(141)

STATEMENT OF MICHELLE DE-ANN HUNTER of address know to the Queensland Nurses' Union of Employees

Qualifications and experience

1. I am a Registered Nurse licensed to practise in the State of Queensland. I have been registered since 1994. I graduated with a Bachelor of Nursing from Central Queensland University at the end of 1994.

Patient names

2. In this statement, in the interests of protecting the privacy of patients and the feelings of patients' family and friends, I have referred to patients according to a key devised by my lawyers which I have sighted and which I understand is to be supplied by my lawyers to the Bundaberg Hospital Commission of Inquiry on a confidential basis.

Background

3. I am employed by Queensland Health in the Surgical Ward at the Bundaberg Base Hospital ("BBH"). I have worked at the BBH in the Surgical Ward on three separate occasions: from 1995 – 1998, end of 2000 to November 2002, and from January 2004 to the present time. In the intervening periods I have worked as a casual at the Gold Coast, both public and private, I have worked in the UK for one year doing agency work, and from November 2002 to January 2004 I worked in the Vascular Surgical Ward at the Royal United Hospital in Bath.

4. I have been an Acting Clinical Nurse in the Surgical Ward of the BBH since February 2004. My role is to coordinate the shift, liaise with all members of a multi-disciplinary team, and care for patients. I also act as the Nurse Unit Manager ("NUM") when the NUM is away and I am a resource person for the nursing staff, which means I provide advice on clinical issues. I am a member of the Infection Control Committee.

5. The Surgical Ward has 35 beds. We are only funded to operate 26 beds, but we frequently have up to 31 patients. Often when there aren't any beds, the elective admissions wait in the waiting room until a bed is ready. As we are not a specialty ward, we deal with orthopaedics, colorectal, plastics, maxillo-facial, trauma, urological and any other surgical conditions that aren't transferred to Brisbane. We also often receive medical outlies. We have one orthopaedic consultant and two private orthopaedic consultants who only do joint replacements, and usually two general surgeons. Dr Patel was one of those general surgeons.

Through knee amputation of the patient P26

6. On the 30 December 2004 on the evening shift where I was team leader, I looked after a patient by the name of P26, a 15 year old boy. He had been in a motor bike accident on 23 December 2004. He had sustained a laceration to his left groin and was taken to Theatre on arrival to the department of Emergency Medicine.

7. From his chart and Theatre notes I learnt the following about this patient. During the first procedure P26 had a femoral vein repair, debridement, wash-out and wound closure. The notes stated that at this time his femoral artery and nerve were intact. He was then admitted to ICU and intubated. A few hours later he returned to Theatre as he had a pulseless left leg. The patient had fasciotomies performed to his thigh and lower leg. The patient was again returned to ICU. Within a few hours, P26 was sent back to Theatre with acute ischaemia to his left leg despite the fasciotomies. During this procedure he had an exploration and arteriotomy with a gortex bypass graft. These procedures were all undertaken by the general surgeon, Dr Patel.

8. On the 30 December, a week after P26 had presented in Emergency Medicine and gone into Theatre, he became one of the patients I was to look after on my shift in the Surgical Ward. He had been moved to the Surgical Ward from the ICU. At the beginning of my shift, my assessment of P26 was that he was tachycardic, febrile and his left leg was grossly swollen and oozing very large amounts of

serous ooze. His left foot was purple and mottled to the ankle he had a posterior tibial pulse on Doppler but no dorsalis pedis pulse. He was unable to move his leg, was cold from the ankle down and had very patchy sensation.

9. I informed the intern who was on the ward that afternoon of my observations and she came to check the patient. The intern told me "They knew all of that", meaning the doctors, and she told me that they were considering taking out his central line as it may have been a point of his sepsis. I asked her if they were considering changing the antibiotics and she said "Not at this stage". She told me that Dr Patel was on holidays and Dr Gaffield was covering. I was very concerned about this patient and thought he should be transferred to Brisbane and see a vascular specialist.

10. My shift finished at 23:00 hours. I didn't look after P26 on the next shift, but I was the team leader and asked Kylie Johnston on a number of occasions about his condition. Nothing had changed, he was still very unwell.

11. On arrival at work on the afternoon of Saturday 1 January 2005 the staff told me P26 had been transferred out to Brisbane in the morning.

12. On Sunday 2 January 2005, I heard from the nursing staff in the ward and from Dr David Risson, who was on call, that Brisbane had performed a through knee amputation and that during this procedure they had found that the patient's femoral vein had been tied off. From that moment on I felt that Dr Patel had been incompetent and I was determined to voice my concerns as how the care of this patient was managed.

13. On Tuesday 4 January 2005 I had gone to Toni Hoffman (Level 3) seeking advice as to how to deal with this problem, as I knew she had had similar problems with her patients. I discussed P26 with her and she said that she had a folder full of similar incidents. Toni Hoffman told me she had made a complaint to the executives in October 2004 and had had no meaningful feedback since. She had been told that there was no problem with Dr Patel, and that it was a personality clash. I suggested that we should go to the Health Rights Commission about this.

She said she had thought about this but the union had advised her to go through the hospital channels.

14. That same day I told Dianne Jenkin (Level 3) that I was concerned about this and was going to make a complaint to the Health Rights Commission. I wanted to write to the Health Rights Commission because I felt management wouldn't do anything about the incident, as I felt Dr Patel was protected. This was particularly so after speaking to Toni Hoffman earlier in the day.

15. Di Jenkin went to Linda Mulligan, the Director of Nursing, with my concerns, and told Linda Mulligan I was intending to write to the Health Rights Commission. Linda Mulligan told Di Jenkin that that was not the right way to go about it and I should write a letter to her about P26 and about any other issues relating to Dr Patel.

16. I rang the Queensland Nurses Union and asked how I should go about it. They advised me to write a letter to Linda Mulligan, and if nothing was done about it, the QNU would take it further.

17. That same day, the 4 January 2005, I was on lunch when I received a call from Hazel Evans, a nurse on my shift, who told me that Executive Services wanted P26's chart straight away. Hazel asked whether I still going to make a complaint and did I want her to copy anything before they took the chart. I said yes and that I wanted a copy of the chart, but she was only able to photocopy two pages before someone arrived to take it away.

18. That night I wrote a letter addressed to Linda Mulligan, dated 4 January 2005 (attached and marked **MH1**). She wrote a letter to me saying she had referred the matter to Peter Leck.

19. I was interviewed by Sue Jenkins from the Queensland Health Review team on the 14 February 2005 in the Executive Services offices. I asked the secretary what it was in relation to, she could not tell me, so I went to the meeting presuming it was about P26. I was told to come up the front steps and go down the back steps as they were trying to keep the interviewees separate. There were

two union representatives present, Kym Barry and Vicki Smyth. I wasn't asked any questions, and was told by Sue Jenkins that she wasn't there to ask questions and that I was there to give information. I told them what I knew about the P26 incident.

Above knee amputation of patient unknown

20. Sometime last year I recall one patient that had an amputation of his leg. Dr Patel ordered that a plaster be put on the amputation in Theatre. I have not seen plaster used on an amputation and I felt that this was not an appropriate way to manage the wound as the man was obese and immobile.

21. The plaster remained on for a few days and caused pressure areas on the stump and posterior thigh. I asked Dr Patel to look at this patient's wound as the plaster had come off and the stump was completely dehisced. He said to me to take out some sutures and to debride some of the necrotic tissue and he said there is not much else he could do because the patient was a huge anaesthetic risk. The patient died a few weeks later.

The ERROMED meetings

22. The ERROMED meetings started in July 2004. Dianne Jenkin asked Dr Patel, Kylie Johnston and myself to be on the committee. I was to be the chairperson. The purpose of the meetings was to look at the adverse events that had occurred in the surgical ward in the previous month to ensure that the adverse events issues had been dealt with and to develop risk management strategies. We managed the workload by dividing up the adverse events into different categories. Each of us would report at the meeting on our designated category. Dr Patel handled any of the doctor related incidents and medication errors, Di Jenkin did the miscellaneous issues and staffing issues, Kylie did falls and I did pressure areas.

23. At the meetings, Dr Patel was poorly prepared and it seemed that he hadn't researched his problem areas. After each report was discussed we talked as a group about risk management strategies. The doctor related issues were to be followed up by Dr Patel. I have not seen any evidence that these issues have been

dealt with. The meetings were supposed to be monthly, but we had only three meetings, one in July August and December 2004 because Kylie and I worked shift work and Dr Patel would not commit to attending.

Wound dehiscence

24. We had numerous wound dehiscences in the time I worked with Dr Patel, especially in comparison to other places where I have worked. I asked Di Jenkin whether these statistics were kept and who looks at them. She said that she had been keeping figures on dehiscences and she took them to a meeting. I do not know which meeting this was. At this meeting Di told me that Dr Patel argued about the definition of wound dehiscence and that most of the figures presented to the meeting should not be included as they didn't fit his definition of dehiscence. She also told me that problems with patients including the dehiscences were also dealt with by the Mortality and Morbidity committee of which Dr Patel was the chairperson.

The Google Search

25. Sometime in the middle of 2004 after a number of disasters involving Dr Patel I began to wonder if Dr Patel had been involved in any negligence cases. Dr Patel had told us that he got his degree in Oregan, America. I did a Google search for the Oregon Medical Examiner's Board, found the site and put his name into the search facility on their site. I found that 'Jayant Patel' had been involved in negligence cases and he wasn't to perform certain types of surgeries.

26. I didn't know if this was Dr Patel, but I was shocked. At work I told my colleagues what I had found and they couldn't believe it. If it was true, we presumed the Queensland Medical Board must know about this.

27. When I spoke to Tony Hoffman about the P26 incident on the 4 January 2005 I mentioned the results of my Google search in conversation to her.

Dr Patel's behaviour

28. In February 2004, when I recommenced at the BBH, I heard that Dr Patel was aggressive and a bully. I found this to be true as he often berated nurses and junior doctors in front of patients. One incident occurred when I was facilitating university students, a patient P38 had received free fluids for lunch when she was supposed to be on clear fluids. I was outside the patient's room and he came at me angrily wanting to know who gave the patient free-fluids. In a raised voice he said "I want to know who it was". He was fuming. I told him to back-off that I wasn't working on the ward, that I was facilitating, and that he needed to take it up with whoever was in charge. From down the corridor in the office I heard him demand an adverse event form. I felt the way he handled this was very unprofessional.

29. When I was acting NUM Dr Patel came into the office and asked if he could speak to me. I said yes. He came in and closed the door. He asked me whether I knew that Jenny White in Theatre was resigning from the NUM position and he said he thought I would be a good candidate and encouraged me to apply for it. I told him that I had no Theatre experience. He continued to talk to me about it for about 10 minutes, and I couldn't really get him out of the office. I said I wasn't interested. I felt very uncomfortable in this situation and around him generally.

30. When doing rounds with Dr Patel I saw him take down the dressings of a patient, inspect the wound and then go to the next patient, take down their dressing and inspect their wound. He would work his way around the ward and not wash his hands between patients. The first time I did rounds with him I insisted he wash his hands between patients, as this is basic infection control, and part of the BBH policy. On that occasion he did comply with my request but he continued his practice of not washing his hands on other occasions. He disregarded other basic policies and procedures at the BBH. Even after being advised that he was not to wear Theatre attire in the wards, in accordance with policy, he blatantly ignored this and did what he wanted.

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Signed: MICHELLE DE-ANN HUNTER

Date: 23/5/05.

I **Michelle De-Ann Hunter** do solemnly and sincerely declare that the content of this my statement for the Bundaberg Hospital Commission of Inquiry (this declaration being at the foot of the last page of the statement comprising 8 pages) is true and correct to the best of my knowledge and belief and I make this solemn declaration conscientiously believing the same to be true and by virtue of the provisions of the *Oaths Act 1867*.

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MICHELLE DE-ANN HUNTER

Declaration Taken By:

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Lawyer

Date: 23.5.2005

4 January 2005

Michelle Hunter
Acting Clinical Nurse
Surgical Ward
Bundaberg Health Service

Lynda Mulligan
Director of Nursing
Bundaberg Health Service

Dear Lynda

I would like to express my grave concern about a recent patient [redacted] P26 [redacted] had a motorbike accident on 23/12/04 and sustained a laceration to his left groin area. He was subsequently taken to theatre on arrival to DEM and had a femoral vein repair and debridement/washout and wound closure. At the time of this surgery his femoral artery was intact. P26 is admitted to ICU intubated post op and a few hours later had to return to theatre with a pulseless left leg and he had fasciotomies performed to his thigh and lower leg. Again he returned to ICU for a few hours and then again went back to theatre with acute ischaemia to his left leg despite the fasciotomies. He had an exploration and arteriotomy with a Gortex bypass graft. My dealings with [redacted] started on the 30 December when I looked after him on an evening shift. He had recently been transferred to the ward from ICU. My assessment of [redacted] showed he was tachycardic, febrile and his left leg was grossly swollen and oozing very large amounts of serous ooze. His Left foot was purple and mottled to the ankle, he had a Posterior Tibial pulse on Doppler but no Dorsalis pedis pulse. He was unable to move his leg, was cold from the ankle down and had very patchy sensation. This information was made available to the Doctors on duty that afternoon.

I did not look after [redacted] again but was team leader for other shifts in which he was an inpatient in the surgical ward. [redacted] was transferred to the Royal Brisbane Hospital for vascular surgical care on 1 January 2005. I have since learned that [redacted] is in a grave condition in ICU there and he has undergone an amputation of his left leg as well as other procedures.

My concerns are with the surgeon that performed his initial 3 operations whilst in the care of the Bundaberg Health Service. I am concerned that if the patient had been transferred to Brisbane initially he my not of lost his leg or be in such a grave condition.

I would like his treatment at this hospital investigated as I fear his health and well being has been compromised by inadequate, sub standard treatment by the medical team.

Your urgent assistance in this matter is greatly appreciated.

Yours Sincerely

Michelle Hunter

Supplementary Statement of Michelle De-Ann Hunter.

Michelle De-Ann Hunter states:

I refer to paragraph 12 of my statement dated 23 May 2005 wherein I state that I heard from the nursing staff in the surgical ward and from Dr David Risson that when a through knee amputation had been performed in Brisbane, it had been discovered that the femoral vein had been tied off. Upon reflection, I am unsure whether Dr Risson did tell me this, but I was told by nursing staff from the ward that this had occurred in Brisbane.

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Michelle De-Ann Hunter

Date: