BUNDABERG HOSPITAL *COMMISSION OF INQUIRY*

STATEMENT OF STEPHEN JAMES RASHFORD

I, STEPHEN JAMES RASHFORD make oath and say as follows:

1. I was born on and I reside in Brisbane at an address which I have provided to the Commission.

2. I graduated from the University of Queensland in 1990 with the degree of MBBS. I am a Fellow of the Australasian College for Emergency Medicine, and I am the Director of the QEMS Coordination Centre (QCC), namely the Queensland Emergency Medical System Coordinator Centre. The QCC is based in the Brisbane Operations Centre of Queensland Ambulance Service. It is a joint Queensland Health and Queensland Ambulance Service (QAS) initiative which provides clinical co-ordination across the State. We aim to ensure that the right vehicle is used to transport the right patients to the right hospitals around the State. At the moment, we work primarily in the central and southern zones of Queensland Health. We are staffed by, amongst others, senior emergency physicians, intensive care specialists, registered nurses and Queensland Ambulance communications experts.

3. My official title is Director of Clinical Co-ordination and Patient Retrieval Services for Queensland Health. Effectively, I have been involved in emergency transport and retrieval of patients for about 14 years. The Centre opened on 2 August 2004, and I have been the Director from inception. We started with a very small budget for the work at hand, but, otherwise, I believe that Queensland Health has been very supportive of us.

4. It is not all about retrieval services. We also provide a service in terms of simple communications. A doctor can phone and speak to a very senior

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Signed..... Taken by:.....
Deponent **Solicitor/Justice of the Peace**

person about a clinical issue. This means that a practitioner in a country setting is able to have the benefit of advice from a senior clinician in navigating a particular issue. Other QCC functions include vetting all rescue helicopter scene responses, adjudicating resource disputes between the QAS and local health services and support of multi-casualty incident management.

5. When the case of P26 was initially brought to our attention, the medical officer in charge of the co-ordination centre was Dr Peter Thomas, the Deputy Director of Emergency Medicine at the Princess Alexandra Hospital. Looking at the records of the Centre I can say that we were contacted at about 11am on 23 December 2004. We were requested to authorize a helicopter emergency response from Woodgate for a 15-year-old fellow who had a major injury to his groin after a motorcycle accident. I recall that, at the time of the initial phone call, I was showing an Intensivist around the Centre. He was from the Royal Brisbane Hospital. We understood that P26 was really on death's door. He was grossly shocked. He was very hypotensive (that is, he had very low blood pressure), bleeding heavily, and exceedingly tachycardic with a pulse rate of around 150. He was resuscitated at the scene by a para-medic and we then air lifted him from Woodgate to Bundaberg Hospital.

6. I have no doubt that this was the right option. The destination had to be Bundaberg because he would not have survived a longer trip elsewhere. When he did arrive at Bundaberg, I understand that the staff there took P26 straight to the Operating Theatre to stop the heavy bleeding, and I believe this was the right thing to do also. I do not have first hand knowledge of what happened next. My understanding, based on the records, is that P26 suffered complications within 4 or 6 hours of surgery. There was a concern that his left leg was ischemic (that is, it was not receiving enough blood). The records suggest that P26 was returned to surgery for fasciotomies. That is usually performed when the surgeon is concerned that something is causing pressure

to build up in the legs and the surgeon cuts down to the level of the fascia in the leg to relieve the pressure. Again, without first hand knowledge, my understanding, based on the records, is that the fasciotomies did not work, and that P26 was taken to surgery a third time. On this occasion, the staff observed an injury to the femoral artery and did a prosthetic graft.

7. The Centre received a call on 1 January 2005. The call was from the Vascular Surgery Senior Registrar/Fellow at the Royal Brisbane Hospital, namely, Mark Ray. Mark was extremely concerned. He told me he had just found out that there was a fellow in a very poor condition at Bundaberg, that his leg was dead, and that the situation was time critical. That fellow was P26. We had planes in all different directions and we try not to use the Bundaberg helicopter if possible for long transfers, because paramedics "off the street" staff it. Therefore Bundaberg does not have those senior paramedics whilst the helicopter is in the air. Instead, we sent the Maroochydore Helicopter. The paramedic rang me from the Bundaberg ward and described what he was seeing. I considered on that information that P26 was septic, that is, he had very significant signs of infection. He was exceptionally unwell, and although he was in a surgical ward bed at Bundaberg Base Hospital, he really should have been in their intensive care unit.

8. The flight from Bundaberg to Brisbane takes about 1 and 3/4 hours if a helicopter is utilized. I was so concerned for the condition of P26, as it was described by the paramedic, that I spoke with the paramedic a number of times during the flight to check on progress. I also spoke to a Neil Widdicombe (the Intensive Care Specialist from the RBH with whom I was meeting at the time of the initial contact), and said that they should really make an intensive care bed available at the Royal Brisbane Hospital for the fellow. I also liaised at this time with Dr Mark Ray.

Signed..... Taken by:.....
Deponent **Solicitor/Justice of the Peace**

9. It was the weekend and the Centre is located away from the Royal Brisbane Hospital but, nevertheless, I drove across town to see this fellow when he arrived. I was struck by his condition. He was about 6ft 4inches and well built. His leg was unbelievably swollen. It was disgusting. The wounds were full of pus and he was very, very unwell. In my opinion, the fact that the patient had held it together was in no small part due to the more robust physiology of a 15 year old.

10. In the treatment that followed, I understand that the surgeons at the Royal Brisbane Hospital were very concerned by a number of issues in the earlier surgical management of this boy. For my part, I was very upset that this boy had been the subject of three operations in Bundaberg within the first 12 to 14 hours of admission but the clinician had not thought to call the Royal Brisbane Hospital for advice. It was my view that, unless the doctor in Bundaberg was a specialist vascular surgeon, he should have approached the Royal Brisbane Hospital or the Centre for advice. Further, I have trouble understanding how this boy could have spent three and a half days on a ward rather than in intensive care. I was struck that warning bells had not gone off earlier in Bundaberg, and that the patient had not been transferred to Brisbane. They just didn't realize how sick he was in terms of sepsis. There's an old adage that you never let the sun set on pus. You need to clean it out so that the antibiotics can reach the viable tissue, but no one seemed to appreciate that basis fact.

11. We sometimes have trouble finding places for people. There have been times when I have had to call eight or more "ICU"s to find a bed, and there have been times when the helicopter is lifting off in some regional centre and I still haven't found a bed in Brisbane for the patient. But it's our job to manage the resources and we do it. If we had been referred someone young and in dire

need like P26 at any earlier time, we would certainly have found him an ICU bed very quickly.

12. I called Mark Ray on the day following P26's transfer to find out how he was doing, and because I thought someone should sought out what had happened in Bundaberg. Mark told me that they had performed an amputation through the knee and I thought that was a really good outcome for the boy, having regard to his condition when he reached Brisbane. I then thought about whether or not I should lodge a complaint or a report about what I had seen. Dr Ray said that I should leave it in the surgeons' hands. I sat on it for about 24 hours but then I decided that it was appropriate that I make a complaint and I wrote an e-mail to the Medical Superintendent at Bundaberg Base Hospital, namely, Darren Keating. Now shown to me and marked **SJR 1** is a copy of that e-mail dated 4 January 2005.

13. I sent a copy of my e-mail to Dan Bergin (Zonal Manager) and the District Manager (Peter Leck). I did that just to make sure that the e-mail reached the right levels. My line manager in a functional sense is the Chief Health Officer, Gerry Fitzgerald, but I see our Centre as having an intelligence role and I thought it was the appropriate thing to do.

14. When I wrote the e-mail, I did not know the name of the surgeon, but I was concerned that the care was sub optimal. I later found out that the surgeon was Dr Patel. It wasn't really the surgery, per se, with which I took issue. That is a matter for the surgeons. I just didn't understand why the case had remained in Bundaberg for almost a week instead of being sent to a tertiary hospital. Telephone calls like that one happen all the time. Referring physicians make a phone call to a public hospital switch and then get people to talk to you. It is not always easy. Some doctors are in theatre or you have difficulty in getting someone who is prepared to give advice over the phone. It

is an everyday process which eventually works, and, in my experience, the vascular surgeons are generally quite easy to deal with.

15. I have since been shown a copy of an email from Dan Bergin to Peter Leck dated 4 January 2005 concerning the patient issues raised by me, a response email from Peter Leck to Dan Bergin dated 5 January 2005, a further email from Dan Bergin to Peter Leck dated 7 January 2005 and an email leaving a telephone message from John Scott, Corporate Office to Peter Leck dated 10 January 2005. The emails are now shown to me marked **SJR 2.**

16. I have also been shown a copy of an email from Peter Leck to John Scott dated 13 January 2005. That email is now shown to me marked **SJR 3**.

17. On 25 January 2005, I attended the Bundaberg Base Hospital on a pre-arranged visit. I had arranged the visit to speak with the ambulance service up there and to speak with the staff on the helicopter. Whilst I was there I met with Darren Keating, and later Martin Carter. I have only a general recollection of our discussions. I recall that I outlined the circumstances of the P26 case and that I came away with a feeling that Dr Keating was not as outraged as I thought he should be. Martin Carter arrived later in the meeting.

18. I do not know Dr Patel personally. In about July 2004, the Director of the Royal Flying Doctor Service, Gerry Costello, told me that he had concerns about the level of surgery coming from Bundaberg generally, and about oesophagectomies coming from there in particular. I remember also that in about February or March 2005, I went up to pick up a patient from Bundaberg. A cow had kicked at him and pushed a stick through his chest. In order to extract the stick, we needed to mechanically ventilate the patient and we were very lucky because the stick had only missed the major arteries by a fraction. We went to move the patient to the Operating Theatre so we could work on

him carefully and I could hear Dr Patel saying that he didn't think it was necessary to go to Theatre because the procedure could be done there and then. In my view, he just did not appreciate the scope of the problem. I gained a strong impression from watching him that he was a 'big noter' and that he could be dangerous.

19. I would say that I speak with Dr Fitzgerald, the Chief Health Officer, on a weekly basis because he's effectively one of the sponsors of the Centre, and I raised my concerns about P26 with him in January 2005. He was going to look at the case.

20. I would also mention for the sake of completeness that retrievals are paid from Queensland Health's central budget, rather than by the referring hospital (as was the case in the early 1990's) so that there is no financial reason, in that regard, to refrain from transferring patients.

All the facts and circumstances above deposed to are within my own knowledge and belief, save such as are deposed to from information only and my means of knowledge and sources of information appear on the face of this my affidavit.

Affidavit sworn on
at

in the presence of:

. . . . . .

Deponent

. . . . . .

Solicitor/Justice of the Peace

Signed..... Taken by:.....

Deponent **Solicitor/Justice of the Peace**

SJR1

From: Steve Rashford
To: Dan Bergin; Darren Keating; Peter Leck
Date: 4/01/2005 11:54:46 am
Subject: Sentinel Case

Dear Dan, Darren and Peter,

Re: P26

I would just like to touch base regarding this young man. It might be prudent to examine his Bundaberg chart and management.

He is a 15 YO male who was retrieved from Woodgate to Bundaberg by rescue helicopter on the 23/12. He suffered a motor cycle accident. He was shocked at the scene from a left femoral A bleed - BP 80/- PR 150/min! (QCC coordinated the case - Dr Peter Thomas)

I understand he underwent emergency surgery at Bundaberg (saphenous vein ligated) and was admitted to the ICU post operatively.

I was contacted on 1/1 for an urgent transfer for vascular opinion at RBH - his left leg was ischaemic and he was septic++.

Bundaberg 23/12 to 1/1:
During the subsequent 8 days his left leg had become extremely swollen and he had fasciotomies performed. It was discovered the femoral artery was injured and a prosthetic graft was inserted. I understand from the Bundaberg duty registrar on the 1/1 that he had just started back to discover the overtly ischaemic lower limb.

A paramedic staffed helicopter was the closest available resource and we dispatched it. I spent a lot of time giving the paramedic advice in flight re fluid/blood management.

I wandered up to RBH on the day. On arrival he was mildly acidotic with an ischaemic left leg - blue, cold and blistered. All the wounds were purulent. He had spiked fevers to 40C and had a HR of 140/min in flight.

I believe he had a debridement Day 1 and a thru Knee amputation Day 2. I think he may have had or be heading for a hind quarter amputation.

I guess the role of earlier transfer needs to be assessed. Peter Thomas - the coordinator on the 23/12 - thought he would have received a call for secondary transfer. There is no doubt Bundy hospital saved his life day 1. Peter and I have had long discussions about our (QCC) role in a case such as this. It is quite dangerous ground to ring in and ask why the transfer is not being done but we do it with smaller hospitals. Unfortunately our current workload - often with non essential minutiae - precludes this type of intervention. We would hope that given the chance we might improve morbidity and mortality.

We will be urgently examining our role in this type of case.

Thank you for looking at this case.

Regards

Steve

Dr Stephen Rashford
Director
Clinical Coordination and Patient Retrieval Services
Queensland Health

Mobile:
Pager:

CC: John Scott; Peter Dr. Thomas

SJR 2

From: John Scott
To: Dan Bergin
Date: 4/01/2005 11:57:58 am
Subject: Fwd: Sentinel Case

Dan
Could you follow this up and provide me with a brief?
Thanks
John

From: Darren Keating
To: Judith Woods
Date: 4/01/2005 12:16:14 pm
Subject: Fwd: Sentinel Case

Hi JW

Can you get this file ASAP ?

Thanks

DK

>>> Steve Rashford Tuesday, 4 January 2005 11:54:41 >>>
Dear Dan, Darren and Peter,

Re:

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quite dangerous ground to ring in and ask why the transfer is not being done but we do it with smaller hospitals. Unfortunately our current workload - often with non essential minutiae - precludes this type of intervention. We would hope that given the chance we might improve morbidity and mortality.

We will be urgently examining our role in this type of case.

Thank you for looking at this case.

Regards

Steve

Dr Stephen Rashford
Director
Clinical Coordination and Patient Retrieval Services
Queensland Health

Mobile.
Pager:

From: Peter Leck
To: Keating, Darren
Date: 4/01/2005 12:23:21 pm
Subject: Fwd: Sentinel Case

Darren,

Please see me.

Peter

From: Dan Bergin
To: Peter Leck
Date: 4/01/2005 2:06:45 pm
Subject: Fwd: Sentinel Case

Peter,
could you please provide me with a brief.
Dan

Dan Bergin
Zonal Manager
Central Zone

Phone :
Fax :

CC: Darren Keating

From: Peter Leck
To: Keating, Darren
Date: 4/01/2005 3:54:42 pm
Subject: Fwd: Sentinel Case

Darren,

As discussed, it would be helpful if a brief could be prepared.

Dan has telephoned me and also suggested we have an external review of the case. He wanted to know what your thoughts were about same and if much opposed for you to give him a call.

Any thoughts?

Peter

From: Darren Keating
To: Peter Leck
Date: 5/01/2005 12:12:57 pm
Subject: Brief - P26

Hi Peter

Here is brief for ZM on P26 with clinical summary.

Darren

Queensland Government
Queensland Health

A BRIEFING TO THE ZONAL MANAGER

BRIEFING NOTE NO:	Click, enter Briefing Note Number, if known
REQUESTED BY:	Dan Bergin, Zonal Manager
DATE:	Click, enter Date
PREPARED BY:	Dr Darren Keating, DMS BHSD, 4150 2210
CONSULTATION WITH:	Dr James Gaffield - Staff Surgeon BHSD, Dr Martin Carter – Director of Anaesthetics & ICU BHSD.
CLEARED BY:	Peter Leck, DM BHSD, 4150 2020
DEADLINE:	Click, enter Date
SUBMITTED THROUGH:	Click, enter Details
SUBJECT:	**MANAGEMENT OF** P26

COMMENTS ZONAL MANAGER:

DAN BERGIN
Zonal Manager
Central Zone

/ /

PURPOSE:

Provide brief on clinical management of P26 at Bundaberg Base Hospital (BBH).

BACKGROUND:

Dr Steve Rashford, Director of Clinical Coordination and Patient Retrieval Services raised concerns in an email dated 4 Jan 05 about possible delay in transfer of above patient to a tertiary centre from BBH, after he sustained critical injury to vascular structures of left groin plus associated pelvic fractures and possible sciatic nerve damage.

15 y.o. male patient sustained deep laceration to left groin in MBA on 23 Dec 04 and was noted by QAS to be profoundly shocked at injury site. Transported by helo to BBH and immediately transferred to OT at BBH on arrival due to shocked state.

Patient underwent three operations by general surgeon (as no vascular surgeon available) in next 12 hours. Initial operation repaired 1cm laceration of femoral vein, while at second operation 3 fasciotomies were performed to relieve compartment syndrome and third operation (for acute ischaemic limb) required bypass of occluded femoral artery. Patient was admitted to ICU after initial operation.

Patient's condition improved/stabilised and he was transferred to general surgical ward on 27 Dec 04. He was regularly reviewed by treating surgeons (as care handed over between surgeons on 26 Dec 04 due to planned leave). Patient's general condition and left leg continued to gradually improve with respect to size, colour and sensation while pulses were maintained. Daily wound checks revealed a small area of superficial muscle necrosis in 1 fasciotomy wound on 30 Dec 04 and no evidence of overt infection.

An antibiotic were begun at time of initial operation and another antibiotic added on 31Dec 04 after patient became intermittently febrile from 27 Dec 04 and white cell count began to rise on 30 Dec 04.

Patient transferred to RBWH on 1 Jan 05 because treating surgeon was concerned that leg had failed to improve as quickly as expected, muscles remained grossly swollen and distal foot colour had changed in last 12-24 hrs with some reduction in pulses. Treating surgeon had no sense of impending problems as outlined in Dr Rashford's email.

KEY ISSUES:

- Life threatening/critical injuries to left groin vascular structures/pelvis of 15 y.o. male.
- Emergency surgery by general surgeon saved patient's life and attempted to save limb. No vascular surgeon available in Bundaberg region.
- Multiple operations maintained limb viability for period after operation.
- Limited improvement in limb observations from 23 Dec 04 until 1 Jan 05.
- Early evidence of infection from 27 Dec and increasing infection from 30 Dec 04 despite investigation and antibiotic cover.

- Transfer on 1 Jan 05 to RBWH – In retrospect transfer was delayed by a number of days as condition of patient's leg failed to improve as quickly as expected combined with evidence of infection. Transfer was possibly affected by handover of care from initial treating staff surgeon to other staff surgeon. Ideally patient should have been transferred to RBWH when stable on or about 25-26 Dec 04.

RELATED ISSUES:

Initial treating surgeon unable to make comment as he is on leave.

Medico-legal issues – Dependant upon information provided to family of patient by staff at RBWH, civil proceedings under PIPA/CLA may occur.

Public Affairs – Increased risk of negative publicity related to delay in transfer to tertiary facility.

BENEFITS AND COSTS:

N/A

ACTIONS TAKEN/ REQUIRED:

BHSD will institute policy of transfer to tertiary facilities of patients with emergency vascular conditions when condition is stable (i.e. life and limb are safe).

Note information provided plus proposed policy change.

ATTACHMENTS:

Clinical summary – P26

Clinical Summary - P26

15 y.o. male sustained deep laceration to left groin in MBA on 23 Dec 04. At scene showed signs of shock with reduced conscious state, hypotension and tachycardia.

Arrived at BBH via helo and taken straight to theatre due to ongoing evidence of shock with extensive bleeding from wound, hypotension and peripheral shutdown. Resuscitated with blood, FFPs and fluids.

Initial Operation – 1215h

Operation findings – 1 cm laceration of femoral vein at saphenofemoral junction, femoral artery and nerve intact. Rectus femoris transected and incomplete laceration of adductors with associated muscle contusion.

Femoral vein repaired, wound debrided and washed out, muscles approximated with primary wound closure.
Transferred to ICU via Medical Imaging.

CT Head/Thorax – NAD. CT Abdomen – Free peritoneal fluid, pneumoperitoneum and surgical emphysema of the lower half of abdomen and pelvis with evidence of air tracking in muscles of anterior abdominal wall. Multiple fractures of pelvis and roof of left acetabulum.

Second Operation – 1700h

Operation findings – Pulseless left leg with left leg compartment syndrome.

Upper and lower leg fasciotomies performed with all compartments decompressed.

Returned to ICU.

Third Operation – 2100h

Returned to theatre due to acute left leg ischaemia despite fasciotomies. Bedside USS showed no flow distal to CFA.

Operation findings – 5cm thrombus in femoral artery due to intimal injury.

Arteriorotomy with Gortex bypass graft inserted. Good PT pulse. Femoral vein appeared patent with no evidence of thrombus.

Returned to ICU.

Total blood products – 12 U RBCs and 6 U FFP.

Remained in ICU until 27 Dec 04, when transferred to general ward area. Care handed over from Dir of Surgery to Staff Surgeon on 26 Dec 04 due to planned leave.

During period until 1 Jan 05 regularly reviewed by surgical team. Patient appeared to be improving with increasing appetite, improving urine output and passing flatus.

Left leg showed some improvement in size, colour, sensation and pulses, although no movement noted. Inguinal wound continued to drain serous fluid.

Wounds reviewed and dressings changed daily. No evidence of overt wound infection in any wounds. Superficial muscle necrosis in one fasciotomy wound noted on 30 Dec 04.

Became intermittently febrile from 27 Dec 04 with increasing WCC from 30 Dec 04.
CXR – RLL collapse, blood cultures negative, urine MCS – negative, CVC tip – negative.
Wound swabs fm 30 Dec 04 – gram positive bacilli and gram positive cocci – 1+. Identification pending (probable enteric and skin flora).
Begun on cephalothin on 23 Dec 04 and timentin added on 31 Dec 04.

1 Jan 05

Febrile, tachycardia (upto 110-120bpm) and increasing WCC with neutrophilia (23.1x 10^9/L).
Blood pressure WNL.
Left foot was cool from midfoot distally with very mottled appearance (with some worsening in last 12-24hrs). Treating specialist noted that colour had improved over previous week with only distal foot being very mottled.
Pulses
Popliteal – palpable
PT – weakly palpable
DP – not palpable and no evidence on Doppler.
Transferred to RBWH on 1 Jan 05 by helo because leg had failed to improve as quickly as expected, muscles remained grossly swollen, distal foot colour had changed in last 12-24 hrs with some reduction in pulses. Treating specialist had no sense of impending problems as per Dr Rashford's email.

Summary

Life threatening/critical injuries to left groin vascular structures/pelvis of 15 y.o. male.
Emergency surgery by general surgeon (no vascular surgeon in Bundaberg area) saved patient's life and attempted to save limb.
Multiple operations maintained limb viability for period after operation.
Limited improvement in limb observations.
Early evidence of infection from 27 Dec and increasing evidence from 30 Dec 04 despite investigation and antibiotic cover.
Transfer on 1 Jan 05 to RBWH.

In retrospect transfer was delayed by a number of days as condition of patient's leg failed to improve as quickly as expected combined with evidence of infection. Transfer was possibly affected by handover of care from initial treating staff surgeon to other staff surgeon. Ideally patient should have been transferred to RBWH when stable on or about 25-26 Dec 04.

Recommendation

Transfer of patients with major vascular injury from BBH to vascular service should occur as soon as possible after patient's condition is stable (i.e. life and limb are safe).

Dr Darren Keating
DMS BHSD

5 Jan 05

From: Dan Bergin
To: Peter Leck
Date: 6/01/2005 11:29:35 am
Subject: Re: Brief re Patient Issue raised by Dr Steve Rashford

thanks Peter

Dan Bergin
Zonal Manager
Central Zone

Phone :
Fax :

>>> Peter Leck 5/01/2005 1:32:58 pm >>>

Hi Dan,

Please find attached Brief and background material prepared by Darren Keating in relation to this matter.

Darren is not sure in the circumstances that an external review is warranted.

Would welcome your further advice re same.

Thanks

Peter

From:	Judith Woods
To:	Peter Leck
Date:	10/01/2005 10:00:10 am
Caller:	john scott
Company:	corporate office
Phone:	see message

[*] Telephoned	[ ] Please call
[ ] Will call again	[ ] Returned your call
[ ] Wants to see you	[ ] Came to see you
[ ] Urgent	

Peter, John said if you were calling about the issue of Steve Brashford, as far as he is concerned it is all fine.

if it was another matter, please call him back.

SJR 3.

COPY

From: Peter Leck
To: Scott, John
Date: 13/01/2005 10:39:25
Subject: Bundaberg Director of Surgery - Dr Jay Patel

Hi John,

Sorry we have missed each other over the last week.

I was really trying to catch up about Dr Patel, our Director of Surgery; who undertook the procedure on the 15 yo male who had initial surgery in Bundaberg and subsequently transferred to Brisbane where he had a leg amputation. You will recall that Steve Rashford raised some concerns.

I was just wanting to flag, that I actually do have some concerns about the outcomes of some of Dr Patel's surgery. Late last year I received some correspondence from a member of the nursing staff outlining a number of concerns about outcomes for patients (including some deaths). This is coloured by interpersonal conflict between Dr Patel and nursing staff - particularly in ICU.

Until the last week, my Medical Superintendent did not believe the complaints were justified and were completely driven by the personality conflict - however he has now expressed some concern although he still believes most of the issues are personality driven.

Late last year I made contact with Mark Mattiuissi for advice about who could conduct a review of the concerns - and particularly of elective surgical ICU cases. My Med Super is keen not to have a professorial "boffin" from a tertiary hospital undertake such a review for fear that they might not relate to the "real" world demands of surgery in regional areas.

Mark suggested Alan Mahoney from Redcliffe. I flagged this also with Audit and Operational Review seeking some assistance for the review. They have referred me to Gerry Fitzgerald.

Unfortunately Gerry has been away (back next week) - I was really ringing to flag this with you as I'm becoming increasingly anxious about the need for a swift review process and wasn't sure I could wait until next week to get something going (now I think that this is okay - sorry!).

A few of the nursing staff have advised that they reported the matter to the QNU before coming to management (thankfully the QNU advised them to report to us).

Peter