Submissions

Queensland Clinician Scientists' Association &

Dr Con ARONEY

Facsimile from

Raelene Kelly

Barrister at Law

134 Fifth Avenue Windsor

Qld 4030

Ph 07 3315 6611

Fax 07 3315 6288

Email raelenek@bigpond.net.au

TO:	Qld Public Hospitals Commission of Inquiry
ATTN:	David Groth
FAX NO:	07 3109 9151
DATE & TIME:	27 October 2005: 9.28 pm approx
NO OF PAGES:	21 (including cover sheet)

MESSAGE:

Re: Queensland Clinician Scientists' Association

David,

A copy of the previously emailed submissions for the above and Dr Aroney is attached.

Yours Sincerely,

Raelene Kelly

This facsimile document (including any attachments transmitted with it) is intended exclusively for the use of the individual or entity to which it is addressed and may contain information that is privileged, confidential and exempt from disclosure under applicable law. If the reader of this document is not the addressee or the employee or agent responsible for delivering the message to the addressee, you are hereby notified that any use, dissemination, distribution or copying of this document is strictly prohibited. If you have received this document in error please notify this office immediately by telephoning the sender on (07) 3315 6611, faxing (07) 3315 6288, or e-mailing to raelenek@bigpond.net.au and destroy this document. Any confidentiality or legal professional privilege is not waived or lost by any mistaken delivery.

In the Matter of
QLD PUBLIC HOSPITALS COMMISSION OF INQUIRY
pursuant to the *Commissions of Inquiry Act 1950*

Submissions on behalf of the

Queensland Clinician Scientists' Association

and Dr Con Aroney

27 October 2005

1 The Queensland Clinician Scientists' Association ("the QCSA") is an unincorporated association of medical officers of varying levels of seniority and includes Visiting Medical Officers engaged by Qld Health.

2 The Association produced to the Morris Commission two statements of evidence, of which one was put into evidence, being that of Dr Con Aroney. Dr Aroney's evidence was primarily concerned with the impact of non-clinical decisions (of an administrative or budgetry nature, and in some cases, in the nature of misconduct) on clinical care in the Prince Charles Hospital and generally in cardiology services.

3 Dr Aroney's statement was Exhibit 263 (with Ex. 264 being the confidential patient identity key), he gave oral evidence on 10 August but had not yet been cross-examined when the Morris Commission ended. His cross-examination occurred on 30 September.

4 Dr Aroney's evidence is valuable for the demonstration it offers of some of the multifarious dysfunction in Queensland Health ("QH"), namely –

4.1 The inability of hospital and QH management to deal honestly and reasonably with both a service delivery problem and the exposure of that problem;

4.2 The subordination in priority of critical patient care to corporate-style planning targets, when the people affected by the planning (patients, clinicians and even local managers) do not support the changes or the means of their achievement;

4.3 The willingness on the part of management to sacrifice the interests of patients and the public health career of a leading specialist, in a misguided attempt to protect QH's corporate reputation and punish him for (initially) writing to the Premier;

4.4 The readiness of QH's resort to overseas-trained doctors to patch up management failures which result in clinical staff attrition, and to threaten clinical staff with their replacement by overseas-trained doctors;

4.5 The misuse by a hospital of the priviliging and credentialling procedure to achieve improper purposes, namely the punishment and exclusion of a former specialist from the hospital, even when that specialist is volunteering assistance on (his own) groundbreaking clinical procedures;

4.6 The willingness of QH and hospital management to wield budget allocations and cuts as mechanisms of control of clinical staff, or at the very least, to represent to clinical staff that QH in fact punishes/rewards by means of budget.

5 Dr Aroney also provided an interesting catalyst for measuring QH's current respect for the Commission's endeavour, for the need to respond transparently and fairly to his evidence.

Submission 4.1 The inability of hospital and QH management to deal honestly and reasonably with both a service delivery problem and the exposure of that problem
and
Submission 4.6 The willingness of QH Aroneynd hospital management to wield budget allocations and cuts as mechanisms of control of clinical staff, or at the very least, to represent to clinical staff that QH in fact punishes/rewards by means of budget.

6 The first service delivery problem to which this submission relates is the massive increase in demand for cardiac services up to 2003, for which no provision was made: Ex 263, par 5-11. QH's responses were to do nothing (Ex 263, par 11), to walk out of meetings (Ms Podbury- Ex 263, par 14), to replace clinical management with a cumbersome administrative structure (Ms Podbury- Ex 263 par 10), to close the anti-smoking clinic (Ex 263 par 10), to threaten to dismiss a critical clinician (Ex 263 par 8, Ex 401), and finally to institute budget **cuts** (Ex 263, par 12-15).

7 The second service delivery problem followed the first round of cuts referred to above. Rather than welcome Dr Aroney's exposure of the problem to the Premier, QH threatened him with reprisals. Dr Scott's extraordinary response to Dr Aroney on 8 January 2004 was that he regarded the letter (which didn't mention him) as "personally offensive" to him, and threatening to "come after" Dr Aroney: Ex 263 CA5, par 23.

8 Dr Buckland responded to the service delivery problem in cardiac services by attending a Cardiac Society meeting chaired by Dr Aroney and behaving aggressively with the effect of intimidating speakers, and claiming the information being presented was "Prince Charles-centric". [A similar line has been pursued by QH in cross-examining Dr Aroney and in QH's non-tendered statements in response to Dr Aroney].

9 When Dr Aroney and his colleagues compiled a very detailed submission, at QH's request, on the future of cardiac services in Qld, submitted in July 2004 (Ex 263, CA2), neither Dr Scott nor the Minister were able to say that they had read it.

10 The third round of cuts was represented to the clinicians as a punishment for Dr Aroney's public statements (Ex 263 par 44- Dr Scott); and indirectly by Ms Wallace when she was announcing the cuts. In response to Dr Aroney's claim to be advocating for the patients, and saying "we are bullied", Ms Wallace's response, as minuted, was-

> *"Perceptions of the cardiology programme are not good. We have to be more politically savvy"*: Ex 301C MIC 19 page 2

11 The obvious inference was the one which Dr Aroney drew. The "political savvy" statement was made in the context of patient advocacy by Dr Aroney, an assertion of being bullied, and the announcement of budget cuts.

12 Ms Wallace was not produced. Clearly, as current Deputy Director-General of QH she could have provided a statement to rebut Dr Aroney's evidence, but did not do so. A Jones v Dunkel inference should be drawn.

13 In the circumstances of

- that inference,
- Dr Scott's statement to the cardiologists,
- the preceding threats against Dr Aroney in January by Dr Scott, and
- Dr Buckland's aggression in February -

it is submitted that the finding is open that the third round of cuts was an improper response to Dr Aroney's disclosures, designed to punish him without regard for cardiac patients.

14 Even if not satisfied of that on the evidence (which evidence remains in the control of QH, it must be said), it is submitted that the Commission should at least find that the representation was made to clinicians that QH had the power and the willingness to wield the power to control clinicians' conduct by means of budget allocations and cuts.

15 In October 2004 Dr Scott again attacked Dr Aroney, this time on ABC television. Dr Scott's statements were plainly dishonest. See Ex 263 par 46, CA 13, CA 14 and CA 11; transcript at 3945 line 35ff; transcript at p5268 line 10 to p5271; transcript at p5274-5.

16 The following week, Dr Buckland was reported in the Courier Mail which interpreted his remarks as a "crackdown" on Prince Charles hospital, which was alleged to have been applying guidelines in an inappropriately liberal way: Ex 263 par 48. Dr Buckland's reported remarks were directly contradicted by the determination of the Cardiac Procedures Workshop the following month (MIC 24 to the untendered statement of Dr Cleary dated 29 September 2005) which found that it was Princess Alexandra hospital whose guidelines were not consistent with other hospitals.

17 There is, it is submitted, in the conduct of Messers Scott, Buckland and Cleary a cavalier disregard for accuracy and transparency. A failure to respond reasonably to a health funding crisis was covered up by attacks on the messenger, in this case Dr Aroney. Dr Aroney's disclosures were not characterised as assisting them in the joint endeavour to make politicians and Treasury more acutely aware of the crisis, but rather as a failure of QH's 'damage control': see Scott's response at transcript p5290-1, which is a clear example of the priority placed on QH media management over public knowledge of death rates.

18 There are many failings of Scott's and Buckland's period of QH management, but the most profound is the dishonesty which became the management tool of choice.

Submission 8.2 The subordination in priority of critical patient care to corporate-style planning targets, when the people affected by the planning (patients, clinicians and even local managers) do not support the changes or the means of their achievement

19 QH's defence of the budget and service cuts to Prince Charles cardiac services in 2003-04 was a master plan to support the development of cardiac services at Princess Alexandra (PA) hospital: Ex 301C pars 23-30. It was acknowledged by Dr Cleary that Prince Charles was better equipped and more experienced in cardiac care, that the transfers themselves would give rise to an estimated 188 additional procedures required per annum, and that Prince Charles hospital could treat the patients more cheaply than PA: transcript at 4842 line 45ff; Dr Cleary also testified that he "personally found it difficult to support the transfer" (transcript 4843 line 4), and that a large number of people on the working party expressed that view, including cardiac clinicians: 4844 line 38 ff. He said the decision was ultimately made by Dr Buckland: 4845 line 10.

20 Whether the proposal was well-intentioned or not, the bungling in its planning and execution was inexcusable. Dr Cleary claims not to have known for 18 months after the hospital administrators had agreed in principle to proceed (July 2003: Ex 301C par 28) that PA had a non-

standard categorsiation of patient priority: Ex 301C par 41; 4833 line 20 to 4835. Certainly there is no evidence that anyone questioned or challenged Dr Buckland's assertion in Ex 301C-MIC12 of there being no Category 1 patients and only 2 Category 2 patients at PA, while there were 229 and 78 at Prince Charles respectively.

21 Ultimately, it was conceded by documents attached to the untendered statement of Cleary that there was a miscategorisation at PA and adjustment was required. That was at the end of November 2004, more than a year after cuts at Prince Charles had commenced. There has been no evidence produced by QH (whether tendered or not) showing that patients transferred pursuant to this master plan were actually treated at PA. Indeed it seems likely, at least prior to the end of 2004, that Cat 1 patients from Prince Charles went to PA and were there categorised as Cat 3 and accordingly placed on the waiting list for non-urgent patients. Dr Aroney's evidence was that a Cat 3 categorisation meant that treatment was not required within three months (4802 line 10 to 4803), so if Cat 1 (treatment required within 48 hours) patients from Prince Charles went onto a Cat 3 waiting list at PA, then it is likely that at least some of them were not ultimately treated.

22 The effect of the above is that a transfer of resources occurred, but there is no evidence that the alleged transfer of services occurred.

23 A close examination of MIC 12 (to Ex 301C) is warranted- this is Dr Buckland's memorandum recording the decision. Its subject is not "proposal to support the cardiac program at PA", but "cardiac services at the Prince Charles hospital". It commences by referring to Dr Scott's meeting with Dr Aroney on 8 January (the "we'll come after you" meeting). At the top of page 2 after some self-serving statements for the record, Dr Buckland attributes the failure of equitable access to treatment for urgent patients to a failure of clinical collaboration by cardiac services at Prince Charles with other providers such as PA. There is nothing in the memorandum consistent with the position which Drs Buckland and Scott now present to the Commission, namely that theirs was a brave and constant struggle for resources. On the contrary, inadequacy of resources is not mentioned at all, self-promoting spin is evident (see eg last paragraph), and the real subject of the memorandum is to insitute transfers following Dr Aroney's allegations.

24 Finally in relation to this issue, Dr Aroney said at 6242 line 6ff:

> *"There's been a lot of talk about classification of lists today and yesterday, but these patients were misclassified and put on an elective list, and this was the reason, over a 12 month period, why patients were then transferred, in the full knowledge of Queensland Health of this misclassification, to the Princess Alexandra Hospital, and that those patients on Category 3 presumably were put further and further back. We have no knowledge of what the death rates were on that Category 3 list. So to say that there was no hidden list is clearly untrue. Dr Cleary's statement, MIC(12), from Dr Buckland doesn't mention any Category 3 patients, and we know they existed. It's a fact,*

and those numbers should be able to be obtained from Queensland Health exactly how many there were. We understood there were several hundred."

Submission 8.3 The willingness on the part of management to sacrifice the interests of patients and the public health career of a leading specialist, in a misguided attempt to protect QH's corporate reputation and punish him for (initially) writing to the Premier

25 There is no question that Dr Aroney was a thorn in the side to QH management; he was articulate, well-acquainted with his facts, well-credentialled, and authoritative. He refused to be bullied, responding to Dr Scott's threats by issuing a press release: Ex 263, par 25. It is important to remember that the first threat to Dr Aroney was after he had *written to the Premier:* this was hardly the act of a media-manipulating terrorist, but was an attempt to get through to the person ultimately responsible and accountable for the consequences of his administration.

26 Equally, there is no question that Dr Aroney was and is a highly-esteemed and dedicated expert clinician; he was the principal author of the National Guidelines in his field (MIC 1 to Ex 301C; Ex 263 CA1), several witnesses spoke highly of him (eg Dr Molloy at 583 line 38ff; Dr Nankivell at 3053 line 30), and even Dr Cleary conceded his contribution (Ex 301C, par 18). He pioneered three procedures in Qld (at 6289 line 3).

27 Rather than an appropriate response to Dr Aroney (which might range from fixing the problem of which he was complaining, to engaging in an

honest and open debate to remonstrate and defend), QH resorted to threats, lying about the facts on ABC television, criticising Dr Aroney's hospital in the newspaper, keeping the Maher and Thomas-Ayre reports into deaths confidential, and insinuating that Dr Aroney had breached the QH Code of Conduct for "releasing into the public arena details of the hospital's waiting lists without approval": Ex 301C, MC20 page 3.

28 Far from breaching the QH Code of Conduct, Dr Aroney was in fact the only person involved in these events who complied with it. It required all employees to resolve conflicts in the public interest, to disclose maladministration of which they were aware, to advance the common good of the community they serve: transcript 6290.

29 Wallace and Scott then linked the third round of cuts to Dr Aroney's outspokenness (Ex 301C MIC 19 page 2; Ex 263 par 44; transcript 6290 line 47ff), whereupon Dr Aroney felt that it was necessary for him to leave in order to protect the hospital from further retribution: Ex 263 par 56; transcript 3951 line 15ff; transcript 6266.

30 The priority which QH places on its public image was established elsewhere in the Morris Commission's evidence. Its treatment of Dr Aroney in order to uphold that public image was not unconscionable, it resulted in the loss to the public patients of Qld of a much-needed committed and world-class specialist.

Submission 8.4 The readiness of QH's resort to overseas-trained doctors to patch up management failures which result in clinical staff attrition, and to threaten clinical staff with their replacement by overseas-trained doctors

31 QH was cavalier as to the loss of Dr Aroney, as outlined above, because as Ms Wallace indicated before the event, Dr Aroney and his colleagues could be readily replaced with overseas-trained doctors: Ex 301C MIC 19.

Submission 8.5 The misuse by a hospital of the priviliging and credentialling procedure to achieve improper purposes, namely the punishment and exclusion of a former specialist from the hospital, even when that specialist is volunteering assistance on (his own) groundbreaking clinical procedures

32 The punishment of Dr Aroney continued after his resignation, in the form of refusal by Dr Cleary to accept his offer to *volunteer* his services to assist his colleague in developing the expertise to conduct Dr Aroney's groundbreaking procedures: transcript page 3925; 6287-9. The refusal continues: transcript 6291.

33 [Cross-examination of Dr Cleary as to this matter was curtailed by Commissioner Morris' view that he was" frankly not interested in looking for someone to blame" 4836 line 16, but only in what he termed "systemic issues": 4846 lines 29-30. Mr Morris explained his approach to these halfway through Dr Cleary's evidence on 23.08 (at 4791 line 5 to 4792) and 24.08 at 4796 and then fully in a three page statement read into the record commencing at 4820. However it is clear from the attachments to Ex 301B dealing with priviliging that the refusal to

privilege Dr Aroney ought to have been referred to the appropriate clinical committee, rather than be a decision of Dr Cleary.]

Submission 9- ongoing matters

34 The capacity of Dr Aroney's to answer challenges to his evidence was jeopardized by the late delivery and non-delivery of evidence by QH and Dr Scott. Specifically –

- Dr Aroney's statement was tendered on 10 August (Ex 263 and 264), his evidence-in-chief given that day, with a re-appearance due on 12 August;
- QH privately, with Counsel assisting's knowledge, requested a longer period than planned before Dr Aroney's resumption, in order to prepare its cross-examination. Dr Aroney agreed to that;
- Dr Aroney was then scheduled for 19 August and sent away due to witness overruns;
- Dr Cleary's statement was not produced until 23 August, a fortnight after Dr Aroney's evidence-in-chief, and the day before Dr Aroney was booked (for the third time) for resumption;
- Dr Aroney received Dr Cleary's statement late on the night before his resumption of evidence on 24 August (page 4816-7);
- Because Dr Aroney responded orally to some matters traversed in Dr Cleary's statement, QH sought and received a further

adjournment to take instructions to respond to those matters (page 4816-7);

- More than a month elapsed before Dr Aroney resumed his evidence on 30 September. For the second time, QH produced statements relevant to Dr Aroney only on the day before he was due to give evidence, (this time from Drs Cleary and Garrahy). Dr Aroney was only able to read them for a few minutes before entering the witness box;
- Further, although Dr Aroney was cross-examined by Senior Counsel for Dr Scott, the statements of Dr Scott's witnesses, Drs Galbraith and McNeil, were not put to Dr Aroney, despite that the statements bore word processor dates of 7 and 12 September respectively. These statements were not available to Dr Aroney until 4 October, after his evidence was finished.

35 The last four statements (of Drs Cleary, Garrahy, Galbraith and McNeil) were then not tendered, after Dr Aroney had advised of a requirement to cross-examine the deponents. The lateness of evidence allowed challenges to be made to Dr Aroney's evidence as to particular preventable deaths, but those challenges were themselves protected from scrutiny by the decision not to tender the statements.

36 Further there was no evidence at all from Ms Podbury or Ms Wallace, both of whom were in a better position than Dr Cleary to answer Dr Aroney's allegations.

37 Similarly, QH did not produce evidence which could have settled a number of issues in contention, namely

- the petition to Podbury which Cleary said she could not recall (unearthed by Dr Aroney and now Ex 401)
- the waiting list data for cardiac patients at PA, as to which the untendered Statement of Dr Garrahy makes oblique denial, and which Dr Aroney invited QH to produce: transcript 6279 line 12
- Dr Pohlner's evidence as to the Biomedicus device issue (invited by Dr Aroney at 6282 line 40ff).

38 QH's attitude to Dr Aroney's evidence was that it was something of a side-issue or distraction: its junior counsel suggested that two matters required re-examination of Dr Cleary, and that

"both regrettably relate to the cardiac issue, Commissioners." page 4863 line 49-50

39 It is submitted that the late dropping on the table of statements relevant to Dr Aroney was conduct tactically designed to prejudice rather than facilitate the Commission's examination of these issues.

Credit- Cleary

40 Dr Cleary was not the best-placed witness for QH to produce to answer Dr Aroney's allegations, as Podbury and Wallace were more directly concerned in the events to which Dr Aroney referred. Leaving aside the issue of his reliance on Podbury's reported memory of the threatened dismissal and consequent petition (Ex 401), he was in error

even in those matters he could be expected to know: eg, his assertion that Dr Aroney had been on leave for two years (Ex 301C par 16; transcript page 4774 line 3 and page 4831); the wrong identification in his report which was Ex 301C, MIC17A of patients alleged to have died: see transcript 4805, line 4ff. Dr Cleary persists that he did not know of the miscategorisation of patients at PA until January 2005, even though he had been through an 18 month long process to transfer patients to there. When pressed, he says clinicians' concerns were expressed to him but were not specific. Given that people were likely to die if miscategorised, that was an extraordinary position for him to accept without query, a point which he finally conceded: transcript 4864-5. In any event, Dr Aroney insists that Dr Cleary was told repeatedly throughout 2004 of the discrepancy: transcript 4802-3. Dr Cleary's history included a stint as medical advisor to the elective surgery team for QH in 1996-7, in which the categorisation of patients was proposed and standardised: see Ex 301A, MIC1 pages 6-7; transcript 5725 line 19 where Dr Stable said Dr Cleary was "in charge of" waiting lists. In those circumstances, his failure to tune in to the allegations of clinicians is spurious.

41 Finally, Dr Cleary's history and demeanour all suggest he was very much a headquarters man, defending the corporate line, and following Dr Scott's example in being "too much an activist" for the government

(a concession which Dr Scott made about himself at transcript 5287 line 40).

Credit- Scott

42 It is submitted that the concession made by Dr Scott is wholly warranted:

> *"I think probably if I look back in retrospect, I would say that I probably was more of an activist for the Government and the Minister than perhaps I should have been."* at 5287 line 40 ff

Other concessions which ought to have been made were as to what constitutes a "cut" to services, that threatening to "come after" Dr Aroney was to bully him, that his and Buckland's opposition to the publication of death rates (Ex 263, CA8) was nonsensical, that bullying and dysfunction within QH were some of the reasons for medical staff attrition (transcript at 5289), that the "no surprises" rule in JS3 to his statement meant what it said, viz, the Minister only wanted good news (5265 line 25).

43 Dr Scott shamelessly lied on television to the public, about matters with which the public ought properly to have been concerned. Prior to their dismissals, it was his, and Dr Buckland's, persistent position that waiting lists ought not to be published: transcript at 3941 line 39 to 3942 line 17. As Dr Aroney said, regardless of what position he now attests to, when he was in a position of power to make a difference, Scott adopted a very different approach: transcript at 6252.

44 A further notable discrepancy with Dr Scott's position is the claim to credit now being made in submissions made on his behalf dated 7 September 2005. At paragraphs 4(b), 4(g) and 6, credit is claimed for Dr Scott providing funds in response to need. First, it is odd that Dr Scott should claim credit for the provision of public funds at all, but secondly, it is at odds with the denial that it was within her "client's gift to be handing out money for this or that..." made by his senior Counsel to Mr Morris at 4827 line 10. Dr Scott ought not to claim credit for matters which elsewhere he asserts were beyond his control and responsibility.

45 As to the character references for Dr Scott provided by Edmond and Nuttall: there was no point even in cross-examining Ms Edmond, given that the day before Mr Morris had indicated his attitude to her likely fate and that of others, including Dr Scott. There is no question that Mr Morris favoured the witness, and protected her from scrutiny: see for example, page 5008 at line 30 to Page 5009 line 10.

46 Further, at 5092 line 22ff, Mr Morris said -

> *"Commissioner: ...Ms Edmond, can I tell you really from the bottom of my heart how much we appreciate your coming out of political retirement to assist this Inquiry with your evidence. I have to be careful in what I say because I don't want anyone to think I've prejudged things, but my impression, I can say very confidently, is that the evidence you've been giving over the last two days has been accurate, honest and reliable to the best of your recollection. If there are some inconsistencies that come to light, I have no doubt that that's because you've put things out of your mind for obvious reasons?-- Mmm.*
> *Your insights into the broader issues of the administration of*

Queensland Health have been extremely valuable and will be at the forefront of our consideration as we're pondering the matters before this Inquiry. We are very grateful to you and you're formally excused from further attendance."

47 As to the proposition put to Ms Edmond that Dr Scott had been alleged to have a " bullying, attacking, overbearing and intransigent" manner (4970 line 58 to page 4971), if that was a reference to Dr Aroney's evidence, it mis-stated it. Dr Aroney did not assert that Dr Scott's manner was, in any general sense, "bullying, attacking, overbearing and intransigent", but merely that Dr Scott had bullied him. The facts of what was said are not contested- merely the inference which might be drawn from them. Further, Ms Edmond did not explain what staff it was in what office who fell about laughing when "they read that in the paper", given that she had retired the year before, a point she made repeatedly in her evidence.

48 Similarly, Mr Nuttall sought to resist the inevitable conclusion that either Drs Scott and Buckland had failed to keep him fully and frankly informed, or he had failed to respond to the crisis in QH (transcript 5348ff). He couldn't account for why Dr Scott had been dismissed, and denied unsurprisingly that he had seen Dr Scott bully anyone (transcript 5362-3). Mr Nuttall's evidence is unreliable.

Credit - Aroney

49 Dr Aroney was a careful and measured witness; he made important concessions where necessary (transcript at 3940 line 31ff; 3926 line

25ff; 3947 line 45), and even in case they were necessary (6283 line 10).

50 In what has become a standard QH response to criticism, Dr Aroney's motivation has been impugned as if it were self-interested. The best answer to that is Dr Aroney's own words: (at 3945 line 10) -

> *"This lack of accountability to our patients really was a thing that hurt me most about what had happened in Queensland Health, that there really was no human face to Queensland Health and that we were faced with a massive cut which would lead to further deaths..."*

Raelene Kelly
Counsel for the QCSA