't answer, then the process is that they call the local
33 police.
34
35 Now, obviously if that's in the day and the police are
36 available, the local police will come to the hospital to
37 check on us. If that's not, then they will send police
38 from Goulburn hospital over, if they're the nearest, to
39 check that we're okay, if they want get in touch with us.
40
41 Q. Sorry, that was a bad question. Was the issue of
42 false alarms raised with your management?
43 A. It was, yeah.
44
45 Q. And what happened as a result of that?
46 A. Well, they did actually make some changes to the
47 alarm. They took the man down function off, which was one

1 of the issues that was causing a lot of false alarms, and
2 that certainly reduced them somewhat, so I think that was
3 largely the action that came from that.
4
5 Q. Do you currently have a functional man down mechanism
6 on your duress alarms?
7 A. No, we don't.
8
9 Q. What do you think about that?
10 A. Yeah, my personal preference would be to have it taken
11 off because I thought it was actually causing too many
12 false activations, which I think is problematic in itself
13 because people weren't taking them seriously anymore
14 because they would activate multiple times during the day
15 and people just didn't even bother responding anymore
16 because they just assumed it was an inappropriate man down.
17
18 Q. As a matter of principle, assuming you can get around
19 the problem of false alarms, do you think having
20 a functional man down system is important?
21 A. I don't personally. I don't see a great value in it.
22 I don't think its value is there, personally.
23
24 Q. The last issue that you raise in your statement is
25 about the transfer of patients for x-ray services, starting
26 in paragraph 33.
27 A. Yes.
28
29 Q. I understand Yass hospital has a radiography service
30 that operates 9am to 3.30pm Monday to Friday, with no on
31 call, that's the current situation?
32 A. That's correct.
33
34 Q. That means, does it, that you have to transfer
35 patients to another hospital for x-rays outside those
36 hours?
37 A. That's right. So if a patient urgently needs an x-ray
38 outside those hours then they must be transferred to
39 another hospital to get that x-ray done.
40
41 Q. What are the sorts of situations where a patient might
42 urgently need an x-ray and require a transfer?
43 A. Well, it can be multiple things but, for example, if
44 somebody presents with respiratory illness, severe
45 respiratory illness; if they have chest pain that's thought
46 to be cardiac; if they have a really severe fracture that's
47 limiting circulation to a limb, then that might be

1 a situation where you need to have urgent x-ray.
2
3 Q. How often would that happen in your experience, or to
4 your knowledge?
5 A. I - regularly. I would say regularly. I don't know
6 if I can give you a number.
7
8 THE COMMISSIONER: Do you mean how often outside of the 9
9 to 3.30 when it is available?
10
11 MR FULLER: I'm sorry, Commissioner.
12
13 Q. How often outside of the period where you have
14 a radiographer on site.
15 A. Sorry, I didn't catch that? Sorry.
16
17 Q. How often would you require an urgent x-ray outside of
18 the hours that you have a radiographer on site; would that
19 be regular or not?
20 A. I would say it would be regular. I don't have the
21 specific figures.
22
23 Q. You have said in paragraph 35 that often those
24 patients would be transferred in an emergency ambulance.
25 What other ways of transferring them might happen?
26 A. Well, the local district actually has a patient
27 transfer or transport service, and that is a service that
28 comprises of normally a registered nurse and a driver that
29 are supposed to be able to transfer patients between
30 hospitals that aren't sort of critically unwell.
31
32 Unfortunately, the patient transport services don't
33 actually run out of hours. I don't know what time they go
34 up until, but also, getting their services for an emergency
35 issue seems to be very, very difficult, because most of
36 their transfers are actually booked long in - well in
37 advance. So they often don't have to - don't have the
38 capacity to actually do any emergent transfers.
39
40 Q. So you require in your experience an emergency
41 ambulance, firstly, outside ordinary business hours, 9 to 5
42 Monday to Friday; would that be right?
43 A. Yeah, I think they run a bit later than that. I'm not
44 entirely sure what they run until, but certainly sort of
45 during the night. I mean - but often, as I say, they are
46 unable to sort of offer a service to the emergency
47 department because they just don't have the resources.

1
2 Q. So even if it's between, say, 3.30 and 6pm Monday to
3 Friday --
4 A. Yes.
5
6 Q. -- you might still have to call an emergency ambulance
7 because the patient transfer service is unavailable?
8 A. Absolutely; that's correct.
9
10 Q. When you refer to an emergency ambulance, is that
11 New South Wales or ACT Ambulance?
12 A. New South Wales.
13
14 Q. Are you aware of whether the local health district
15 makes any payment for that?
16 A. I believe they do.
17
18 Q. Have you been informed as to why the on call 6 D?
19 Radiographer service was cut?
20 A. The reason given was because they thought it was
21 a work health safety issue because they didn't want her
22 working during the day and being on call during the night.
23
24 Q. So was there just one radiographer?
25 A. One person, yeah.
26
27 Q. There's currently only one radiographer at the
28 hospital; is that right?
29 A. Well, we have one person who works regularly at the
30 hospital and we have some casuals who work at the weekend
31 to cover Saturdays and Sundays.
32
33 Q. Do you know whether there is a reason why the casuals
34 couldn't cover overnight?
35 A. They probably just don't want to, to be honest. They
36 actually work 9 till 5 in the ACT. So the one casual that
37 I'm thinking of actually has a full-time job in the ACT and
38 just does the extra time at Yass hospital for some extra
39 money.
40
41 Q. Are you aware of whether, in the Yass area, there are
42 radiographers available, either on a contract basis or
43 otherwise, who might be able to perform the work?
44 A. I'm not aware.
45
46 MR FULLER: Those are my questions, Commissioner.
47

1 THE COMMISSIONER: Q. Just what you have said in
2 paragraph 35 - so I get an idea - and obviously I expect it
3 varies, but patients having to be transferred from Yass
4 hospital to other hospitals and often in an emergency
5 ambulance for a simple diagnostic test - give me an idea,
6 would it average out at once a day, once a week, once
7 a month? How often are we talking?
8 A. Very, very difficult to say. Let's say three times
9 a week. Maybe more than that.
10
11 THE COMMISSIONER: All right. Thank you. Mr Dawson, do
12 you have anything?
13
14 MR DAWSON: No, thank you.
15
16 THE COMMISSIONER: Mr Gyles?
17
18 MR GYLES: Thank you.
19
20 THE COMMISSIONER: This is Mr Gyles who is acting for
21 NSW Health, Mr Haines. He is going to ask you a few
22 questions.
23
24 MR GYLES: Just before I do, one issue that has emerged is
25 some evidence given about the redevelopment of Yass
26 hospital.
27
28 THE COMMISSIONER: Yes.
29
30 MR GYLES: That redevelopment no doubt would have been the
31 subject of a lot of work in terms of design, input from
32 clinicians, decisions made about the way it was to be done,
33 how it was implemented, et cetera. If that's going to be
34 something that is going to be part of what you are dealing
35 with, or perhaps I could speak to counsel assisting about
36 this, I can't do justice to that issue now, but there would
37 be a lot to that issue. I suspect I won't need to come
38 back to this witness, because he had, at best, peripheral
39 involvement in it, but I'm not in a position to deal with
40 that.
41
42 THE COMMISSIONER: What it costs and whether it went over
43 budget, I don't know that that's really anything I would be
44 making a finding on. The fact that water poured through
45 the roof the first time it rained and why that occurred is
46 unlikely to be - I'm unlikely to be urged to make a finding
47 or a recommendation about that. It doesn't sound great,

1 but --
2
3 MR GYLES: No, I agree.
4
5 THE COMMISSIONER: Either an ED waiting area or a mental
6 health room which no-one can see - can't see the patients -
7 doesn't sound particularly clever, but it also doesn't
8 sound like a systemic issue across the state. So I'm not
9 sure this is going to be a big area, but I think your first
10 idea about talking with counsel assisting might be the best
11 route to go.
12
13 MR GYLES: Equally, I can ask a few questions about the
14 issue of the personal duress alarms. A lot of - well,
15 material has emerged during those questions which we would
16 need to look into. There is no doubt that it is a complex
17 issue, and I can ask the witness about it - perhaps I will
18 do that now.
19
20 **<EXAMINATION BY MR GYLES**:
21
22 MR GYLES: Q. Mr Haines, you have been on the health and
23 safety committee at Yass District Hospital now for about 18
24 months?
25 A. That's correct.
26
27 Q. And the duress alarm issue is something that you have
28 a strong interest in?
29 A. That's correct.
30
31 Q. And it's a source of frustration for you that now
32 in February 2024, you haven't got what you regard as
33 a satisfactory system?
34 A. That's correct.
35
36 Q. The current system has been in place since about 2022;
37 is that your - would that be consistent with your
38 recollection, that is the--
39 A. No, I think - I think it's before then.
40
41 Q. Can I suggest to you that post the redevelopment of
42 the hospital, there was an initial system that came in in
43 which the personal duress alarms were used in the ED but
44 then if one needed to go outside of the ED, there was
45 a different alarm that was required. Do you recall that?
46 A. No.
47

1 Q. Can I suggest to you that - perhaps we will start this
2 way. You say in paragraph 32 of your statement that it's
3 very frustrating to see the amount of money and effort that
4 is being spent on trying to rectify the current ineffective
5 system?
6 A. Yes, that's correct.
7
8 Q. And you've told us that there was a big effort at one
9 stage put in, in the last short period, by a senior nursing
10 officer at the hospital; is that right?
11 A. Director of nursing, yes.
12
13 Q. Director of nursing was on top of the issue and was
14 trying to deal with it. You have said SafeWork NSW have
15 been involved?
16 A. Yeah.
17
18 Q. And you've seen a lot of money and effort being put in
19 to try to deal with the problem?
20 A. That's correct.
21
22 Q. So it's not an issue that is not being addressed; the
23 issue is that it's not being addressed in a way or has not
24 been addressed in a way which has given rise to an
25 effective current system?
26 A. Well, I think you have to consider how long this has
27 actually been going on for. I mean, this is a culmination
28 of years and years and years of work so it has taken quite
29 a push, including industrial action from the nurses, to
30 actually get to this point, even though we're actually left
31 with a duress system that doesn't actually function.
32
33 Q. I'm not saying that there isn't some justification for
34 your frustration, but you accept, or your evidence is, that
35 you've seen a lot of time and money put in to trying to get
36 this system working?
37 A. That's correct.
38
39 Q. Would it also be consistent with your knowledge that
40 the age of the Yass hospital, difficulties with wi-fi and
41 those sorts of matters can make this perhaps a more
42 challenging issue than it may be at other hospitals?
43 A. Yes, that may be the case, yes.
44
45 Q. And if it was --
46
47 THE COMMISSIONER: Wouldn't the witness need to be a wi-fi

1 expert --
2
3 MR GYLES: Well, he seems able to give evidence about a
4 few other things.
5
6 THE COMMISSIONER: I don't know about the age of the
7 building should make a difference, except for perhaps this
8 one, but --
9
10 MR GYLES: Q. Anyway, you would agree that it seems to be
11 an issue that people are having difficulty dealing with?
12 A. That's correct.
13
14 Q. Despite it seemingly being escalated to something that
15 people are spending time and money on right now?
16 A. That's correct.
17
18 MR GYLES: Commissioner, I think with that issue, it's
19 really, I think - I do need to leave that.
20
21 THE COMMISSIONER: If you needed to come back at a later
22 time, it doesn't have to be in this hearing block, with
23 some further evidence, if you were concerned about anything
24 or if you needed to follow up in some other way, that can
25 be accommodated.
26
27 MR GYLES: The evidence at the moment suggests that it is
28 a complex issue to deal with, steps are being taken. So we
29 can look into what's being done about it.
30
31 THE COMMISSIONER: I mean, I don't know whether
32 functioning security alarms or duress alarms should be that
33 complex, but I also don't know, so --
34
35 MR GYLES: Yes. So perhaps we'll reserve our position
36 about that. Would you like me to finish? I will finish
37 very quickly.
38
39 THE COMMISSIONER: I think we should finish because the
40 witness is on stream, it's better we finish him and start
41 after 2, I think.
42
43 MR GYLES: Thank you. I won't be very much longer.
44
45 Another issue, Commissioner, which has been raised, is
46 this question of the availability of the x-ray or
47 radiological services. Presumably that was a decision made

1 by someone, a resourcing issue. Again, we would need to
2 look into that if that's --
3
4 THE COMMISSIONER: Of course, yes.
5
6 MR GYLES: If that's important, we can look into that.
7 There is no doubt that would have been a consideration
8 given to these issues.
9
10 THE COMMISSIONER: The witness suggested one reason as to
11 why it was done. There might be other reasons that are
12 known only to decision-makers about these things, rather
13 than the clinicians.
14
15 MR GYLES: Q. Finally can I deal with one issue, which
16 is the stock ordering issue, please, Mr Haines?
17 A. Certainly, yes.
18
19 Q. Am I right in thinking that you have, in effect,
20 a monthly stocktake which is done where you each divide up
21 the consumables and someone goes through and works out what
22 of those consumables may be coming to the end of their
23 useable life and is that recorded in a document?
24 A. With regard to stock ordering, we do that on a weekly
25 basis. With regards to expiry dates, we generally do that
26 on a monthly basis because old stock expires at the end of
27 a month.
28
29 Q. So there's a stocktake, in effect, each week?
30 A. Yes.
31
32 Q. But then there's a particular monthly run through the
33 storeroom to make sure that if a particular piece of stock
34 is at the end of its useable life, you know about that?
35 A. That's correct.
36
37 Q. And that system - that is, the weekly stocktake
38 and the monthly review for the serviceable life of the
39 product - is that something that is part of the project
40 that the local nurse is putting in place now or is that
41 something that has always been put in place?
42 A. No, no, that's not something that's always been in
43 place. So the minimum stock levels is what the local nurse
44 was actually trying to address. With regards to the expiry
45 dates or the end of the month expiry dates, that's
46 something that we've been doing on an ongoing basis.
47

1 Q. So the idea of the minimum level of stock is that that
2 will engage, in effect, an automatic reordering to get the
3 maximum?
4 A. That's correct.
5
6 Q. So you will be within a band of minimum and maximum
7 going forward?
8 A. That's exactly, and hopefully to prevent over-ordering
9 as well.
10
11 Q. So that would, as you say, deal with the issue of
12 gross over-ordering?
13 A. Yes.
14
15 Q. So you are not allowed to go beyond your maximum?
16 A. Yeah.
17
18 Q. You were asked some questions about the DeliverEase
19 ordering system, and I think you didn't have any knowledge
20 of that?
21 A. No, that's right.
22
23 Q. And at the moment, the Yass hospital does not have the
24 DeliverEase ordering system and so to the extent that that
25 might alleviate some of these issues, that's not something
26 that you are in a position to have seen working?
27 A. No, I'm not.
28
29 MR GYLES: That's all, thank you, Commissioner.
30 Thank you, Mr Haines.
31
32 THE COMMISSIONER: Did anything arise from that?
33
34 MR FULLER: No, thank you, Commissioner.
35
36 THE COMMISSIONER: Mr Haines, thank you very much for your
37 time. It is greatly appreciated and you are excused.
38
39 THE WITNESS: You are very welcome. Thank you so much.
40
41 **<THE WITNESS WITHDREW**
42
43 THE COMMISSIONER: All right. Unless there is anything
44 further now, we will come back at 10 past 2.
45
46 **LUNCHEON ADJOURNMENT**
47

1 THE COMMISSIONER: Yes, Mr Fuller?
2
3 MR FULLER: Thank you, Commissioner. I call Nicholas
4 Tribbia. T-R-I-B-B-I-A.
5
6 **<NICHOLAS TRIBBIA, affirmed: [2.11pm]**
7
8 **<EXAMINATION BY MR FULLER:**
9
10 MR FULLER: Q. Can you state your full name, please?
11 A. Nicholas Gerard Tribbia.
12
13 Q. G-E-R-A-R-D?
14 A. G-E-R-A-R-D, yes.
15
16 Q. What's your occupation?
17 A. I'm a registered nurse.
18
19 Q. You are currently employed in the Nepean Blue
20 Mountains Local Health District?
21 A. I am.
22
23 Q. You have given a statement to assist the Commission?
24 A. I have.
25
26 Q. You have a hard copy there in front of you. The
27 document number is [SCI.0003.0001.0446]?
28 A. It is.
29
30 Q. There is one annexure to that statement; is that
31 right?
32 A. Correct.
33
34 Q. I'm not going to read the number of that one. Is
35 everything in that statement true and correct to the best
36 of your knowledge and belief?
37 A. It is.
38
39 THE COMMISSIONER: Is that annexure the procedure? Is
40 that what it's headed?
41
42 MR FULLER: That's right.
43
44 THE COMMISSIONER: I have got it, yes, thanks.
45
46 MR FULLER: Q. You have been employed substantively as
47 a registered nurse in the Nepean Blue Mountains Local

1 Health District from February 2017, is when you started; is
2 that right?
3 A. It is.
4
5 Q. Until September 2020, then you had a break until May
6 2021; is that right?
7 A. Mmm-hmm.
8
9 Q. And you have worked in the same local health district
10 since then?
11 A. Yes.
12
13 Q. Have you worked exclusively in mental health nursing?
14 A. I have.
15
16 Q. You currently work in the Blue Mountains mental health
17 unit; is that right?
18 A. It is.
19
20 Q. That's on the grounds of the Blue Mountains District
21 ANZAC Memorial Hospital?
22 A. Yes.
23
24 Q. For what period have you worked in that particular
25 mental health unit?
26 A. The last two years.
27
28 Q. So since you started again in May 2021; is that right?
29 A. No. So from May 2021 I was working with the Blue
30 Mountains mental health access team, which is a community
31 mental health team and I've come over to work in the
32 inpatient unit since January of 2022.
33
34 Q. Are you full time currently?
35 A. I am.
36
37 Q. Previously, you worked in the Nepean Hospital mental
38 health centre; is that right?
39 A. It is.
40
41 Q. That's on the grounds of Nepean Hospital?
42 A. Correct.
43
44 Q. What period did you work there for?
45 A. Yeah, so in the mental health centre, from February
46 2017 for a period of four months as a new graduate on
47 a rotation, and then again from 2017, October 2017 onwards

1 until September 2020.
2
3 Q. So you were working there continuously, February 2017
4 to September 2020; is that right?
5 A. At the Nepean Hospital, yes, and for the overwhelming
6 time, excepting four months on a medical rotation in the
7 main hospital, in the mental health centre.
8
9 Q. I see, so those first four months you were on
10 a rotation in the main hospital rather than in the mental
11 health centre?
12 A. For the first four months on rotation in the mental
13 health centre, then followed by four months on rotation in
14 the hospital, then back to mental health where I've been
15 since.
16
17 Q. Thank you. That's my fault. You were full time at
18 the hospital, at the Nepean Hospital, for that period; is
19 that right?
20 A. Yes.
21
22 Q. You said that after you stopped working at Nepean full
23 time, you very occasionally picked up casual and overtime
24 shifts; is that right?
25 A. It is.
26
27 Q. How do you get those shifts? Is it part of a pool
28 arrangement?
29 A. Yes.
30
31 Q. When you say "very occasionally", how many shifts
32 would you have done since you stopped working there full
33 time?
34 A. Yeah, so I'd say it's been variable. There have been
35 times where I've taken shifts, you know, every pay period,
36 every fortnight; and there have been times where it's been
37 a couple of months at a stretch between shifts.
38
39 I mention in my statement about shifts at the Triage
40 and Assessment Centre and the last of those being in May of
41 2022, at which time I would have been working again in the
42 district, so those would have been overtime shifts where
43 I would have come down the hill from the Blue Mountains to
44 work overtime where needed.
45
46 Q. The last time you worked at Nepean was May 2022; is
47 that right?

1 A. Yeah.
2
3 Q. You say that you've also worked in both inpatient and
4 community mental health settings across a number of other
5 districts in New South Wales; is that right?
6 A. Yeah, correct.
7
8 Q. That's Western Sydney, South Western Sydney and South
9 Eastern Sydney?
10 A. Correct.
11
12 Q. Was that also by way of casual or overtime shifts?
13 A. Yeah, casual arrangements, yeah. I spent some time in
14 south west Sydney in a substantive role, so the period of
15 absence I suppose from 2020, September 2020 through
16 till May of 2021, I would have been in south west Sydney.
17
18 Q. And what role was that?
19 A. Both in a community mental health team, as
20 a registered nurse, as a mental health clinician on that
21 team providing care coordination, and also in an inpatient
22 psychiatric acute unit, Banks House, at Bankstown-Lidcombe
23 Hospital.
24
25 Q. At Bankstown hospital; is that right?
26 A. Yeah, Bankstown-Lidcombe Hospital.
27
28 Q. What facilities did you work in in Western Sydney
29 Local Health District?
30 A. I have worked in Western Sydney at Cumberland,
31 Westmead and Blacktown hospitals at different points during
32 my career, including as an undergraduate AIN.
33
34 Q. Cumberland Hospital is a specialised psychiatric
35 hospital; is that right?
36 A. It is.
37
38 Q. What about South Western Sydney?
39 A. Yeah, I have worked in Banks House on the grounds of
40 Bankstown-Lidcombe Hospital; I've worked at Liverpool
41 Hospital also, both as mentioned in the community mental
42 health team and in the inpatient units there, the HDU and
43 some of the other acute units there.
44
45 Q. Which facilities in South Eastern Sydney?
46 A. At Sutherland, Prince of Wales and St George
47 hospitals.

1
2 Q. In your experience, is it common for nurses to work
3 across different facilities in either the same or different
4 LHDs?
5 A. Yes.
6
7 Q. And why is that?
8 A. Dare I say, the cost of living, it's - you know, to
9 make a crust, it's what you have to do, picking up overtime
10 or casual shifts, especially those that attract penalties,
11 are quite appealing.
12
13 Q. You have a number of colleague who do the same thing?
14 A. Oh, most definitely.
15
16 Q. I'm going to start by asking you about your
17 experiences at Nepean and then I will move to asking you
18 about Blue Mountains, where you are now. At the Nepean
19 Mental Health Centre, at least from your knowledge of it,
20 up to May 2022, how many beds were there in that centre?
21 A. I would say there would be something in the order of
22 28 in the acute unit, 12 in the HDU, another 20 in the
23 older persons unit, six in the PECC, and then the Triage
24 and Assessment Centre doesn't have beds but often has
25 patients awaiting admission sleeping in the waiting room.
26
27 Q. Starting with the acute - sorry, you list these units
28 in paragraph 7 of your statement. Starting with the acute
29 unit, can you just describe what the purpose of that unit
30 is?
31 A. Sure. It's an inpatient psychiatric acute unit, as
32 its name implies, it does what it says on the tin, really.
33 Most of the patients admitted there are detained on an
34 involuntary basis and having treatment provided to them
35 under the authority of the Mental Health Act.
36
37 These are people who, you know, for one reason or
38 another, are deemed at risk to themselves or others. We do
39 treat patients on a voluntary basis there as well, but
40 yeah, for one variety or another, experiencing some sort of
41 psychiatric malady.
42
43 Q. Do you know what the general criteria are for
44 admission as an involuntary patient under the Mental Health
45 Act?
46 A. I mean, I would refer you to the Mental Health Act,
47 you know, substantively but again, which is where a person

1 is experiencing some sort of, you know, perturbation in
2 their mental state and are at risk to themselves or others
3 as a result and hence needing or warranting detainment.
4
5 Q. You referred to the HDU, with about 12 beds; is that
6 right, that's the high dependency unit?
7 A. Correct.
8
9 Q. What sorts of patients are in that unit?
10 A. So I guess relative to the acute unit, we're dealing
11 with patients who are presenting a greater risk than those
12 in the acute unit and are thus needing a more restrictive
13 environment for care, where there is a staffing at a higher
14 level, where there is a lower stimulus environment, where
15 observation is - where those patients can be more easily
16 observed and so on. So a safer environment, more
17 appropriate environment for their care.
18
19 Q. Would patients normally be moved there from one of the
20 other units or might they be assessed and put immediately
21 into that unit?
22 A. I'd say as a rule we are dealing with patients
23 admitted in the first hand to the HDU, coming from the
24 community. Generally, people get better over the course of
25 admission and thus would be moved down into an acute unit
26 or a subacute unit. So generally we're dealing with the
27 pointy end in the HDU. There are times when someone may be
28 decompensating in the acute unit and they warrant
29 escalation in their care and hence transfer to the HDU but
30 usually it's the other way around.
31
32 Q. The next unit was the older persons unit. I suppose
33 that's what it says on the tin as well; is that right?
34 A. Yeah, if a patient is, generally speaking, of the age
35 65 or older.
36
37 Q. The final unit that you referred to is the PECC or the
38 Psychiatric Emergency Care Centre, that's what that stands
39 for?
40 A. Correct.
41
42 Q. Six beds in there?
43 A. Correct.
44
45 Q. What's the purpose of that centre?
46 A. I mean, PECCs - I think the intention of PECCs is
47 somewhat different to the way that they currently function,

1 at least in Nepean, I think it's best summed up as a ward
2 for folks that are needing - patients that are needing
3 short admissions, so, you know, 72 hours or less, more
4 often than not, voluntary, and often younger, and hence
5 needing, you know, a more appropriate setting for their
6 care and in lieu of having a dedicated child and adolescent
7 unit, the PECC often functions ad hoc as one.
8
9 Q. Is that what you meant when you said that the
10 intention seems to be different from how it's used in
11 practice?
12 A. Yeah. The PECC is situated adjacent to the ED and
13 I mean it somewhat predates me but there is a model of care
14 where the PECC was really to be functioning something
15 different to the way that it currently does, well and truly
16 integrated into the emergency department, you know, not
17 just situationally adjacent but really meaningfully
18 adjacent to the care provided in the emergency department.
19 I don't know that that's currently the way that it acts.
20 But again, brief admissions, crisis type admissions.
21
22 Q. Is it the case, at least up to May 2022 when you were
23 there, that a lot of the patients are children and
24 adolescents?
25 A. Yeah, correct. More so than elsewhere.
26
27 Q. Sorry, also?
28 A. More so than elsewhere.
29
30 Q. The last part of the MHC that you described is the
31 Triage and Assessment Centre. Can you just describe what
32 the purpose of that is, please?
33 A. So the Triage and Assessment Centre, I guess, is in
34 some ways responsible for the PECC being something other
35 than it is. Previously it was the clinicians that were
36 based in the PECC that would be doing assessments to
37 patients presenting to the emergency department for
38 psychiatric care. Again, either voluntarily or
39 involuntarily, either hauled in by the cops or there off
40 the street of their own accord.
41
42 The TAC again does what it says on the tin, it does
43 triage and assessment. A person may present to the Triage
44 and Assessment Centre, seeking assessment, seeking
45 treatment for a mental health condition, or they may be
46 brought in under duress by the ambos, by the cops, and be
47 getting triaged and assessed and having their care

1 subsequently provided either on an involuntary basis,
2 admitted into the ward, or sent back home perhaps with some
3 community follow-up.
4
5 Q. You have said that the Psychiatric Emergency Care
6 Centre, is in a different building on the Nepean Hospital
7 campus from the rest of the centre; is that right?
8 A. Yeah, correct. It was previously adjacent to the
9 emergency department. The emergency department has
10 recently moved to a new tower, new building, but the PECC
11 remains in that sort of now decommissioned ED.
12
13 Q. When did that occur?
14 A. Oh, the move would have happened some time in last
15 year, I believe.
16
17 Q. Do you know that from other people telling you about
18 that?
19 A. I mean, I've been - having been down at the Nepean
20 Mental Health Centre for one reason or another, either to
21 take casual work or, you know, to attend a study day,
22 I have at some - you know, one time or another seen the
23 movement across to that new tower. I couldn't pin down the
24 dates again, not working there substantively.
25
26 Q. Do you think it had moved by the time of your last
27 shift at Nepean in May 2022?
28 A. I'm not sure that it had moved by then, no. But it
29 definitely has moved - has moved since, yeah.
30
31 Q. Are the other parts of the mental health centre in one
32 building together?
33 A. Yeah, that's correct.
34
35 Q. Are those parts connected to each other?
36 A. They're part of the one building, yeah. They do
37 share, in some cases, a corridor with locked doors, so the
38 acute and HDU really you can prop open all the doors and
39 walk freely through them theoretically, but there is
40 a locked swing corridor, so again, that - there's actually
41 a series of doors and those wards can be changed in their
42 size. The acute unit is set at 28 beds and the HDU is set
43 at 12 but that can vary, theoretically.
44
45 Q. You referred to some area being able to be locked off.
46 Can you just elaborate on that?
47 A. Yeah, so the mental health - in the mental health

1 centre we do have locked doors, these are again units that
2 provide care on an involuntary basis. So those doors are
3 magnetically locked. They are able to be opened with
4 a swipe or a hard metal key. Yeah. So there are a number
5 of locked doors, there are a number of entrances to the
6 ward and, yeah, as mentioned, the HDU and the acute unit
7 are sort of part of the one floor. The older persons unit
8 is downstairs and not directly accessible other than via
9 a lift or a set of stairs.
10
11 Q. Are there locked rooms where, on some occasions, only
12 one patient would go into those rooms?
13 A. Oh, yeah, certainly. Bedrooms are able to be locked
14 but, you know, they are able to be opened from the inside.
15 They're not seclusion rooms. But we do also have those.
16 So in the HDU there are dedicated solution rooms that are
17 locked, secure rooms, with lightly padded walls with, you
18 know, CCTV surveillance, with - and very restrictive
19 environments. These are essentially just, you know, smooth
20 walled boxes. There is not much more in there. They
21 really are designed to be a safe place where a person
22 in a - who is grossly disturbed can be housed for some
23 period of time when they are posing an immediate threat to
24 others that is not otherwise managed less restrictively.
25
26 Q. How many of those rooms are there in the HDU?
27 A. Two.
28
29 Q. What's the distance between the PECC and the building
30 where the rest of the mental health centre is - about how
31 long does it take you to get?
32 A. Oh, it would be no more than a - no more than
33 a three-minute walk, probably more like two.
34
35 Q. Is that internal?
36 A. There's no way to access it entirely internally.
37 You - one does have to leave the mental health centre into
38 a public area. It's for as short as perhaps 10 metres,
39 a span, to get from one side of the road to the other. And
40 then through internal corridors, a person can access the
41 PECC internally. A member of the public would not be able
42 to take such a direct or such an enclosed route; they would
43 have to walk along a sidewalk or a pavement, footpath.
44
45 THE COMMISSIONER: There is a map of the hospital online.
46
47 MR FULLER: Thank you, Commissioner.

1
2 Q. Can you just describe the sorts of activities you
3 perform as a registered nurse in the mental health centre,
4 or would it depend on where you're working on a particular
5 day?
6 A. It would. But there are certainly some commonalities.
7 I would say that, look, there is treatment being provided.
8 This is a place for people to receive mental health
9 treatment, treatment often looks like medication, so
10 registered nurses are administering medications.
11
12 Registered nurses and enrolled nurses are also
13 monitoring the patients in their care, be that for their
14 physical wellbeing, monitoring of their vital signs, but
15 they're also monitoring their mental state, so making
16 a record of that, making ab assessment of that and
17 documenting those observations.
18
19 There is also therapeutic activity that is provided,
20 you know, picture things like - you know, we do have
21 a craft room where groups are run, you know, art groups and
22 the like; there is a smaller range of gym equipment
23 available, treadmills and some weights and a boxing bag and
24 things of this nature, you know, Swiss ball and yoga mats.
25 And again, where groups are run, there is a courtyard
26 available, where patients can get fresh air. There is also
27 some gym equipment located out there.
28
29 There are consult rooms where doctors can see their
30 patients in relative privacy. There is a family room where
31 people can have loved ones come in and visit with them,
32 again in a space of relative privacy. There is a dining
33 hall where patients can eat their meals. There is
34 a beverage bay where they can make cups of tea and coffee.
35 There is a lounge, you know, where people can sit around
36 and watch TV, watch movies. And there are bedrooms that
37 are individual, all individual throughout the ward, where
38 again, people can have relative privacy that they can
39 access throughout the day.
40
41 Because we are dealing with patients that are free
42 living in the confines of the ward, nurses are often
43 milling about the floor monitoring those patients, their
44 whereabouts, and making a record of those. For example,
45 you know, all patients admitted to the ward will be on some
46 sort of constant visual, or some sort of visual
47 observations, and they may range from at least every two

1 hours through to constant visual observations or constant
2 observations where the person is within the immediate reach
3 of the clinician providing care. So what we call
4 observation levels 1 through 5, or 5 through 1, rather,
5 respectively. So it is common - most common for a person
6 to be, for example, admitted on a basis of a level 3, you
7 know, observation, where they are observed at least every
8 half an hour and where there is a record of their location
9 and their activity at that time.
10
11 Q. At least back in May 2022, do you know what the shift
12 structure was for nurses in the mental health centre or did
13 it again vary across parts of it?
14 A. Look, I guess I would answer that question by, you
15 know, there is a morning shift, an afternoon shift and
16 a night shift, chiefly. Morning shift running 7 through
17 3.30, afternoon shift running 1.30 through 10, night shift
18 running 9.30 through 7.30 - 9.30 at night through to 7.30
19 in the morning.
20
21 Q. Did all parts of the centre operate on a 24/7 sort of
22 roster structure do you know?
23 A. All the inpatient units, correct. The TAC also, yes.
24 There are nurses on shift, doctors on shift, at all hours,
25 at all times in the mental health centre, yeah.
26
27 Q. Are you able to speak to approximately how many nurses
28 would be on each of those shifts across the centre?
29 A. Yeah, sure. So, I mean, there is some difference in
30 the staffing model used. So in places like the PECC or the
31 HDU, there is a constant level of staffing, so in the PECC,
32 as mentioned, six patients, but with two nurses on shift at
33 all times, plus a nurse unit manager during the business
34 hours.
35
36 In the HDU you've got again 12 beds, you know, usually
37 12 patients, with five nurses on the floor working
38 clinically, plus a nursing - sorry, a nurse unit manager
39 during business hours. The acute unit, the older persons
40 unit, because they operate under an NHPPD staffing model,
41 nursing hours per patient day, their level of staffing does
42 fluctuate. I couldn't tell you off the top of my head what
43 that usually looks like, but there is some more variation
44 in that level of staffing. They are staffed to an NHPPD 6
45 for what that's worth. The Triage and Assessment Centre,
46 again, I couldn't tell you the level of staffing exactly.
47 There is again - my understanding is more variation in

1 that, by virtue of the fact that the Triage and Assessment
2 Centre, being akin to an emergency department, there is no
3 predicted number of, you know, patients that may be in your
4 care. You might have people sleeping in the waiting room;
5 you might have, on a Monday or Tuesday morning, no-one walk
6 through the doors needing care. So the work is somewhat
7 lumpy where you have either got not a lot going on or, you
8 know, beds in the corridor sort of situation, you know,
9 people sleeping in the waiting room situation.
10
11 Q. Would there be occasions where you are the only nurse
12 in a given part of the mental health centre?
13 A. No. In the PECC is probably the case where you're the
14 most isolated. Again, there are times - well, on the
15 afternoon or the night shift, you've only got two
16 clinicians on shift. It means to take a break, for
17 example, you need the after hours manager to come down and
18 relieve you for your time to have some tucker or close your
19 eyes.
20
21 Q. I understand from your statement that there are times
22 when you would have to move between the mental health
23 centre and the ED; is that right?
24 A. It is. If working in the Triage and Assessment
25 Centre.
26
27 Q. And you would be specifically rostered on to work in
28 the Triage and Assessment Centre; is that right?
29 A. Correct. It's not graded as an acute inpatient unit,
30 it previously fell under the community directorate, which
31 doesn't mean a lot clinically. It sure looks a lot like an
32 inpatient unit, in that you are staffed with nurses and you
33 are providing care to patients. Again, you don't have
34 beds; it is a waiting room.
35
36 But the Triage and Assessment Centre, the clinicians
37 there also provide in-reach to the emergency department.
38 So not only do you have a waiting room where you may have
39 patients waiting to be assessed or having been assessed,
40 waiting for admission; there may be patients who are
41 needing those services but, for other reasons, unable to be
42 kept in that waiting room - so, for example, a person who
43 is intoxicated, this would be an exclusion criteria for the
44 person being in the Triage and Assessment Centre, and they
45 should remain in the emergency department awaiting, you
46 know, clearance; or if a person is medically compromised in
47 some way, perhaps after an overdose or some sort of

1 misadventure, they would be in the emergency department
2 receiving medical care.
3
4 Again the Triage and Assessment Centre is a glorified
5 waiting room. There is no oxygen on the walls, for
6 example. This would be something a person would need to be
7 kept in the emergency department for and clinicians working
8 the TAC would provide in-reach to.
9
10 Q. And by "in-reach", do you mean they would go to the
11 emergency department and, for example, perform mental
12 health assessment on --
13 A. Exactly.
14
15 Q. -- a patient there? Might there be times where you
16 have to move a patient, as a nurse, you move a patient from
17 the ED to the TAC or another part of the mental health
18 centre?
19 A. Correct. So suppose that we had a person, as
20 mentioned, who was in the emergency department for reason
21 that they were unstable physically, perhaps they were
22 stabilised, they may be able to be moved over to the Triage
23 and Assessment Centre, or who presented intoxicated, were
24 assessed in the emergency department, are awaiting
25 admission and that, you know, due to a long wait for the
26 admission, have sobered up and are able to be moved over to
27 the Triage and Assessment Centre.
28
29 The Triage and Assessment Centre is or the intention
30 was to be an alternative to the emergency department. For
31 people that are experiencing psychological distress, being
32 in an emergency department can be really unfortunate state
33 of affairs. Emergency departments are not a very
34 hospitable places, they are noisy, they are bright, you
35 know, hard to sleep in, hard to get much rest in, they are
36 not very private to even have an assessment conducted when
37 you have a - you know, the curtain is not a cone of
38 silence. So where possible, being over in the Triage and
39 Assessment Centre is a preference.
40
41 Q. If you're a nurse rostered on in the Triage and
42 Assessment Centre, about how often would you find yourself
43 going to the ED?
44 A. Oh, most shifts. Most shifts. There would be
45 clinicians - it's more common, for example, that a person
46 in the emergency department will be detained. Again,
47 generally speaking, if someone is in a state to present

1 themselves, they're in a state to be in the TAC. It's
2 often where a person is - you know, has made an attempt to
3 harm themselves or has attracted the attention of the
4 police, for example, are in a grossly disturbed state and
5 needing sedation, that they would be in the emergency
6 department; they would be detained.
7
8 So it's often the clinicians who are more senior, it's
9 medical officers with the ability to lift a schedule, for
10 example, that would be assessing those patients in the
11 emergency department.
12
13 So a junior clinician may spend their shift in the TAC
14 seeing people, you know, who'd presented to the TAC on
15 a voluntary basis, whereas a doctor may be spending their
16 whole shift to and fro the ED.
17
18 Q. And just from that last part of the answer, it sounds
19 like there are ED doctors and other clinicians who might
20 have to move to the TAC as well on a given shift; would
21 that be right?
22 A. I don't know that an ED doctor would have cause to
23 come over to the TAC, excepting a medical emergency, you
24 know, someone is in the waiting room and has collapsed,
25 they have taken an overdose prior to presenting and not
26 told anyone and then succumbed. But no, as a matter of
27 routine you wouldn't have an emergency department doctor
28 come to the TAC but it would be common for a TAC doctor to
29 be doing in-reach to the ED.
30
31 Q. How many TAC doctors would there be generally on a -
32 at a given period of time?
33 A. Oh, look, there's always someone on. I - there is
34 some overlap. But I couldn't tell you there's ever more
35 than one at a stretch.
36
37 Q. And as a nurse rostered somewhere in the mental health
38 centre, would there ever be an occasion for you to go to
39 other parts of Nepean Hospital than the ED?
40 A. As a nurse in the TAC?
41
42 Q. Yes.
43 A. Look, on the weekend, the psych CL, the psychiatric
44 consultation liaison service, may be fulfilled by the TAC.
45 In other words, you know, this is providing consultation,
46 you know, psychiatric consultation for patients that are,
47 you know, commonly admitted medically. So you've got

1 someone who's up on, you know, a cardiac ward, unrelated to
2 their mental health. There's some need for psychiatric
3 care to be provided and thus, you know, on the weekend, for
4 example, a doctor stationed in the TAC may, you know, go up
5 to one of the medical wards and provide care. But this is
6 seldom - seldom the case.
7
8 Q. Can I just contrast some of what you have said about
9 Nepean with the Blue Mountains Mental Health Unit where you
10 are now. So I understand Blue Mountains is a smaller
11 facility; is that right?
12 A. Most definitely.
13
14 Q. How many beds in Blue Mountains?
15 A. The mental health unit, 15. Five graded as close
16 observation and 10 as acute.
17
18 Q. Are they all - it is all inpatients at the Blue
19 Mountains Mental Health Unit?
20 A. We also have a psych CL, you know, psychiatry
21 consultation liaison role filled by a clinical nurse
22 consultant. This is staffed during business hours Monday
23 to Friday, and this is the clinician that would be
24 conducting assessments for patients presenting to the
25 emergency department. So in lieu of having a TAC, we're
26 dealing with that older model of care where a person is in
27 the ED and is having in-reach, in this case by the psych CL
28 clinician. They are based in office space adjacent to the
29 mental health unit.
30
31 Q. How does the patient demographic compare between Blue
32 Mountains and Nepean?
33 A. It's different, I'll say that. I don't know the level
34 of detail that you're wanting there. The demographic
35 observations.
36
37 Q. Just at a high level.
38 A. Sorry?
39
40 Q. At a high level, if you can?
41 A. Yeah, look, I'd say that generally the acuity is
42 lower, the demographics in the mountains, you know, are
43 such that they're reflected in our patient profile. We do
44 have again five close observation graded beds and we have
45 a seclusion room but we also have one of the lowest rates
46 of seclusion in the state, so perhaps I will answer the
47 question by way of that. We have one of the lowest

1 seclusion rates in the state, is my understanding, so the
2 acuity is lower.
3
4 Q. What about the comparative proportions of involuntary
5 versus voluntary patients? Is there much difference there?
6 A. No, much the same. Generally, overwhelmingly we are
7 providing care on an involuntary basis.
8
9 Q. How would your day-to-day activities as a registered
10 nurse in the Blue Mountains compare with Nepean?
11 A. Oh, not much different, really. The ward is divided
12 into two wings, as mentioned, close observations and acute.
13 The acute unit's quite large, lots of room to roam, we have
14 a table tennis table and an activities room. We have
15 a nurse, you know, when we're fully staffed, that's
16 providing activities, you know, running groups throughout
17 the day, be that a meditation group or, you know, an art
18 therapy session. There may be small excursions out, walks
19 around the grounds of the hospital, those sorts of things.
20 But the work is chiefly the same. We're providing
21 inpatient psychiatric care.
22
23 Q. Is it the same sort of shift structure for nursing?
24 A. It is.
25
26 Q. Are there occasions where you would be the only nurse
27 working in Blue Mountains?
28 A. No, most certainly not. We are staffed at a constant
29 level, which is five nurses on the morning shift, five on
30 the afternoon shift, and three at night, including a team
31 leader who doesn't carry a direct patient load, is a
32 so-called supernumerary, and a nurse unit manager during
33 business hours, Monday through Friday.
34
35 Q. Are there occasions when you'd have to move between
36 the ED and the mental health unit at Blue Mountains?
37 A. As a nurse working on the mental health unit, there
38 is. So during an admission, the - a person will need to be
39 escorted up to the ward and a nurse will make their way
40 down to the emergency department, along with security,
41 typically speaking, escorting that patient up to the ward
42 and settling them in.
43
44 There will also be the psych CL clinician who will be
45 making their way to and fro the ED typically multiple times
46 throughout their shift.
47

1 Q. Against that background, I'm going to ask you some
2 questions about what you say about duress alarms. Can you
3 just describe the circumstances in which, in your job as
4 a mental health nurse, you might need to activate a duress
5 alarm?
6 A. So as the name implies, it's a situation of duress.
7 It's where you've been bailed up in a room by someone. You
8 know, to paint a picture, you know, again, we have patients
9 that are admitted because of psychosis and you know, if you
10 are bailed up in a room with someone thinking that you're
11 an impostor or thinking that you're trying to kill them,
12 that's the kind of situation where your entry from that
13 room is blocked and you think you're at immediate risk of
14 harm, you're going to be activating that duress alarm.
15
16 When there is some sort of incident of aggression or
17 agitation, where you're needing the assistance of your
18 colleagues to deescalate or make that situation safe,
19 situations that may result in restraint, manual restraint
20 of a patient and their sedation and seclusion - those are
21 the kinds of situations that one is activating a duress
22 alarm and what may result.
23
24 Maybe also to answer, it may be pre-empting here but,
25 you know, a duress alarm will be activated in the course of
26 work perhaps every week or so. Again, we're not the most
27 acute ward, the demographics in the mountains are such that
28 on the spectrum, compared to Nepean, you know, it's a lower
29 acuity setting. At Nepean it's quite often, in the HDU,
30 seldom a shift would go past, dare I say, where you
31 wouldn't be activating the duress alarm. Again, these are
32 people that are unwell and are in a high dependency setting
33 because of disturbed behaviour which contrasts with the
34 Blue Mountains mental health unit somewhat.
35
36 Q. Starting with the Blue Mountains, you say every week
37 or so, is that for an individual nurse or across the whole
38 of the nursing --
39 A. Oh, across the whole of the shift, yeah.
40
41 Q. And similarly in Nepean, when you say every shift, on
42 average, that's across all nurses, not for one individual
43 nurse?
44 A. Yeah, most definitely.
45
46 Q. Starting with fixed duress alarms you haven't raised
47 any issues about those in your statement. Have you

1 experienced any issues with those?
2 A. No, and I would add that that's in context of them
3 being seldom used. As mentioned or in my description of
4 the ward, you know, we are milling about the place, it's
5 a big area, and to be observing patients, you know, moving
6 through the environment freely and carrying out their
7 business at will, you're likewise on foot moving around,
8 you're seldom in the office sitting with a duress alarm
9 under the table ready to be tapped.
10
11 Q. So where are the fixed duress alarms in the mental
12 health - in Nepean, starting with Nepean?
13 A. Yeah, I - it would be hard for me to describe their
14 location exactly, other than to say that they are located
15 under desks. There will be a push button, you know, sort
16 of fixed to the bottom of a desk, of a computer, you know,
17 workstation.
18
19 Q. Similar in Blue Mountains, I take it?
20 A. Yeah.
21
22 Q. In terms of the personal duress alarms, you have
23 referred to three different models in your statement.
24 There is an Ascom i62, used in the Nepean Mental Health
25 Centre; that's right?
26 A. Yeah. There are two Ascom models and an Airista.
27
28 Q. Can you just describe physically, if you can, what are
29 the differences between them? What do they look like?
30 A. Yeah. So the model that is used in the Blue Mountains
31 hospital, it's described by the manufacturer as a pager.
32 It's maybe fist sized, a bit thinner but this sort of
33 profile from the front, maybe a couple of fingers wide. It
34 can be worn in my top pocket, right?
35
36 It has three functions that can activate an alarm.
37 One of which is a man down function, so if the alarm is
38 tilted off of its axis it will alarm, after a pre-warning
39 alarm. There is a push button alarm, where the clinician
40 can activate the button on the top of the device, and also
41 a pull cord function, which is intended to prevent the
42 alarm from being removed from the user by force.
43
44 So if someone tries to strip the alarm out of my
45 pocket so that I can't hail for help - again, if I'm bailed
46 up in a room, let's say - by having the device clipped to
47 my pocket, in a separate location, when the main device is

1 removed by force, it pulls a magnetic - there's a mechanism
2 that pulls the - it releases the magnet, leaves the cord
3 strapped to me and, in doing so, activates the alarm.
4
5 Q. Just in your description earlier, you said something
6 like "it looks like this". You were holding up a fist; is
7 that right?
8 A. Yeah; that's correct.
9
10 THE COMMISSIONER: Q. So it's more like a small mobile
11 phone than a credit card, as someone else described a --
12 A. Yeah, so the Airista model, which is used in Nepean,
13 is the profile of a cassette or a card. Somewhat thicker
14 than a bank card - perhaps 10 of them piled high. A tape,
15 you know, an old tape, a cassette. That would be the
16 profile of those devices. They can be attached with
17 a metal clip, you know, to your pocket. They dangle off of
18 you along with your other ID and cards perhaps. They have
19 a small screen, again maybe the width of your pinky finger.
20
21 Speaking of the screen, coming back for a moment to
22 that palm-sized alarm that's used in the mental health unit
23 at the Blue Mountains, it does have a small screen, again,
24 perhaps a pinky finger's width, where it lists the handset
25 number and if an alarm is activated, it will list the
26 location of that activation, or if your own alarm is
27 activated, that a signal has been sent.
28
29 The final model referred to in my statement used at
30 Nepean in the mental health centre, these are, as
31 I understand it, the newest of the lot. They have the form
32 factor of a mobile, they look a lot like an old brick,
33 Nokia phone. They have a keypad, numerical keypad. They
34 can be clipped on to your pocket or on to your chest, they
35 can be clipped on to your belt. They have a man down
36 function, as described previously. They have a push button
37 function, likewise. No pull cord function but they do have
38 a very large colour screen that displays the handset
39 number, the local of alarms if they're activated, a message
40 to reveal that your alarm has been - you know, a message
41 has been sent from your alarm.
42
43 But most importantly, they have a function that allows
44 you to call other users, so using that numerical keypad,
45 you can call another handset. So if there was an alarm
46 activated and I can see that it's alarm number 13, I can
47 call alarm number 13, get them on the blower and hear

1 what's going on. You know, "Are you okay?" If there's no
2 answer, that's a good reason that while you're on foot to
3 that direction, to make your way quickly.
4
5 MR FULLER: Q. Just to be clear, there are two different
6 models used at Nepean, one in the ED and a different model
7 in the mental centre; is that right?
8 A. Correct.
9
10 Q. In Blue Mountains, do you know, is the same model used
11 across the whole hospital, including the mental health
12 unit?
13 A. It is.
14
15 Q. Have there been any changes to those systems since you
16 started working at each facility or have they been the
17 same?
18 A. They've been the same.
19
20 Q. In paragraph 9 of your statement, start with the Ascom
21 i62 in the mental health centre, which is the Nokia style
22 one that you've just described, you say that it does not
23 allow for mapping of duress alarm signals for anyone moving
24 around or across the hospital campus. Can you just
25 elaborate on what you mean by that?
26 A. Yeah. So the alarms are mapped to a network that
27 extends to the boundaries of the mental health centre.
28 A feature that I failed to mention was that this model of
29 alarm does alert the user, if they are leaving the gated
30 zone, it has an out of range alarm, okay so it will sound
31 every couple of minutes to let you know that you're out of
32 range, that if you do activate it, it won't go anywhere.
33
34 So if one does leave the mental health centre, making
35 their way to the emergency department, if you needed to
36 activate that alarm for any reason during that transit,
37 well, there's no-one that's going to hear you to know you
38 are in need of help.
39
40 Q. When you say it is mapped to a particular location,
41 you mean it only functions within that zone; is that right?
42 A. Correct.
43
44 Q. And so if you moved out of the mental health centre
45 and you attempted to activate it, would it notify anyone?
46 A. No.
47

1 Q. So it wouldn't notify the people back in the mental
2 health centre either?
3 A. No.
4
5 Q. And you have gone on in your statement to describe if
6 you go to the ED with that duress alarm, is it again a case
7 that it doesn't notify anyone at all?
8 A. Correct. It's no good to you.
9
10 Q. And so you say you have to pick up a new duress alarm
11 when you go in to the ED; is that right?
12 A. Correct.
13
14 Q. And conversely, if you go back to the mental health
15 centre, you would pick up the i62 again; is that right?
16 A. Correct.
17
18 Q. Tell me if you just don't know the answer to this, but
19 do you know if the systems in the ED and the mental health
20 centre are capable of communicating with each other or you
21 just don't know?
22 A. I don't know that. I suspect it is not the case.
23
24 Q. Why do you suspect that?
25 A. Completely different manufacturers. The alarms in the
26 mental health unit in the Blue Mountains and the Blue
27 Mountains emergency department are of the same type,
28 they're the Ascom - the pager style Ascom 71s and they're
29 not mapped to the same network. If you take your alarm
30 from the mental health unit in the Blue Mountains mental
31 health unit down to the emergency it's no good to you, and
32 I suspect that if even the same manufacturer, the same
33 model, doesn't work across two different gated zones, that
34 you're not going to have much luck with one manufacturer's
35 alarm working on the other.
36
37 Q. So just to be clear, you've got the same issue in the
38 Blue Mountains even though it's the same model; is that
39 right?
40 A. Correct.
41
42 Q. As far as you know, the only solution to that problem
43 is to pick up physically a different duress alarm when you
44 move between the locations?
45 A. That's correct. And my experience working in the TAC,
46 you know, having mentioned last shift down there in May of
47 2022, is that going to the emergency department to conduct

1 an assessment, I was instructed - I think this was my first
2 time going across to the ED, it's seldom that I worked
3 shifts in TAC - that I would need to pick up another alarm.
4 And so I had to make it known to the staff there that,
5 "Hey, how do I use this thing, and what do I need to know?"
6 For that reason again - I'm alerted to the fact that they
7 are not working one or the other; you have to pick up,
8 I was told, the other sort of alarm.
9
10 Q. Have you experienced any incidents as a result of this
11 issue, either at Nepean or at Blue Mountains?
12 A. I have not.
13
14 Q. Why do you think it's a problem?
15 A. The fact that I had to be alerted or that I had to
16 ask, rather, about the function of the alarm, it's
17 concerning to me that if I hadn't asked or hadn't been
18 told, that I wouldn't know otherwise; that it would also be
19 an easy enough thing to forget. I don't work in psych CL,
20 but up in the Blue Mountains, carrying the same alarm,
21 moving between the spaces multiple times a day, I could
22 imagine it being simple enough to forget that you're not
23 wearing one, or not wearing one of the, you know, correct
24 zoning, to find yourself in a situation where you are
25 needing to activate one, which, again, these things, these
26 incidents, happen seldom, you know, fortunately, but the
27 stakes are high and it concerns me that such a mistake
28 could be easily made and could really jeopardise someone.
29
30 Q. Do you find yourself having to travel urgently between
31 the mental health centre or unit and the ED?
32 A. Not urgently, no. In the mental health unit - or,
33 sorry, on the grounds of the Blue Mountains district
34 hospital, response teams are such that the mental health
35 unit, we're not leaving our post to tend to the ED, but
36 staff in the ED may have to make their way swiftly to the
37 mental health unit in the case of a code black, so there is
38 case for the need to make one's way quickly from the
39 emergency department to the mental health department, if
40 that level of assistance was needed in managing a personal
41 threat, which is what we term a code black.
42
43 Q. In circumstances where the duress alarms don't talk to
44 each other, as I understand it, how would a person in the
45 ED get a code black from someone in the mental health unit?
46 A. They would be alerted by the switch, and I believe an
47 internal pager system. I'm not sure what happens on the

1 back end, but to call a code black formally, it is required
2 to call the internal emergency, you know, line, 2222, and
3 tell the operator "Code black mental health", which is then
4 actioned by an operator to hail additional supports,
5 including security, medical officers from the emergency
6 department, to make their way up, and I believe an orderly,
7 to make their way up to the mental health unit. You get
8 people, is the picture I want to paint, you get lots of
9 people very quickly, which is a different process to just
10 activating the alarm, which will notify the personnel in
11 the mental health unit, and will also notify security, who
12 will make their way to the mental health unit, to respond
13 to the duress.
14
15 We also have a walkie-talkie in use that we can speak
16 with security. So if we're needing assistance but not
17 lights and sirens level of threat, we can radio security.
18 So typically, you've got a graded response, radio only,
19 duress only, duress and radio or duress and code black,
20 2222.
21
22 Q. And for a code black, you have to sort of manually
23 activate it through the 2222; is that right?
24 A. That's correct.
25
26 Q. You've referred in your statement to not having
27 received any formal education in the use of duress alarms
28 in the ED. Have you received any sort of training at all
29 about the use of duress alarms?
30 A. During orientation, I've certainly been shown how the
31 duress alarms work. I don't know how formal I would
32 describe any of these processes. There is a - there is
33 a procedure, a local procedure, that does describe duress
34 testing and activation. I don't know that I was, during
35 orientation, referred to this procedure or policy. I mean,
36 gosh, there's a lot of policy to read, starting in a place,
37 you're not going to know everything on your first day. But
38 I would have been given a show-through by one of my
39 colleagues on the - in the mental health unit.
40
41 Q. And this is a procedure that's annexed to your
42 statement; is that right?
43 A. Yeah. There are a number of procedures that describe
44 the use of duress alarms across the district. I think
45 there are about five current procedures, some of which
46 describe the use of the Airista models in other parts of
47 the hospital, and chiefly the ED.

1
2 Q. You have described some other differences in
3 functionality between the various duress alarm units.
4 I think we have covered some of them already. But
5 paragraph 19, you say that the i62 lacks the pull feature.
6 And you described that earlier. Have you experienced any
7 incidents as a result of not having a pull feature in the
8 i62?
9 A. I have not.
10
11 Q. Are you aware of any?
12 A. No, not directly.
13
14 Q. Paragraph 20, you say that the Airista and the a71
15 have no ability to contact the user remotely by the duress
16 alarm. Is that what you were talking about earlier about
17 being able to call between to two duress alarms?
18 A. That's correct. I'd also add mentioning the gating
19 earlier, yeah, that the Ascom a71 and the Airista used in
20 the ED do not have a gating function to my knowledge, so
21 one can leave the environment, have the alarm on them, not
22 be aware that it's no longer working; or, as is often the
23 case, end up with it in your car. And, you know, we
24 certainly, in the mental health unit, have a serial
25 offender in that regard that we know will bring in, you
26 know, half a dozen alarms from their car every month or so.
27 This is - it's common for these things to go missing and at
28 great expense and a gating feature is a way that we
29 actually prevent loss of alarms.
30
31 Q. And the gating feature is the feature you described
32 where it notifies you if you are out of range?
33 A. Out of bounds, yeah.
34
35 Q. Are you aware of any incidents arising from the lack
36 of remote contact feature that you describe in
37 paragraph 20?
38 A. I am not.
39
40 Q. We discussed earlier that you have worked in various
41 other districts throughout metropolitan Sydney. Have you
42 used the same or different models of duress alarms in those
43 districts?
44 A. All - I have used some others. There is another - at
45 Banks House, we had two of the pager-style alarms that we
46 use in the Blue Mountains, one of which was the same and
47 one of which lacked some of those features, for example,

1 lacking a screen altogether. So there was no way of
2 knowing when an alarm was activated somewhere in the
3 environment, as to where that alarm was activated. You had
4 to then make your way to a computer where a software -
5 a piece of software was running that would display a map of
6 where the alarm was activated, or just sort of use your
7 ears and eyes and see where the commotion was coming from,
8 in which case your duress alarm wasn't much use at all.
9
10 I've also used a device very similar, an Ascom device,
11 I believe, in use at the St George mental health unit,
12 a bit more burly than the one used in Nepean, but having a
13 numerical keypad and colour screen and the like, able to be
14 called.
15
16 Q. Have you experienced the gating or zoning issue with
17 other duress alarms you have used elsewhere - that is, the
18 issue where it doesn't activate if you go outside, for
19 example, a mental health centre?
20 A. The alarms at Banks House, I recall - I don't recall
21 having that feature. They are the same as the ones used in
22 the Blue Mountains. And I don't recall that ever being -
23 on my breaks I often go for a walk, it's what I do to clear
24 my head and get some steps in for the day and I can think
25 about walking the streets around Bankstown hospital and
26 I can't recall it buzzing, like the ones at Nepean do. The
27 ones at St George, I can't recall whether they have
28 a gating function.
29
30 Q. About how many different types of duress alarms would
31 you say you've used across metropolitan Sydney?
32 A. Five.
33
34 Q. And would you say all of them have some functions that
35 are different from each other?
36 A. Yes.
37
38 Q. The issues you've experienced with duress alarms that
39 you've raised in your statement, have you raised those with
40 anyone?
41 A. I have not - not formally, no.
42
43 Q. Do you have any involvement in procurement processes
44 for items such as duress alarms?
45 A. No, not substantively. I'm part of the - I'm a member
46 of a newly formed health and safety committee, and my
47 understanding is that a procurement process for duress

1 alarms would involve, in future, consultation with the
2 health and safety committee, so my hope is that if that
3 were to be the case, that I would have some involvement.
4
5 Q. What's your basis for that understanding?
6 A. That health and safety committees are consultative
7 bodies where workers can be involved in the process of
8 assessing risks, identifying mitigating means, and a duress
9 alarm system is exactly that, it's a means of mitigations
10 the risk to a clinician's personal safety when working in a
11 high-risk setting like a mental health unit.
12
13 Q. Who set up that committee?
14 A. So the health and safety committee in operation in the
15 Blue Mountains Mental Health Unit was at the initiative of
16 workers. We made, through - you know, the union branch
17 made the request in June of 2023. So last year.
18
19 Q. Does the committee have a member from the local health
20 district on it?
21 A. It does, yes.
22
23 Q. In paragraph 24 of your statement, you say that
24 consideration should be given to the centralised
25 procurement and/or approval by NSW Health of a particular
26 model of duress alarm, and so on. Why do you think that
27 centralised procurement and/or approval by NSW Health would
28 help to solve the problems you have identified?
29 A. In the ministry policy, "Protecting People and
30 Property", there are clearly outlined functions that ought
31 to be possessed by duress systems. It strikes me as,
32 therefore, only reasonable that we would avoid the issue of
33 procuring inappropriate systems by having those systems
34 identified centrally and not leaving it up to the
35 discretion of local health districts who may not be either
36 consulting with workers to understand the - you know, the
37 problems that the lack of those features present or have
38 parameters that would otherwise prohibit them from
39 procuring inappropriate devices.
40
41 It also - having some consistency between facilities
42 would make sense insofar as you have workers moving between
43 facilities, doing casual or overtime shifts in other wards
44 or other districts, where having that familiarity with the
45 alarms would improve safety. Also, hopefully, avoiding any
46 issues, yeah, within a facility, clinicians moving between
47 wards and having a device on them that isn't operable in

1 another wing, another ward.
2
3 THE COMMISSIONER: Mr Fuller, I was reminded at lunch that
4 I should be giving the people in control of the transcript
5 a short break, even during this period, so I'm going to do
6 that now.
7
8 Q. Just before we do, though, can I just ask you a quick
9 question before we have a break about paragraph 21 of your
10 statement, where, having described what you see as gaps in
11 relation to the duress alarms you've mentioned in the
12 earlier part of your statement, you say:
13
14 *... I suspect either appropriate*
15 *consultation with workers did not occur, or*
16 *feedback provided at the time of*
17 *procurement was disregarded.*
18
19 Your suspicion there, is that - dealing with each aspect of
20 that, is it based on something you have been told by other
21 people, that there wasn't consultation with workers, or
22 that there was feedback provided and it didn't seem to be -
23 no-one seemed to have regard to it?
24 A. My impression there is - I've gained that impression
25 for a number of reasons.
26
27 Q. Yes?
28 A. One of which is, yes, I've certainly been privy to
29 many a conversation about, you know, "These [insert
30 expletive] things". At the time of my onboarding with
31 Nepean, the facility had just moved, you know, into a new
32 building, the alarms had been newly acquired and therefore
33 workers were quickly discovering the problems with them.
34 So I was privy to lots of those sorts of conversations that
35 gave me reason to think that there was a failure to
36 actually consult with workers. I have also seen or been
37 witness to a culture of disregard for consultation with
38 workers and its value.
39
40 Q. Disregard by whom?
41 A. By the local health district. So the health and
42 safety committee that I am a member of and have been
43 involved in convening took seven months to get there - to
44 the day, it took seven months from the time that workers
45 made the request to when that committee met. This,
46 I think, demonstrates a clear disregard for the
47 obligations --

1
2 Q. What was the cause of such a long period of time to
3 get that committee up?
4 A. I haven't been provided with any good reason for it.
5 And I think this demonstrates a culture that doesn't
6 actually value the input of workers. Workers know the
7 squeaky floorboards. We spend, you know, so many hours in
8 this place. We know the ins and outs of these things, and
9 I think we have something that we can really meaningfully
10 contribute. But that hasn't been valued, I think, the way
11 that it should.
12
13 Q. Just on your suspicion, then, regarding feedback
14 provided at the time, has someone told you that there was
15 a discussion between workers and the LHD about these
16 particular alarms before they were acquired?
17 A. I've done my best to follow the chain back through,
18 you know, union minutes and the like. I can't seem to
19 find - and asking around on the grapevine. I can't seem to
20 find any evidence that there was consultation.
21
22 THE COMMISSIONER: Okay, all right. I might leave that
23 there and you can pick it up later, but I'll give the break
24 now. So we will break until 3.20.
25
26 **SHORT ADJOURNMENT**
27
28 THE COMMISSIONER: Yes, Mr Fuller, you go.
29
30 MR FULLER: Thank you, Commissioner.
31
32 Q. Mr Tribbia, earlier, just before the break, you
33 mentioned the "Protecting People and Property" manual. Are
34 you familiar with what that manual has to say about duress
35 alarms?
36 A. I am.
37
38 Q. Very familiar or not very?
39 A. I couldn't recite it.
40
41 Q. You have used five different duress alarms in the
42 various districts you've worked in. Based on your
43 knowledge of the manual, would you say that any of them
44 fully meets the requirements of the manual?
45 A. No.
46
47 Q. Why do you say that?

1 A. I can tell you - if I recall correctly, it specifies
2 the requirement for the duress alarm to be used across the,
3 you know, the breadth of the facility. I think it even
4 specifies car parks, as an example of the kinds of places
5 that the duress system should be mapped to include. So no,
6 I haven't used an alarm system that is mapped as such, that
7 allows for the user to carry that alarm anywhere across the
8 campus.
9
10 Q. So you have experienced with each of the systems
11 you've used them not being able to work outside
12 a particular zone that you might be working in; is that
13 right?
14 A. Yeah. I don't know that I've tested, for example, the
15 alarms in St George. I have not carried them through the
16 hospital and activated them there, but I'm not aware of
17 a system that has that, you know, that breadth of
18 capability.
19
20 Q. Before the break we were talking about your suggestion
21 of having centralised procurement and/or approval by
22 NSW Health. Obviously we've discussed in Blue Mountains,
23 you've got the same model of duress alarm that still
24 doesn't work between two different locations. So it sounds
25 like centralised in the sense of standardised procurement
26 wouldn't resolve that issue; would that be right?
27 A. No, I don't imagine it would resolve that issue.
28
29 Q. Is the point that, in your view, there needs to be
30 appropriate oversight to make sure there are functional
31 duress alarm systems that, among other things, meet the
32 requirements of the "Protecting People and Property"
33 manual?
34 A. Yes.
35
36 Q. In paragraph 27 of your statement, you just raise two
37 other procurement issues. Can I just ask you to elaborate
38 on each of them. The first one, you say a concern was
39 raised by staff about approval to purchase a particular
40 kind of lightweight furnishing - can you just explain what
41 the issue is there?
42 A. I mean this is sort of adjacent to the matter of
43 duress alarms but it is, I think, an example of procurement
44 where the failure to adequately consult with workers has
45 resulted in the wastage of health care funding or, you
46 know, inappropriate spending.
47

1 The example of a very recent - I mean, just the other
2 week, not more than two weeks ago - a sit/stand desk mount
3 for a computer in the Blue Mountains Mental Health Unit,
4 there wasn't any consultation around this; it was not fit
5 for purpose; it was rickety and not secure. It was
6 initially fixed to a wall but made the wall deform when
7 workers put their hands on the keyboard. This was - yeah,
8 it blocked access to drawers where syringes and needles
9 were kept. You know, this is something that in a mental
10 health unit, if you need to be giving someone an injection
11 of sedative medication, you need those to be readily
12 accessible and very quickly.
13
14 This was - yeah, inappropriate, and if there had been
15 consultation with these workers I think these issues would
16 not have eventuated. It surely wouldn't have been
17 installed as well or it would have been quickly - you know,
18 upon realisation of what the thing was, been removed.
19 I think this is an example of the kind of failure to
20 consult with workers and the consequences of that that have
21 resulted in wastage of, you know, healthcare dollars.
22
23 Likewise, these lightweight furnishings that
24 I mention, the fact that there has been a culture where you
25 can say off the cuff, "Just buy them" - I was told
26 something to the effect that these were the words uttered -
27 without any consultation with a health and safety committee
28 that had been newly convened, I think is really
29 demonstrative of the culture.
30
31 Q. What are the furnishings you're talking about here?
32 A. So, you know, working in a mental health unit,
33 obviously there are environmental modifications that need
34 to happen to make the place safe. You know, the door
35 handles that we use in this building, you would not see in
36 a mental health unit, right? They are ligature points, you
37 know, a person can suspend themselves from that, you know,
38 tearing a bedsheet into strips, for example. The handles
39 may be downward facing or rounded in some way to prevent
40 them from supporting weight, or hooks on the back of doors
41 be hinged - those sorts of things are what we are talking
42 about, you know, taps being push-button as opposed to
43 having nice arms on them.
44
45 Likewise, furnishings in the ward, in the close
46 observations unit, that close observations wing, rather, we
47 have weighted furniture, which has, you know, rounded edges

1 and no easy points to pick them up from, right? They are
2 Rhino branded chairs. They are safer than an alternative,
3 the kind that we might, you know, sit on here in this room,
4 that can be easily picked up and used as missiles.
5
6 There was a suggestion that unweighted Rhino chairs
7 could be used in the open wing of the ward or a soft sort
8 that are akin to - there's no structure in them other than
9 a foam skeleton, as I understand it, and they're otherwise
10 stuffed with cotton or the like, they're sort of squishy -
11 sort of. They're not a beanbag but they're a little bit
12 less than a chair.
13
14 Again they pose a risk - not by virtue of them being
15 so heavy you can't pick them up but so light that they
16 wouldn't be able to bowl you over. So there was
17 a suggestion, "Just buy them", rather than have any genuine
18 consultation with workers about what is the risk posed and
19 the appropriate management. Again we're talking about two
20 very different solutions at getting at the problem: one is
21 lightweight and soft and the other is heavy.
22
23 Q. So am I right in thinking the problem isn't so much
24 whether these furnishings were, in fact, fit for purpose
25 but in your view a lack of consultation about whether or
26 not they would be?
27 A. There is a concern about whether they would be fit for
28 purpose.
29
30 THE COMMISSIONER: I thought it was both.
31
32 Q. I understood you to be saying there is a form of
33 safety risk in relation to what has been purchased as well.
34 Was I wrong to --
35 A. I would say that is the case. Again, when you're
36 having the same chair, one light and one heavy, the light
37 chair can be thrown. In fact, it's thrown more easily than
38 the existing chairs. I would have concerns about that
39 being used, or being, you know, purchased and implemented.
40
41 The soft type are quite large, they're much too big
42 for the living area that we have. They wouldn't fit under
43 the tables or - you wouldn't be able to move through the
44 environment freely. These are the kinds of things that
45 again, unless you consult with workers who can, you know,
46 tell you that it won't do, you don't know, and you end up
47 spending a lot of money to procure, like, a sit/stand

1 computer desk mount that wasn't fit for purpose at all.
2
3 Q. When you're using the term "senior management" in
4 paragraph 27 of your statement, can I just get an
5 understanding of how senior we're talking about? We're not
6 talking, obviously - I wouldn't have thought - chief
7 executive level; the senior management is, you mean - what
8 do you mean by "senior management"?
9 A. Director of nursing.
10
11 MR FULLER: Q. And were those lightweight furnishings
12 ultimately purchased?
13 A. No.
14
15 Q. Why not?
16 A. We - I don't know the reason - the remark was made, so
17 I've been told, off the cuff, that "Just buy them", to the
18 effect, "Just buy them". That hasn't eventuated. I don't
19 know why. But I have insisted since that there be adequate
20 consultation.
21
22 Q. Who did you insist on that to?
23 A. I have written to my nurse unit manager about it.
24 There has been a display model brought to the ward for us
25 to inspect. That's where we are at currently. We have
26 a meeting with the committee tomorrow.
27
28 Q. And writing to the nurse unit manager, is that on your
29 own behalf or on behalf of the health and safety committee?
30 A. Writing as a member of the health and safety
31 committee.
32
33 MR FULLER: Those are my questions, thank you,
34 Commissioner.
35
36 THE COMMISSIONER: Thank you. Mr Dawson?
37
38 MR DAWSON: No, thank you.
39
40 THE COMMISSIONER: Mr Gyles?
41
42 MR GYLES: No, thank you, Commissioner.
43
44 THE COMMISSIONER: Thank you. Thank you very much for
45 your time, sir. It's greatly appreciated. You are free to
46 go.
47

1 **<THE WITNESS WITHDREW**
2
3 MR FULLER: Commissioner, the last witness is Nicholas
4 Howson. Before I call him, there is just a matter of
5 housekeeping of two additional documents that I need to
6 tender, I'm told today. They are not in the existing
7 tender bundle.
8
9 THE COMMISSIONER: Do you want me to go off for five
10 minutes?
11
12 MR FULLER: I think you will have a copy.
13
14 THE COMMISSIONER: Oh, I see, okay. All right, okay.
15
16 MR FULLER: The first document --
17
18 THE COMMISSIONER: I can cope, yes.
19
20 MR FULLER: Thank you. The first document is
21 a "Protecting People and Property" manual, which I think --
22
23 THE COMMISSIONER: What document is that in this? I think
24 I've seen it separately, but, oh, that's 53. Yes, got it.
25 I have that.
26
27 MR FULLER: Thank you, Commissioner.
28
29 THE COMMISSIONER: Is the other one "Improvements to
30 security in hospitals", Mr Anderson's report?
31
32 MR FULLER: That's right, Commissioner.
33
34 THE COMMISSIONER: I have got them both.
35
36 MR FULLER: I tender them both.
37
38 THE COMMISSIONER: You are tendering those?
39
40 MR FULLER: Yes, I tender them, thank you.
41
42 THE COMMISSIONER: They can just go in with the letter and
43 number allocated to them.
44
45 MR FULLER: They are included in the correct order,
46 I understand.
47

1 I call Nicholas Howson - that's H-O-W-S-O-N.
2
3 **<NICHOLAS MORRIS HOWSON**, **affirmed**: **[3.33pm]**
4
5 THE COMMISSIONER: Just have a seat, sir. Mr Fuller will
6 ask you some questions, just listen carefully and answer
7 those.
8
9 **<EXAMINATION BY MR FULLER**:
10
11 MR FULLER: Q. Mr Howson, can you state your full name,
12 please?
13 A. My name is Nicholas Morris Howson.
14
15 Q. And that's M-O-R-R-I-S?
16 A. Correct.
17
18 Q. What's your occupation?
19 A. I'm a registered nurse working in Western Sydney Local
20 Health District in the mental health services.
21
22 Q. You have made a statement to assist the Commission?
23 A. I have.
24
25 Q. I think you have it in the folder in front of you.
26 Can you just have a quick look at that, please. That's
27 a statement, the first tab should be a statement --
28 A. Mmm-hmm.
29
30 Q. -- dated 13 February 2024. Just double-check that.
31 A. My statement is 16/2/2024.
32
33 Q. Thank you, that's my mistake. It's got 40 paragraphs;
34 is that right?
35 A. Correct.
36
37 Q. You have a number of annexures in that folder there?
38 A. Correct.
39
40 Q. Have you had the opportunity to look at that statement
41 recently?
42 A. Yeah, when I signed it on the 16th.
43
44 Q. Is it true and correct to the best of your knowledge
45 and belief?
46 A. It is.
47

1 Q. You were first registered as a registered nurse in
2 2018; is that right?
3 A. Correct.
4
5 Q. And you hold a Bachelor of Nursing from Western Sydney
6 University. Do you hold any other nursing qualifications?
7 A. I currently hold a certificate, a Postgraduate
8 Certificate in Mental Health Nursing and I'm undergoing
9 further studies in a Masters of Mental Health Nursing.
10
11 Q. You are undertaking that at the moment; is that right?
12 A. Correct.
13
14 Q. You have worked in the Western Sydney Local Health
15 District since September 2016; is that right?
16 A. Yes.
17
18 Q. What's your current position?
19 A. I currently work at one of the acute wards at
20 Cumberland Hospital as a registered nurse.
21
22 Q. As a registered nurse, is the title of your position;
23 is that right?
24 A. Yes.
25
26 Q. Can you just describe what your role involves on
27 a day-to-day basis?
28 A. The role in the acute wards on a day-to-day basis is
29 providing care to the inpatients at the ward at the time.
30 That can be anywhere from running errands as a barista, all
31 the way up to complex mental state examinations as well as
32 administering medication when required.
33
34 Q. Since you became a registered nurse, have you worked
35 exclusively in the mental health nursing?
36 A. I have, in a variety of roles within there and also on
37 secondments to other agencies.
38
39 Q. Can you just summarise the other roles that you have
40 had?
41 A. Yeah, sure. So within Western Sydney mental health
42 services, for a period of about a year I worked as the
43 clinical nurse consultant for the acute mental health
44 service, covering all the acute wards at Cumberland and
45 Westmead campuses of the district.
46
47 Q. Is your current position at the Cumberland Hospital or

1 in Westmead Hospital?
2 A. My current position is at the Cumberland Hospital and
3 I'm also going back into a higher-grade duties role
4 starting Friday at Westmead Hospital and I periodically
5 work in the emergency department of Westmead Hospital as
6 the mental health CNC on call for all presentations.
7
8 Q. How often do you that?
9 A. Whenever it's required. It's more of an overtime role
10 for me. I've been assessed to be able to work at that
11 level, so when there's a shortfall there I quite often get
12 called in to do an overtime shift or get pulled from my
13 regular duties to cover an absence, because it's an
14 important entry point.
15
16 Q. Would there be occasions where you move between
17 Cumberland Hospital and Westmead, for example, the ED on
18 one shift?
19 A. Yeah, when I actually - actually one time earlier in
20 my career I actually moved from Westmead to Blacktown to
21 Mount Druitt all in one shift.
22
23 Q. Can you describe the sorts of occasions where that
24 might happen?
25 A. Generally with staffing issues, someone calls in sick,
26 doesn't make it, there's a higher acuity patient that has
27 been admitted somewhere else and they just have to
28 internally shuffle you between locations.
29
30 Q. Would there be occasions where your actual work, for
31 example, with a patient at Cumberland Hospital requires you
32 to move to the ED?
33 A. Yes, there would be. Anybody who requires a higher
34 level of physical care that we are unable to provide in a
35 mental health unit - we don't have heart monitors, oxygen,
36 IV facilities or anything else - they all go through
37 Westmead ED for assessment and then, if required, return or
38 go up to a ward for further treatment.
39
40 Q. And how regularly would something like that happen?
41 A. It's regular enough, I'd say probably once a fortnight
42 there's somebody requiring some level of treatment. We
43 also quite regularly escort people who are under the Mental
44 Health Act or voluntary patients as well, to dental
45 appointments at the Westmead Centre for Oral Health or over
46 to a private imaging facility for MRIs and other things
47 that we need, or x-rays.

1
2 Q. Just focusing on your personal experience, how often
3 would you say you would have to leave Cumberland Hospital
4 for any purpose on a given shift?
5 A. As an individual, it's probably once a month, but it's
6 at least a weekly occurrence that there's some sort of
7 external appointment for the ward staff to attend to.
8
9 Q. And Cumberland Hospital is a separate building from
10 the Westmead Hospital; is that right?
11 A. Yeah, so it's just down the road from Westmead
12 Hospital. It is a stand-alone psychiatric facility that
13 doesn't provide any emergency services for medical
14 treatment. It is quite an old facility. I think it's the
15 oldest continuously functioning psychiatric facility in the
16 country at this point.
17
18 Q. And it's sort of across the road from Westmead
19 Hospital; is that right?
20 A. Yeah, so you've got Westmead, then Westmead Children's
21 then Cumberland Hospital all in a line.
22
23 Q. Do you know how many beds there are in Cumberland
24 Hospital?
25 A. I think there's approximately 160 beds in total, but
26 we also cover - community mental health services are all
27 generally run and managed from Cumberland Hospital's
28 grounds.
29
30 Q. What proportion of the 160 beds would normally be
31 occupied?
32 A. I'd say occupancy is well above 90 per cent most of
33 the time.
34
35 Q. And can you give the Commission a sense of the patient
36 demographic who would be in Cumberland Hospital at a given
37 time?
38 A. Most of the patients in Cumberland Hospital are there
39 for an involuntary treatment order of some description, or
40 a few voluntary patients as well. We also have forensic
41 patients that occupy the Bunya unit as a step down from the
42 forensic hospital; as well as a lower acuity ward called
43 Willow, which is more of another transition out to
44 community living for forensic patients.
45
46 There's also units at Westmead Hospital as well which
47 provide mental health care to involuntarily admitted

1 people, most often than not, but who also have some sort of
2 co-occurring physical health concern, but the reason they
3 are in hospital is because of their mental illness, but
4 they also require physical care on top of that -people with
5 anorexia or other conditions like that, that whilst they
6 are primarily admitted for a mental illness, they also
7 require physical treatment to go along with that.
8
9 Q. Are these the C4A and C4B units that you refer to in
10 your statement?
11 A. So C4A and C4B are both located C block, level 4,
12 wards A and B in Westmead Hospital. C4A is predominantly
13 medical mental health, as I said, that's where you get
14 a lot of eating disorders and other illnesses, and C4B is
15 what we call psycho-geriatrics or older persons' mental
16 health.
17
18 Q. We've talked about moving between Cumberland Hospital
19 and the ED, would there be occasions on a given shift where
20 you have to move between Cumberland Hospital and those two
21 wards?
22 A. Yeah, we quite often do transfers from the acute wards
23 at Cumberland Hospital up to C4A or C4B. Occasionally if
24 people present to the assessment centre at Cumberland
25 Hospital, they may be assessed as needing a C4A or a C4B
26 bed and then they are transferred from there to Westmead.
27
28 Q. And if you are a nurse working in Cumberland Hospital
29 you might have to accompany the patient; is that right?
30 A. Yeah. We quite often accompany patients not only
31 between intra-campuses things but also across districts,
32 sometimes internationally as well.
33
34 Q. You have done shifts in the Westmead ED?
35 A. Yes.
36
37 Q. Have you done shifts in the C4A and C4B as well?
38 A. I have. Not very many but I have done some shifts
39 there.
40
41 Q. Just focusing on Cumberland Hospital, what's the shift
42 structure for nursing there?
43 A. We work on an eight-hour, eight-hour and 10-hour, for
44 AM, PM and night.
45
46 Q. So morning shift, afternoon shift, night shift?
47 A. Yes, morning, afternoon, then night.

1
2 Q. And approximately how many nurses would there be on
3 each shift?
4 A. It depends on the ward that you're in. The amount of
5 nurses you get on a ward is generally based off the acuity
6 plus the amount of beds on the ward. The acute unit where
7 I work, it's a 34-bed unit, we predominantly have 11 staff
8 on in the morning, 10 to 11; eight in the afternoon and
9 four at night. The weekend is slightly less, with eight,
10 eight, four, for AM, PM and night respectively.
11
12 Q. Would there be occasions where you would be the only
13 nurse working in a particular area of the hospital or not?
14 A. Ideally, no. You should never be working in
15 isolation. You should also always have someone with you or
16 at least, at a very minimum, someone knows where you're
17 going.
18
19 The acute wards at Cumberland Hospital are almost
20 large, stand-alone hospitals by themselves, they have
21 a number of rooms, a number of treatment rooms, their own
22 kitchen and dining, their own courtyard and their own
23 ancillary rooms for other staff, so there's quite a lot of
24 people around and they are quite physically quite large.
25
26 Q. You said ideally not working by yourself?
27 A. Yes, ideally.
28
29 Q. Have there been occasions that either you have
30 experienced or your - firstly, have you experienced
31 occasions where you have been working alone in a particular
32 area in the hospital?
33 A. Yeah, they're generally for short stints, you know,
34 a patient comes up and says, "Could I have a new
35 pillowcase?" So you go off with a patient and get a new
36 pillowcase and help them make their bed or whatever. But
37 generally they will have come to find you in a common area,
38 the lounge room, out on the verandah or the courtyard or
39 knocked on the door to the nurses station to get your
40 attention, so someone will generally know that you've gone
41 with person, patient X, to do whatever you've been asked to
42 do.
43
44 Q. And the ideal practice would be that there are always
45 at least two people --
46 A. Ideally there should be two people there at all times
47 but you make that risk assessment at the time. As a nurse,

1 we get very good at doing on-the-fly risk assessments. We
2 know our consumers very well after a period of time.
3 There's plenty of people with no history who would be
4 absolutely no problem and they'd pose no risk to anyone,
5 you wouldn't think twice about walking with them, but there
6 are other people you would consider, "Yeah, of course I'll
7 help you, but give me a moment and I'll grab somebody else
8 and we'll go down there." That most commonly occurs for me
9 if I'm dealing with a female consumer, just the sexual
10 safety point of view.
11
12 Q. Have you worked at Blacktown Hospital at all?
13 A. I have. In their mental health units, though, not in
14 Blacktown Hospital itself but in the mental health units on
15 the Blacktown Hospital grounds.
16
17 Q. I think in some of the annexures to your statement,
18 you've described a - or there's a B22 acute inpatient --
19 A. Correct.
20
21 Q. -- ward referred to; is that in the hospital or in --
22 A. It's now in the hospital. It used to be a stand-alone
23 building on the hospital grounds known as Bungarribee
24 House.
25
26 Q. I see. So Bungarribee - that's B-U-N-G-A-R-R-I-B-E-E
27 House?
28 A. I believe that's the spelling, yes.
29
30 Q. I'm just trying to help others - and B22 are the same
31 thing; is that right?
32 A. Yeah, so they moved - the B22 ward is Bungarribee
33 House and they moved into Blacktown Hospital during part of
34 their remodelling in early 2022, funnily enough on February
35 22, 2022.
36
37 Q. How often have you worked there?
38 A. I worked a number of shifts in Bungarribee House as
39 a deployed nurse; I have yet to work a shift in the B22
40 unit since they moved.
41
42 Q. And when would you last have worked in Bungarribee
43 House?
44 A. It would have been in my very early days of
45 registration, maybe 2017/18.
46
47 Q. You talked in your statement about issues with duress

1 alarms. Just focusing on your own personal experiences,
2 why do you think it's important to have functioning duress
3 alarms in your areas of work?
4 A. As I mentioned before, occasionally you do end up by
5 yourself. Those alarms do give you a certain - well, aim
6 to give you a certain feeling of safety that if you
7 activate them, help will come, for whatever reason.
8 They're not primarily - they are primarily duress alarms
9 but they also have that bonus feature of being able to call
10 people. You could walk into a room and find someone
11 unresponsive, and being a mental health unit, we don't have
12 call buttons on the wall, there's no button to press to
13 summon staff, the only way you can summon staff is a duress
14 alarm or a radio, which we also use on Cumberland campus,
15 but they are limited in number; or yelling.
16
17 Q. You've talked about occasions when you work alone.
18 Are there occasions, though, when you're not working alone
19 where it's still important to have a duress alarm in your
20 experience?
21 A. It' important to have one at all times.
22
23 Q. Why is that?
24 A. Mental health consumers are unpredictable. There'
25 a common misconception that they are more violent than the
26 average person but they aren't, they just are
27 unpredictable. Violence can come for any reason. It may
28 instrumental to get something, it may be because they're in
29 the grips of a psychosis and they believe you to be
30 somebody else, but violence does occur and we need to be
31 protected from that, to provide effective care.
32
33 Q. Are there occasions other than facing a violent or
34 aggressive patient where you might need to use a duress
35 alarm?
36 A. Yeah, as I mentioned, in case someone has a medical
37 episode and you want to go and render aid immediately, you
38 would hopefully activate your alarm and then people could
39 come to provide help or to go and retrieve additional
40 resources.
41
42 Q. You said there are no call buttons in the mental
43 health facilities.
44 A. No.
45
46 Q. Are there fixed duress alarms?
47 A. There are in the older parts of Cumberland Hospital.

1 I don't believe all of them are still working as they
2 should be, because of the replacement to the more - the
3 recent two or three years ago installation of the Airista
4 flow personal duress tags that we use there.
5
6 Q. I take from that answer you wouldn't generally be
7 relying on fixed duress alarms in your area of work?
8 A. No, and because the facilities were older, they more -
9 were more of a localised response that had originally been
10 installed by hospital electricians and other things, that
11 simply lit up a light in the nurses station with a label
12 beside a location saying "Duress here." They're no longer
13 in use.
14
15 Q. Do you know whether any of the fixed duress alarms are
16 still in use?
17 A. Not for the functionality of summoning assistance at
18 Cumberland specifically.
19
20 Q. As far as you know, what they do is light up a light
21 in the nurses station?
22 A. The most common use in the ward that I work in is when
23 someone accidentally gets locked behind one of the dividing
24 doors and the patients know they can whack the red button
25 and a little alarm will go off and someone can come and
26 open the door for them.
27
28 Q. You then mentioned the Airista system. That's
29 a personal duress alarm; is that right?
30 A. Yeah, it's a little white approximately credit card
31 sized alarm that you wear affixed to your chest. I believe
32 there's an image in the evidence I submitted of a number of
33 them.
34
35 Q. I might just ask the operator to show that image.
36 A. Sure.
37
38 Q. It is [SCI.0003.0007.0001] which is annexure A to
39 Mr Howson's statement.
40 A. That's the one.
41
42 Q. So that's the Airista that you're referring to?
43 A. Correct.
44
45 Q. Can I just ask you to describe some features of it.
46 So we see in the bottom of the photo there's a clip?
47 A. There is a clip, yes.

1
2 Q. Where does that attach to normally?
3 A. So pretty much all of our health uniforms have a
4 little lapel thing for badges, pens and other things to be
5 hooked on. That's the common place that you're supposed to
6 wear them, because that allows the upright functionality
7 because they're supposed to have a man down functionality
8 when they're flat.
9
10 Q. Do these alarms have a pull feature - do you know what
11 I mean by that?
12 A. They do. It is obscured by the thumb in that photo,
13 but where the clip connects there's a little tag that when
14 pulled, it activates the pull cord functionality of the
15 alarm.
16
17 Q. Can you just describe how that functionality works, to
18 your understanding?
19 A. So there are three ways those alarms can be triggered.
20 They're the man down, the pull cord or pressing of the red
21 or the blue button for, I think, three to five seconds.
22 Then they all send an alarm regardless of which way it was
23 triggered, and - it's supposed to say on the screen what
24 type of alarm, the unit that has sent it and where it is.
25
26 Q. It looks like there are three buttons that we see in
27 this image. Can you just describe what each of those does?
28 A. The black - or grey, my apologies, the grey hamburger
29 menu, for lack of a better description, opens the menu,
30 allows you to see the previous four alarms or messages
31 received by the device. The red and the blue arrow also
32 function as navigation buttons when you're in that menu,
33 and the blue button also functions as a self-test on the
34 alarm.
35
36 Q. The blue button is the one you have your thumb over?
37 A. Yeah, there's the thumb over that button there
38 unfortunately.
39
40 Q. And either that button or the red arrow button, you
41 can hold for five seconds, to trigger the alarm; is that
42 right?
43 A. Yes, that's my understanding.
44
45 Q. It looks like you're holding that alarm horizontally?
46 A. It's more - that's vertical as if you're, like,
47 holding a phone.

1
2 Q. So this isn't a situation where you would have
3 expected the man down alarm to trigger?
4 A. No, it would not have gone off there, no.
5
6 Q. You have described various events in your statement?
7 A. Mmm-hmm.
8
9 Q. And you have given some annexures. I just want to
10 take you through those, but I'm going to try to do it
11 chronologically, if I can?
12 A. Sure, no problem.
13
14 Q. So I'm going to jump around the annexures a little
15 bit. The Airista alarm you have said, to your knowledge,
16 was rolled out in late 2020; is that right?
17 A. It was a staged rollout. I believe the first area to
18 get them in Western Sydney was then - the then Bungarribee
19 House, and that would have been at some time in the first
20 half of 2021.
21
22 Q. When did you start using the Airista, to the best of
23 your recollection?
24 A. That would have been early 2022, late 2021, around
25 then.
26
27 Q. And that was at Cumberland, was it?
28 A. Yeah, that was on the Cumberland campus at Westmead.
29
30 Q. So you don't have any personal experience of using it
31 before late 2021, early 2022; is that right?
32 A. I do not.
33
34 Q. You wouldn't have used it - you don't recall using it
35 on any shift that you might have worked in Bungarribee
36 House?
37 A. No, those alarms were not in use when I worked in
38 Bungarribee House. We had an older style.
39
40 Q. Just thinking about when you first started using the
41 alarms, late 2021, early 2022, do you recall experiencing
42 issues with them at that time?
43 A. At that time, yes. When we had our first
44 demonstration of them and they asked us to run through the
45 features and trigger them, they were reporting the wrong
46 locations or sometimes not working at all.
47

1 Q. Who is "they" that you are referring to?
2 A. We were receiving training from I think
3 a representative of the company, as well as some educators
4 from the hospital.
5
6 Q. I will just go back in time, because you have included
7 some annexures from earlier in time. As a general
8 proposition, it sounds like you can't talk to the specific
9 events that are referred to in those annexures; is that
10 right?
11 A. I can't speak to them directly as if I experienced
12 them, but in my role as the branch president for the
13 Cumberland Hospital branch of the NSW Nurses and Midwives'
14 Association, a lot of these issues come to me from members,
15 and also from the Blacktown city mental health branch. We
16 work quite closely together because we have the same
17 management structure, as the mental health service in
18 Western Sydney is a district-wide service, so we have the
19 same management structure, the same managers, the same
20 director of nursing and so on, and we work quite closely on
21 these sorts of issues, because, as I said, we do move
22 between these units. It's not uncommon for people to be
23 deployed from the Blacktown mental health service to
24 Cumberland and vice versa for a shift to cover deficiencies
25 or to escort patients between locations.
26
27 Q. I think the first event you refer to after the rollout
28 is in paragraph 18 of your statement, which is 17 February
29 2021.
30 A. Mmm-hmm.
31
32 Q. You refer to a staff consultative committee. Do you
33 know what - were you a member of that committee?
34 A. I believe I was at the time. I don't recall this
35 particular meeting, but I did have the minutes in my email.
36
37 Q. You do have the minutes?
38 A. Yes.
39
40 Q. Is that something that you could provide to the
41 Commission?
42 A. I actually thought it was in the annexures. I will
43 have to double-check but I'm pretty sure I did attach it at
44 some point.
45
46 Q. If not --
47 A. Of course, absolutely.

1
2 Q. -- I might ask.
3 A. Yeah.
4
5 Q. Do you think you might be able to provide that
6 overnight?
7 A. I will do my best. I do not know if I will be able to
8 pick it up being offsite, as quite often our email archive
9 is inaccessible from home. I may have to attend the
10 hospital.
11
12 Q. I won't ask you to attend the hospital but if you are
13 able to access it, if you can provide it overnight?
14 A. Sure, I will have a look.
15
16 Q. Thank you. Can I just ask you just briefly about
17 a couple of the issues you've referred to here. Firstly,
18 you referred to the Anderson report, the 2020 final report
19 into improvements to security in hospitals.
20 A. Correct.
21
22 Q. Have you seen - have you read or looked at that
23 document?
24 A. I have not read the entire document myself, but I have
25 used search functions on the PDF to find relevant things in
26 regards to duress alarms, security and other safety things,
27 depending on - violence in hospitals generally is the main
28 topic we use it to refer to.
29
30 Q. So you have referred to this document as part of your
31 work; is that right?
32 A. It is not necessarily part of my work, it's more part
33 of my role within the NSW Nurses and Midwives' Association
34 as a union representative, as someone interested in work
35 health and safety, and being an HSR as well - a health and
36 safety representative.
37
38 Q. I understand. You have then referred to a lack of
39 duress alarms in the admissions area. Do you recall what
40 that issue was about?
41 A. They didn't have their own supply for a little while;
42 they had to get them from elsewhere. I believe that has
43 since been rectified and they have their own duress alarms
44 now.
45
46 Q. When you say "they", that's people working in the
47 admissions area of Cumberland Hospital; is that right?

1 A. Correct.
2
3 Q. Next, you refer to faults with alarms in the Boronia
4 unit. Do you recall what that issue is?
5 A. I do not recall specifically, no.
6
7 Q. You have referred to action items regarding duress
8 alarm issues as "closed actions". What does that mean?
9 A. So my understanding of what would be considered
10 a closed action is something that the committee has agreed
11 is something - an issue that has been raised, discussed,
12 resolved and thus closed for no further discussion, unless
13 it comes up again.
14
15 Q. And are you saying that based on your observations of
16 the committee's --
17 A. That's the general function of most committees within
18 a hospital: if an action item is closed, it is considered
19 complete or resolved.
20
21 Q. In terms of this particular committee, have you got
22 personal experience of items being recorded as "closed"
23 when the committee has regarded them as resolved?
24 A. I would say that they've been closed at that point
25 when that particular issue has been involved [sic], but if
26 that particular part is of a bigger issue or a larger
27 problem, it would still be ongoing elsewhere, be it at
28 a health and safety committee or at a higher level like the
29 joint consultative committee.
30
31 Q. But you don't recall this particular meeting; that's
32 right?
33 A. No.
34
35 Q. The next event chronologically is in paragraph 16, and
36 you refer there to an email from a colleague, Eliza Wright,
37 at Blacktown mental health service, regarding issues
38 in March 2021. Who is Ms Wright?
39 A. Eliza Wright is one of the branch executives of the
40 Blacktown city mental health branch, our sister branch in
41 the mental health services.
42
43 MR FULLER: Commissioner, I note the time. I'm not going
44 to finish with this witness, obviously, now being
45 4 o'clock, I've probably got another --
46
47 THE COMMISSIONER: How much - because it's probably going

1 to be a lot more convenient to the witness not to have to
2 come back, if that's possible.
3
4 THE WITNESS: I don't mind coming back in the morning,
5 Commissioner.
6
7 THE COMMISSIONER: Sorry?
8
9 THE WITNESS: I don't mind coming back in the morning,
10 Commissioner.
11
12 THE COMMISSIONER: Thank you for that. Are you going to
13 be quite some time?
14
15 MR FULLER: Probably 40 minutes would be my guess.
16
17 THE COMMISSIONER: All right. So you think we should
18 adjourn now, it would be convenient, given the witness has
19 indicated that he is prepared to come back tomorrow.
20
21 MR FULLER: I understand that the witness is prepared to
22 come back tomorrow and in the circumstances, I'd suggest --
23
24 THE COMMISSIONER: All right. In that case, if we're not
25 going to finish in a relatively short period of time and it
26 doesn't put the witness out too much, I will adjourn now
27 until 10am.
28
29 Thank you for indicating you are free to come back
30 tomorrow.
31
32 THE WITNESS: That's all right, thank you.
33
34 THE COMMISSIONER: All right. We will adjourn until 10am
35 tomorrow. Is there anything else that needs to be followed
36 up right now from anyone?
37
38 MR FULLER: Not from my perspective, Commissioner.
39
40 THE COMMISSIONER: All right. Thank you, we will adjourn
41 until 10am tomorrow then.
42
43 **AT 4.01PM THE COMMISSION WAS ADJOURNED TO TUESDAY,**
44 **20 FEBRUARY 2024 AT 10AM**
45
46
47

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