QUEENSLAND

COMMISSIONS OF INQUIRY ACT 1950

BUNDABERG HOSPITAL COMMISSION OF INQUIRY

STATEMENT OF LEONIE THERESE RAVEN

1. I, **LEONIE THERESE RAVEN,** Quality Coordinator, District Quality and Decision Support Unit (DQDSU) of c/-, Bundaberg Base Hospital, Bourbong Street, Bundaberg, in the State of Queensland, acknowledge that this written statement by me dated ~~15~~ 24 June 2005 is true to the best of my knowledge and belief.

2. This statement is made without prior knowledge of any evidence or information held by the Inquiry which is potentially adverse to me and in the expectation that I will be afforded procedural fairness should any adverse allegation be raised against me.

Qualifications and Experience

3. I attained my Certificate of Nursing from St John of God Hospital, Ballarat, Victoria in 1984. I was awarded a Bachelor of Health Science (Nursing) from Monash University in 1994. I also hold a Graduate Certificate in Critical Care Nursing from Griffith University which I attained in 1998.

4. I have been employed at Bundaberg Base Hospital (Hospital) as a Registered Nurse since June 1995. I have held the position of Quality Coordinator since July 2000.

5. In my role as Quality Coordinator, I am responsible for preparing the Hospital for Australian Council for Health Care Standards (ACHS) accreditation first achieved in May 2000; maintaining the adverse events and complaints registers; liaising with Press Ganey, an external organisation, in undertaking the annual patient satisfaction survey; maintaining the central risk register and updating and maintaining Hospital policies and procedures.

6. Attached and marked **LTR1** is a copy of my position description and current curriculum vitae.

District Quality and Decision Support Unit

7. The DQDSU was established in mid-2001. The unit was formed with the intention of centralising data collection for the District. The DQDSU involved the amalgamation of three separate units that, up to this time, had been separately located. These units included the Quality Management Unit, Clinical Benchmarking and Finance.

8. The position of Quality Coordinator was previously part of the Quality Management Unit. Up to mid-2001, that unit was predominantely focussed on preparation for ACHS accreditation and maintaining and updating Hospital policies and procedures.

Functions of Quality Coordinator

9. Adverse event reporting and complaints management was not part of my responsibility at that stage. Historically, they had been managed in a fairly ad hoc way and depending on the nature of the adverse event or complaint, it would be referred onto different individuals to action. There was no central point for management of this information. Often adverse events were dealt with by the Assistant Director of Nursing given that it was traditionally nursing staff who completed the adverse event reports.

10. In approximately mid-2001 I began drafting a policy dealing with complaints management. I had attended a workshop run by Queensland Health (QH) which was looking at implementing some sort of consistent approach to the management of complaints across the State. This was part of the Quality Improvement and Enhancement Project being conducted by QH. We were provided with a complaints framework which I understand had been adopted from the Health Rights Commission complaints management framework. There were 9 categories within which to classify complaints.

11. I developed a Complaints Management Policy and Complaints Registration Form to be completed by any person making or receiving a complaint. The Policy and Complaints Registration Form were implemented in May 2002. Those forms were required to be sent to the DQDSU for registration on the complaints register. Attached and marked **LTR2** is a copy of that policy.

12. In May 2002 I attended a week long risk management course run by Dorothy Vincenzino at QH. This course was also part of the Quality Improvement and Enhancement Project and was conducted by external educators from Monash University. Up to this point, risk management had been a new concept for the Hospital. Given I had been identified as the person to attend the course, risk management became part of my responsibility.

13. I conducted workshops in conjunction with Paul Rolek from the Integrated Risk Management team in October 2002, and December 2002 during which we identified strategic risks for the district. A strategic risk register was developed and submitted to corporate office in May 2003. A central risk register was also developed. I conducted further workshops in June 2003 with middle managers related to the implementation of the Local Risk Management process.

14. Following the course, I also developed a central risk register which identified risks within the District that could be dealt with at the district level.

15. In December 2002 I also developed a Risk Management Policy. That policy came out of the QH Integrated Risk Management policy developed by corporate office.

Attached and marked **LTR3** is a copy of the Bundaberg Health Service District Risk Management Process policy developed by me.

16. In conjunction with some of the senior risk management officers from the QH risk management project, I conducted a number of workshops across the District. I also became involved in implementing risk management strategies across a number of districts within the Central Zone.

17. Toward the end of 2002, ACHS released the third edition of the Evaluation and Quality Improvement Program (EQuIP) guide. This guide provides the framework for the 43 standards to be achieved to enable the Hospital to reach accreditation. These new standards applied to any organisation undergoing accreditation from January 2003.

18. From January to August 2003, the majority of my time was taken up in preparing the Hospital for accreditation. This was a full-time job. This was only our second organisational survey and with the release of the new EQuIP guide, there was a significant amount of work required to be done to prepare the Hospital.

19. In September 2003, ACHS provided a draft report as a result of our organisational survey, along with their recommendations. The official report was released in early November 2003 and contained a recommendation in relation to adverse event or incident monitoring and sentinel event reporting.

20. As a result of this recommendation the Hospital began examining their reporting procedures. I recall around this time that I had a discussion with Peter Leck, District Manager regarding the Hospital's incident monitoring. Mr Leck suggested that I meet with the Patient Safety Officer at Princess Alexandra Hospital (PAH), who was the person responsible for incident monitoring at that hospital. The PAH was regarded across QH as having implemented good systems for incident monitoring. Following that meeting, I drafted a policy for incident monitoring.

21. Attached and marked **LTR4** is a copy of the Adverse Events Management Policy for the Hospital. That policy was developed by me in January 2004 and implemented across the District in February 2004. A new Adverse Event Report Form was also developed and rolled out at that time.

22. In March 2004, I went on extended sick leave for six months. Accordingly, Jennifer Kirby, Manager DQDSU became responsible for providing education to Hospital staff regarding the new Adverse Events Management Policy. This education was undertaken by Jennifer Kirby in conjunction with Dr Darren Keating, Director Medical Services. I am informed by Jennifer and believe that this education was provided by her in conjunction with Dr Keating.

23. From February 2004, all adverse events at the Hospital were reported to DQDSU. Upon receipt of an adverse event form, it was my responsibility to risk rate the event in accordance with the QH risk matrix. A copy of the QH risk matrix is attached and marked **LTR5**.

24. Any adverse event risk rated as low to medium was then inputted into the adverse events register. This register is an Excel spreadsheet which contains relevant data taken from the adverse events report. Adverse events rated as high, very high or extreme, were also inputted into the register and then forwarded by me to the relevant executive director for follow-up. Often the DQDSU would receive reports back from the relevant director who had received the report of action taken in relation to the event. Any relevant information received would then be inputted into the adverse events register under the 'action taken' column.

25. Following implementation of the new Adverse Events Management Policy, it had been the intention of the DQDSU to provide feedback to staff who were reporting adverse events regarding the action taken and the outcome of the event. Due to resourcing issues, this process was unable to be sustained across the District.

26. The Sentinel Events and Root Cause Analysis Policy was also developed by me at the same time. It contained timeframes within which sentinel events were required to be reported to the relevant executive director. A copy of that policy is attached and marked **LTR6**.

27. From March to early May 2004, during part of the time I was on sick leave, the Quality Coordinator position remained vacant. In early May 2004, Dr Jane Truscott a registered nurse in palliative care was seconded into the position as Acting Quality Coordinator.

28. In November 2004, all of these policies were updated in line with the QH policies that had since been rolled out. Whilst the terms 'adverse event' and 'incident' are used interchangeably, the QH policy in relation to adverse events which was rolled out in June 2004, referred to 'incidents'. Accordingly, the hospital policy was amended to reflect this change. This policy also required cost centre managers to risk rate incidents reported from their unit. In addition, the definition of what constitutes a sentinel event also changed. Our policy was amended accordingly. Attached as a bundle and marked **LTR7** are the current policies relating to incident monitoring, reporting and risk management.

Complaints regarding Dr Jayant Patel

29. In preparation for providing this statement, I have caused to undertake a review of the complaints register to identify the complaints received by the DQDSU in relation to Dr Patel. I have been able to identify three complaints which arise out of treatment provided by Dr Patel. It may be that there are additional complaints which have been received, however, there are only three complaints which actually indicate Dr Patel as the medical practitioner involved in treatment. It is not uncommon for a complaint to be lodged without identifying the health care provider involved.

30. Attached and marked **LTR8** are the three complaints received by the DQDSU.

31. The complaint registration form is completed by the person who is handling the complaint. The form contains information relating to the type and source of the complaint; the complainant's objective in lodging the complaint and the action

taken in response. Once that form is completed, it is forwarded onto the DQDSU for inputting into the complaint register.

32. In addition to the Complaint Registration Form, there is often a file held in the Executive Office in relation to the complaint. The DQDSU is not provided with this file and only advised of the outcome of the management of the complaint upon receipt of the Complaint Registration Form.

Adverse events relating to Dr Patel

33. In preparation for providing this statement, I have also interrogated the adverse events register to identify the adverse event forms relating to Dr Patel. I have been able to positively identify five adverse events that arise out of treatment provided by Dr Patel. There is a sixth adverse event form which involves a patient that was subsequently treated by Dr Patel following surgery performed by another surgeon at the Hospital.

34. The first Adverse Event Report Form received was in relation to Desmond Bramich. That report was received into the DQDSU on 2 August 2004, whilst I was on sick leave. The report was completed by Karen Fox, a registered nurse in the Intensive Care Unit (ICU) and arose out of the absence of water in the underwater seal drainage unit. This unit is used in conjunction with an intercostal catheter to drain fluid or air from the lungs. The adverse event was risk rated by Jane Truscott as 'very high' and in the 'action required' column, Jane has noted that the report was forwarded to the District Manager, Director of Medical Services and Director of Nursing for their action. I am unsure what action was taken in response to the adverse event given I was on sick leave at that time.

35. A sentinel event form was also completed in relation to Mr Bramich. That form was filled in by Toni Hoffman, Nurse Unit Manger, ICU on 2 August 2004. The sentinel event reported by RN Hoffman arose out of the perceived delay in transferring Mr Bramich to Brisbane for treatment. A 'post-it' note had been affixed to the form by Jane Truscott who had written that it had been forwarded to the District Manager, Director of Medical Services and Director of Nursing. Again, I was on leave at this time and was not directly involved in either of these events.

36. Attached and marked **LTR9** are copies of the adverse event and sentinel event reports relating to Mr Bramich.

37. Sometime after my return to work in August 2004, I received a telephone call from RN Hoffman enquiring as to the status of the sentinel event report. I believe this may have been around October 2004. I did a search in the adverse event register by patient name for Desmond Bramich. I was only able to identify one adverse event relating to Mr Bramich, which was the form completed by RN Fox. I informed RN Hoffman that the only adverse event logged into the register was in relation to the underwater seal drain. RN Hoffman stated that she had completed a sentinel event form which she had sent to DQDSU. I informed RN Hoffman that I would make some further enquiries and get back to her.

38. I then spoke with Dr Keating and asked him whether he was aware of a sentinel event form in relation Desmond Bramich. He stated that he was aware of the sentinel event and that an analysis of the event had been undertaken. I believed from my discussion with him, that Dr Keating was going to report back to the clinicians involved in Mr Bramich's care.

39. I understand that RN Hoffman has given evidence to the Commission to the effect that it is her belief that the sentinel event was downgraded. This is incorrect. The adverse event and sentinel event forms were received into the DQDSU on the same day. The sentinel event was actioned appropriately and in accordance with the Hospital policy which was current at the time. What appears to have happened is that the sentinel event and adverse event forms were stapled together in error by the Administrative Assistant in the DQDSU given they related to the same patient. Rather than being entered as two separate events, they were entered as an adverse event in the register. Hence, when I undertook a search for the sentinel event notified by RN Hoffman, it did not appear in the database. However, as indicated above, it was appropriately acted upon and was not downgraded.

40. The second Adverse Event Report Form received into the DQDSU related to P127. The report was completed by registered nurse Di Jenkin, Nurse Unit Manager of the Surgical Ward. The 'management report' section of the form completed by RN Jenkin states that she had referred it on to Errormed, which is a monthly meeting conducted by the clinicians to review incidents that have occurred in their area. It is the responsibility of those clinicians to identify relevant incidents that require further review.

41. That report was received in the DQDSU on 20 August 2004 and was risk rated by me as high. Accordingly, it was forwarded to Dr Keating to action. This was the first adverse event report ever received by DQDSU in relation to wound dehiscence or breakdown.

42. A copy of that report is attached and marked **LTR10**.

43. The third Adverse Event Report Form received into the DQDSU was in relation to P15 That report was also completed by RN Jenkin and was received into the DQDSU on 29 October 2004. That report was risk rated by me as high and arose out of a post-operative haematoma following a laparoscopic cholecystectomy. RN Jenkin has indicated in the 'management report' section of the form that the incident would be referred to Errormed. The report was also forwarded by me onto Dr Keating and the Director of Nursing, Linda Mulligan, to be actioned.

44. Linda Mulligan has noted on the form that the incident related to a surgical issue rather than nursing care and she has referred it back to Dr Keating.

45. Attached and marked **LTR11** is a copy of that report.

46. The fourth report relates to Marilyn Daisy. That report was completed by RN Jenkin and received into the DQDSU on 8 November 2004. That report was risk

rated by me as medium and related to retained sutures following amputation on 20 September 2004. The report states that the patient had discharged herself at her own risk, on 4 October 2004, but returned to the Renal Unit on nine occasions for dialysis. RN Jenkin states that on 4 November 2004 she was informed by a renal physician that he had been advised by a surgeon in Brisbane that sutures had been left in the sump. The report notes that at the time the report was completed, the wound had healed. Hence, I risk rated the incident as a medium risk.

47. The report does not identify Dr Patel as the person responsible for the incident.

48. Attached and marked **LTR12** is a copy of that report.

49. The fifth report relates to Trevor Halter. The report was completed by RN Mullins and received into the DQDSU on 7 January 2005. That report was not risk rated by me because, by 3 December 2004, a decision had been made that cost centre managers would be responsible for risk rating their own adverse event reports. Accordingly, the report was risk rated by RN Jenkin, the NUM and Cost Centre Manager for Surgical Unit. RN Jenkin risk rated the event as a medium risk.

50. The report related to a foreign body found in the tubing of a bellovac drain. The foreign body, identified by RN Jenkin was 'an unused skin staple' and the report indicates that it resulted in increased pain for the patient upon removal of the drain. RN Jenkin identified that Dr Patel was the surgeon who inserted the drain. Accordingly, the incident was referred back to Dr Patel and the Nurse Unit Manager of the operating theatre.

51. Attached and marked **LTR13** is a copy of that report.

52. The sixth report I have identified, relates to Doris Hillier. This patient was not initially operated on by Dr Patel however, she was treated on her return to the operating theatre by him. This is how his name came to be identified in relation to this patient. I believe the adverse event relates to the initial surgery rather than the subsequent surgery performed by Dr Patel.

53. Attached and marked **LTR14** is a copy of that report.

54. In preparation for providing this statement, I have also undertaken a search of the Patient Client Incident Reports, which is a paper based system utilised by the Hospital prior to the introduction of the adverse event monitoring system in February 2004, outlined above. These reports were not inputted into the adverse events register and were retained by the Assistant Director of Nursing in her office.

55. I have identified ten reports which contain Dr Patel's name. Of the ten, five relate to equipment failure reported by nursing staff where Dr Patel was the surgeon involved. Attached as a bundle and marked **LTR15** are copies of those five reports.

56. Of the balance of the five reports, the first relates to a surgical procedure undertaken by Dr Patel on the wrong patient. This incident appears to have occurred as a result of a number of systems errors. Attached and marked **LTR16** is a copy of that report.

57. The second incident report relates to an atraumatic needle which had broken intra-operatively and was left insitu as Dr Patel considered that the patient was too unstable for it to be retrieved. Attached and marked **LTR17** is a copy of that report.

58. The third report was completed at the request of Dr Patel. That report relates to an incident involving one of Dr Patel's patient's who was observed to have a distended abdomen. The patient had not passed urine and the nursing staff had failed to notify the medical officer on-call. Attached and marked **LTR18** is a copy of that report.

59. The fourth report relates to a towel clip being inadvertently clipped to the patient's skin whilst Dr Patel was draping the patient. Attached and marked **LTR19** is a copy of that report.

60. The fifth report relating to Dr Patel, arose out of the introducer of a 'pig-tail' catheter being retained during the insertion of the catheter, but not being discovered until the catheter was removed. Attached and marked **LTR20** is a copy of that report.

Committee involvement

61. As part of my role as Quality Coordinator, I am involved in a number of committee's which exist at the Hospital. For example, I provide monthly reports from the DQDSU to the Leadership and Management Committee. That report broadly outlines what I have been doing as Quality Coordinator for that month. In particular, progress with ACHS accreditation, quality activities and our progress with the Press Ganey reports.

62. The committee is also provided with quarterly trend reports on incident reports and complaints. In my role in monitoring all incidents coming into the DQDSU, any trends that I identify that may be emerging, would be forwarded to the appropriate person for follow up. For example, if we were seeing an increased number of reports in relation to wound dehiscence, I would collate those reports and forward them to the Director of Medical Services to action.

63. I also provide reports to the Improving Performance Committee and Executive Council. Both committees' sit monthly but do not necessarily request monthly reports from me. The sort of information I provide to them relates generally to trend reports of complaints and incidents, information in relation to the Press Ganey survey results and ACHS accreditation.

64. In addition, I provide monthly reports to the District Health Council and the District Consultative Forum. I am also a member of this committee.

65. I sit on a number of committees including Continuum of Care; Human Resource Management; Information Management; and Safe Practice and Environment. My function in these committees it to provide guidance, from a quality perspective, in terms of what they ought to focus on, particularly in relation to ACHS accreditation.

66. In mid-2002, I attended the annual conference of the Australian Association of Quality in Healthcare at the Gold Coast. One of the speakers at that conference was Dr Alan Wolff, who presented the Wimmera Clinical Risk Management Model. On my return to the District, I informed Peter Leck of the improvements in patient safety described by Dr Wolff, which had been achieved utilising this model. Subsequently, I again spoke with Mr Leck following his attendance at a District Managers forum where Dr Wolff had also presented. Mr Leck was keen to look at implementing the model across the District with my assistance. I obtained approval to purchase the toolkit which Mr Leck then attempted, unsuccessfully, to roll out on numerous occasions, at the Executive Council. I understand from Mr Leck that he met with considerable resistance from senior medical officers who were not interested in utilising the toolkit. I was also present at a number of Executive Council meetings and observed the medical officers response to attempts to implement the toolkit firsthand.

Additional matters

67. On 20 October 2004 Peter Leck, District Manager sent me an email requesting I see him urgently regarding any adverse events concerning Dr Patel.

68. That email was sent by Mr Leck at 5:17pm, but not opened by me until the next morning. I went over to Mr Leck's office to enquire as to what sort of information he required. I recall Mr Leck telling me in broad terms that he had received a complaint from Toni Hoffman regarding Dr Patel.

69. I recall Mr Leck discussing an incident arising out of a patient with a perforated bowel. I then went back to the DQDSU to look for the information Mr Leck had requested.

70. I sent an email back to Mr Leck at 9:09am on 21 October 2004 to the effect that I was unable to locate an incident report in relation to 'this perforated bowel incidence'. Attached and marked **LTR21** is a copy of that email.

71. It is likely I would have reviewed the adverse event register and, in particular, the adverse events reported from the surgical ward. I would also have undertaken a search for reports containing Dr Patel's name. At that time, I was only able to locate 2 reports in relation to Dr Patel. One in relation to Desmond Bramich (exhibit LTR9) and the other in relation to P127 (exhibit LTR10). I informed Mr Leck of this in my email to him in reply.

72. Whilst the adverse event form in relation to P127 did not contain Dr Patel's name, I had undertaken a search of the adverse events register for reports arising out of the surgical unit. It is likely I would have eliminated reports relating to falls, development of pressure areas, medication errors and focussed on reports

connected with clinical treatment. This is how the adverse event form in relation to P127 was found.

73. At 9:11am I received a further email from Mr Leck which said 'can you please see me and bring the letter re the ventilated patients'. I went to Mr Leck's office and handed him a copy of Hoffman's ICU document. Attached and marked **LTR22** is a copy of that email.

74. On 21 April 2005 at the request of Gail Aylmer, I sent her an email regarding a comment that had been made by Linda Mulligan, Director of Nursing back in August 2004. I have been informed and verily believe that this email has been exhibited to Ms Aylmer's statement dated 24 May 2005.

75. On my return from sick leave in August 2004, I was involved in a strategy meeting as part of the Integrated Strategy and Performance (ISAP) project. That was a project being rolled out across QH. The districts were required to develop a strategy map which focussed on how they were going to deliver clinical services. That meeting was attended by all of the executive plus a person from finance, the rural Directors of Nursing and Jennifer Kirby, Manager, DQDSU.

76. I recall a discussion taking place with Mrs Mulligan regarding an issue with the strategy map. I recall Mrs Mulligan saying that issue would need to go back to the Leadership and Management Committee (composed only of the 6 members of the executive) for their decision. I said to Mrs Mulligan 'you have all the executive here, why don't you just make the decision now?' I recall that Mrs Mulligan was adamant that it needed to be put to the Leadership and Management Committee. I recall that Mrs Mulligan said that the executive were not able to delegate any decision making responsibilities to any middle managers because they did not have any middle managers who were reliable enough to delegate to.

77. I recall after this meeting that I was quite upset at Mrs Mulligan's comments and discussed them in passing with Ms Aylmer.

78. Subsequent to Mr Messenger tabling Toni Hoffman's correspondence in parliament, I recall that the level 3 nurse unit managers were requested to attend a meeting with Dr Gerry FitzGerald. I believe this meeting occurred around 14 April 2005. After the meeting Ms Aylmer (who had attended) approached me and told me that she had indicated to Dr FitzGerald that there was someone who could attest to the fact that Mrs Mulligan held the view that she was unable to delegate to middle management as they were regarded as being unreliable.

79. Ms Aylmer asked me to send her an email outlining my discussion with Mrs Mulligan that had occurred back in August 2004. She assured me that the information would not go any further.

80. On the day that Mr Messenger tabled Ms Hoffman's letter in parliament, I recall discussions between myself, Peter Leck and Jennifer Kirby. Mr Leck had come around to see us that afternoon in the DQDSU and told us that a letter had been given to Mr Messenger from someone at the Hospital. At that stage, Mr Leck appeared not to know who had sent the letter.

81. A few days later, Mr Leck told me that he had it on good authority that the letter had been sent by a group of nurses. I recall that Mr Leck was angry that they had gone to Mr Messenger. I recall that this had all occurred on the second day after Mrs Mulligan had gone on leave.

82. Di Walls was acting Director of Nursing in Mulligan's absence. Mr Leck and Ms Walls spoke with the level 3 nurse unit managers about what had occurred. In my opinion, Mr Leck was a very ethical person and did things 'by the book'. He was upset that these nurses had gone to Mr Messenger and not followed process. He was of the opinion that their conduct was in breach of the QH Code of Conduct. I understand he told them that if they had an issue which they felt was not being dealt with by the executive, that there were other avenues open to them and that this information should not have been leaked to Mr Messenger or the media.

Signed at **Bundaberg** on ~~16~~ 24 **June 2005**.

....

Leonie Therese Raven
Quality Coordinator
District Quality and Decision Support Unit
Bundaberg Base Hospital