

Bundaberg Hospital Commission of Inquiry

STATEMENT OF GEORGE ALEXANDER CONNELLY

George Alexander Connelly makes oath and says as follows:

1. I was born on 6 January 1938 and I reside in the Bundaberg district at an address I have provided to the Commission.
2. My wife, Doreen, died at home of a heart attack on 3 December 2003. I believe that my wife's death was preventable and that the doctor and the nurse involved should have been the subject of disciplinary action.
3. Just after midnight on 2 December 2003, Doreen woke me up and said, "You'll have to take me to hospital." She'd already taken an aspirin and sprayed under her tongue. I called an ambulance and it arrived shortly afterwards with two paramedics. One paramedic gave Doreen an aspirin and sprayed under her tongue. The ambulance took Doreen to the Bundaberg Base Hospital ("the Hospital") and I followed behind in my car. When Doreen arrived, the staff sprayed under her tongue again and gave her another aspirin. The nurse asked her how she was feeling and she responded that "the pain is easing".
4. I stayed with Doreen and, in the course of the morning, the Hospital staff did a number of tests. They did an ECG and the ward doctor said that it was clear. I understand that an ECG is a test used in the investigation of heart disease. I don't know his name. The ward doctor did a blood test and came back and said that it was clear. The staff did a second blood test and apparently it was clear too. They did another ECG and they said that it was fine, too.

Signed: *George Alexander Connelly*
Deponent

Taken by: *[Signature]*
Solicitor/Justice of the Peace


5. In the early hours of the morning, Doreen was admitted to Ward 10 at the Hospital. The staff said that the heart specialist would be there at 8.00am and he would see Doreen then. Doreen said to me that the pain had eased right off. They had sprayed under her tongue again, and she seemed fine, so I went to drop our son Paul off to work.
6. Doreen's general practitioner, Dr Mergard, had booked her in, previously, for a stress "sestamead" test at the Mater Hospital in Bundaberg ("the Mater") at 10.20am on the same day ("the x-ray"). There was a letter with the appointment card that said that, if you can't make it, you have to let the Mater know straight away so that they could re-assign the appointment. My wife is very particular about doing things the right way and she asked me to drop by the Mater when I was taking Paul to work, and to tell them that she would not make it. I dropped off my son at 7.00am and then I went to the Mater. They weren't open yet. I banged on the door. A man came out but he was a little irritable. I decided to tell him, and I told him, that I wasn't sure if my wife would make it because she was at the Hospital and I didn't know if they would run her down.
7. The man said that, once the staff at the Hospital decided what they were doing, they would need to notify the Mater as early as possible.
8. I returned to the Bundaberg Base just before 8.00am. The specialist arrived at 8.30am. I told him about the x-ray that had been organised. I explained that he would need to notify the Mater straight away if he wanted the tests done. He looked directly at the nurse, holding up the appointment card I had given him, and said, "I want this test done straight away".
9. The nurse nodded at the specialist. He had returned the appointment card to me and I gave it to her. I showed her the number to call down at the Mater. I said that she would need to call straight away or they would re-allocate. She went off without speaking to me and I assumed she was going to make the phone call.

10. At about 10.00am, the ward doctor came around and said that they would get Doreen ready to take down. They were wondering how to get her down there and the doctor was saying that maybe I (that is, George Connelly) should just drive down. The nurse, however, said that Doreen should be taken down by ambulance. The ward doctor never asked my wife a question and I started to think that things were pretty serious and that they knew something they weren't telling me. I chased the ward doctor down the corridor, and asked him if there was anything he wasn't saying. He said, "We think your wife has a blockage in her heart. This test will show where it is. We can give her something for it, and we'll have to fly her to Brisbane today, and she'll have to be operated on today to clear the blockage".
11. I went back and told Doreen. She was mostly worried about me and who would look after me in her absence. I have emphysema and I have a collapsed lung. I have oxygen all the time, and I take various other medications
12. The ward doctor then came back. He said that he had called the Mater but they had cancelled the x-ray and re-allocated it to someone else. I was furious. I drove straight down to the Mater and I spoke to the lady at reception in the radiology department. She said that until the doctor called at 10.10am, no one had called. She said that they had waited until 9.30 and then they had re-allocated the appointment. She said that they could still do it as an emergency if the Hospital asked. They could do it later that afternoon.
13. I went back to the Hospital. I found the ward doctor at reception. I complained that no phone call was made. I said that the Mater could still do the x-ray as an emergency if he phoned. He said that the Hospital could not do that because it had no arrangements in place for same with the Mater.
14. I asked what happens to Doreen now. He said "We'll send her home until we can book her in again and get the results. I said, "But 10 minutes ago you were talking about it being an emergency". He didn't really respond.

15. I ~~went and found~~ ^{spoke to} the nurse and asked why she didn't call. She said, "Is not my job; the doctor should have called".
16. I should say that I have had the x-ray myself. There are two types. In one type, they make you do exercise and they assess you. In the other type, you just lie on the table. They inject you with dye and then you just lie there and watch the monitor. When it gets to a blockage it stops, and you can see clear as you like on the screen where the blockage is. It would have been an easy matter to spot the blockage with Doreen.
17. I took Doreen around to see my heart specialist, Dr Kammnoff. He tested her. Her heart had settled down by then, which was hardly surprising because she had received aspirin and injections. He said the matter was in the Hospital's hands. So we went home.
18. I said to my wife that I'd book us on a plane to Brisbane so that she could see my specialist at the Greenslopes Hospital. She said, "no, the hospital knows what they're doing". So we stayed.
19. I spoke to my wife at 4.30am. She was out of bed and I asked if she was okay. She said that she was just going to the toilet. At 6.00, I went to check on her but she had died. I took off my oxygen and gave it to her. I tried to give her mouth to mouth resuscitation but she couldn't be revived. When the ambulance arrived, the lady paramedic said it was too late.
20. I complained to the Police. I went over to the CIB and said I wanted the doctor and the nurse charged. The police officer said we can't charge staff for things that happen in hospital. I have since been told by Neil Armstrong at the CMC (who is a police officer) that that's not true. I am shocked you can't even get accurate information from the CIB.
21. I complained to the director of nursing, Mrs Callinan, and I had a meeting with her.

Signed: 

Deponent

Taken by: 

Solicitor/Justice of the Peace

22. I complained to the Health Rights Commission, and I sent them, in early 2004, a detailed complaint. That complaint is now shown to me marked "GAC1".
23. After I approached the HRC, the Hospital wrote to me by a letter from a Patrick Martin dated 2 March 2004 but that letter did not address the matters at the heart of my complaint about the nurse, namely her failure to call the Mater promptly. A copy of that letter is now shown to me marked "GAC2".
24. I met with the manager of the Hospital, Peter Leck, some weeks later. Also present was the ward doctor, who was called Dr Kahn, and the specialist who was called Dr Strahan. I cannot remember if Dr Keating was there. Mr Leck produced a letter he had written to the HRC. That letter is now shown to me marked "GAC3".
25. The letter from Leck is, to my mind, misleading. I note that:
- (a) Whereas he says that Doreen, on arrival at the Hospital, said she was pain free, in fact she said that the pain was reducing;
 - (b) In any case, it doesn't seem to make much sense to say that she was pain free when no mention is made of the pain killers she had received;
 - (c) Doreen was admitted on 2 December, not 1 December, 2003;
 - (d) The explanation of the failure to secure the Mater stress test appointment does not address the issues raised above;
 - (e) Whereas it is suggested that Doreen was discharged at 14.30 hours on 2 December 2003, in fact, she was discharged late morning. She wasn't there for lunch.
26. I said to the specialist that, if a test was done, Doreen might be alive. The specialist said "maybe". He said, however, that even if we had obtained the test results, we might not have been able to get Doreen on a plane to Brisbane. I went and spoke to the plane people that same day. They told me that often they have people on routine flights and, if there is some emergency, they can exchange places. Anyway, they said, they can always lease planes.

27. I asked the specialist if he was a heart specialist. He said, no, he was a medical specialist. I can't believe that. There are 100,000 people in the Bundaberg area and they don't even have a specialist for hearts.
28. I have spoken many times to John Cake and Karen Ardess at the HRC. They obtained a copy of the hospital file and they sent it to a specialist in Melbourne and another one in Brisbane. They blotted out the identifying features but both specialists said the same thing. They said that the doctors should have known without the x ray that there was a blockage or muscular problem with the heart because the ECG shoed the "t-section" was very high. They also said that the Hospital should have realised the problem from the blood tests. The Tropan levels should be 2% but after 8 hours they were 8.5% and after 16 hours they were 16%.
29. The specialists said that the Hospital should have concluded that Doreen had had one attack and she was due for another. One specialist said that Doreen had been very badly done by. I understand that the CMC holds copies of both the Hospital records and the HRC file.
30. I think that the treatment provided at Bundaberg Base was disgraceful. The Hospital should have:
- (a) Arranged for Doreen to have the stress test at the Mater;
 - (b) Picked up that the ECG was not right;
 - (c) Picked up that the blood test was not right.
31. I can't believe what happened that so little happened afterwards. The HRC is a toothless tiger and sick people don't seem to have any rights. The HRC says it resolves most of its complaints, which usually means, they say, that they encourage the two sides to communicate and get over a lack of information on either side. But they aren't much use if the situation calls for any more important than good communication. John Cake at the HRC told me they get 800 complaints every month and that they don't have nearly enough resources.

Affidavit sworn on 13-07-2015

at

Bundaberg

in the presence of:

[Signature]
Deponent

[Signature]
Solicitor/Justice of the Peace

Signed: *[Signature]* Deponent

Taken by: *[Signature]* Solicitor/Justice of the Peace

"GAC1"

MY HEALTH SERVICE COMPLAINT

An Optional Complaint Form: Please write your own if preferred
I wish to lodge a complaint, and my name is:

Name George Alexander Connelly

Address Bundaberg 4670 Qld

Phone H) _____ W) _____

Date of Birth _____

Aboriginal or Torres Strait Islander? Yes No

Non-English Speaking Background? Yes No

ME KH
© 034 296
13 FEB 2004
JC 237
RECEIVED

I am complaining on behalf of (if relevant):

Name Doreen Connelly (My wife deceased)

Address AS ABOVE

Phone H) _____ W) _____

Date of Birth _____

Aboriginal or Torres Strait Islander? Yes No

Non-English Speaking Background? Yes No

The person (or place) I want to complain about is: Doctor/Hospital/Other Health Care Provider

Name Hospital (Bundaberg Base Nurses Name unknown)

Address Bundaberg St Bundaberg 4670 P.O. Box 34 Qld

Phone _____

WHEN IT HAPPENED (Date) 02.03-02-04

On Separate sheets please outline your complaint with reference to the attached "Guide to Writing a Complaint".

SIGNED: G. A. Connelly

DATE: 12.02.04

Any further queries, contact the Health Rights Commission on (07) 3234 0272 or Qld Toll Free 1800 077 308 (excl. Brisbane Metro) ↓

◆ It is an offence to threaten, punish, harass, discriminate or intimidate a person who has made a complaint to the Health Rights Commission

Please return this completed form to the Health Rights Commission, GPO Box 3089, BRISBANE Q 4001

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046237

On late the 1st or early the 12-12-03 my wife
Doreen Connelly was taken by ambulance to Broadway
Base Hospital with suspected heart attack after
several checks with turned out negative my wife
was admitted to hospital ^{and} as she had been given
several pain killing tablets and springs under
her tongue she was now feeling no pain so suggested
that I go and pick up our son Paul and take him
to work, she had been booked in for a stress
test at 10:20 AM on the 2-12-03 by her
doctor Dr Mergard she asked me to let them know
that she was in hospital this was at the Mater Hospital
I did this and told them that I did not know
if the Base Hospital was going to run her down
or not they told me that they would have to
know early as the time would have to be re-arranged.
The heart specialist was supposed to see her at
8 AM he did not arrive till approx 8:30 AM I told
him about the x-ray at the Mater hospital he turned
to the nurse and said I want this x-ray done ^{and} straight
away he then left. I gave the nurse all the particulars
including the appointment form which included the
telephone number for the Mater hospital and told
her she had to phone them straight away. She
walked off without saying a word. At 10 AM the
ward doctor came ^{up} with ^{the} nurse and said we
will send you up for that x-ray now are you
feeling any pain of course she wasn't she had been
given medication to stop the pain he then started
to work out how he was going to get her to the
Mater hospital I said do you want me to run
her down he said yes the nurse then intervened

you were saying a test was done
He agreed and said I will phone the Mater
and let them know she is on the way down
and headed ^{to} followed him as I thought there
was something they were not telling us. He told
me that we think she has a blockage in the heart
and this x ray will show us where it is and we
will be able to give her something for it and send her
to Brisbane to be operated ^{on} strict survey to clear
it. I went back and told my wife. At 10-30 the doctor
came back and said the appointment had been reallocated
and he ~~was~~ had booked ^{them} for Monday 8-12-03.

On hearing this I went straight down to the Mater Hospital
I was told that the Base Hospital had not phoned
so they reallocated the x ray ^{at 9:30 AM} then went back to the
base hospital and complained to the ward doctor
he said it was too late and there was nothing they could
do about it. (I have since found out that the hospital
could have requested an emergency x ray). I then
asked the doctor what happens now he said she can
go home and that the Mater will send the results back
to them. I went back to my wife she had been told she was
going home, the nurse was attending another patient I
asked the reason she did not phone the Mater she
said in a huff it's not my job the doctor should have
phoned, as she was walking off I said you should
have given all the information to the doctor then. The
hospital refused to give me the nurses name.

My wife passed away between 4:30 AM and 6 AM on the 3-12-03.
It is my opinion that the nurse should never be allowed
to continue in her trade again and put other lives
at risk

G. J. Connelly

000

Doreen Connelly
22/4/1934

2/12/03

Dear Doctor

69 year old lady with prior history of silent MI presented with chest pain relieved by Nitroglycerin. Her Troponin was 0.6 with a flat CK curve. ECG shows old MI.

Past medical history

Prior MI (silent)
hypothyroidism

Meds

Aspirin 100mg OD
Lasix 40mg OD
Lipitor 20mg OD
Thyroxine 100mcg OD

Assessment

Unstable Angina/ Non ST Elevation MI

Plan

1. Booked for a stress sestamibi 8/12/03
2. Started on aspirin and lipid lowering agent.
3. Will hold off beta blockers until stress test performed to allow for an adequate study
4. Started on lasix. Will need to assess long term need based on EF and follow up exam.

Thank you

Abid Khan
Med PHO
4152 1222

NURSE

0004

048237.

**Queensland
Government**

Queensland Health

Enquiries to: Director of Nursing
Telephone: 4150 2025
Facsimile: 41502029
File Ref: 010304

Mr George Connelly
790 Moorlands Rd
BUNDABERG QLD 4670

Dear Mr Connelly

Firstly, allow me on behalf of Bundaberg Health Service District (BHSD) to express my condolences at the passing of your wife late last year.

I understand that you have been in touch with the Health Rights commission regarding events leading up to your wife's death at home following discharge from the Bundaberg Base Hospital on December 2nd, 2003. I have reviewed the notes taken by the then acting Director of Nursing, Ms Beryl Callanan, regarding her investigations of your concerns.

Her investigations have shown that the nurse allocated to your late wife was to rebook your wife's stress test, which had been cancelled as she was at the time an inpatient of this hospital. This nurse did contact the Mater Hospital, however the initial appointment had been reallocated. With respect to your late wife's condition at the time, there was no urgency to undertake the stress test as confirmed with the medical specialist team treating your wife. This team was happy to accept the early appointment date if available, but preferred the later date as is normal practice in such circumstances.

Unfortunately BHSD is not at liberty to provide you with the name of the nurse who was involved with the care of your wife as you request. Staff are employed by Queensland Health and are covered by vicarious liability, and as such the organisation is responsible for the care provided either collectively or individually by the staff. BHSD supports this staff member and can find no fault with her actions in relation to this case.

Whilst I am aware that you have spoken to both the then acting Director of Nursing and the Director of Medical Services by phone and have had a face to face meeting with Ms Callanan, we would be pleased to meet with you again if you wish to discuss any matters pertaining to the care received by your late wife as an inpatient at this Hospital.

Once again, please accept my condolences at the passing of your wife. I am sorry that you feel as though you have been unable to resolve this painful episode surrounding your wife's death. Please feel free to contact us for an appointment if you wish to discuss this further.

page 2. has Patrick Martin's signature - no text - according to e...

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Insert Name
Insert Position Title
/ /

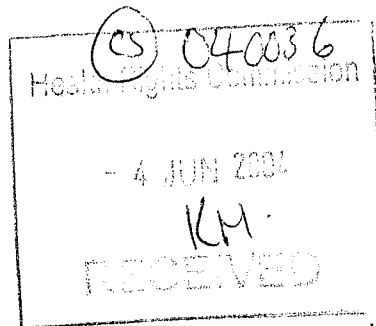
"CAC3"



**BUNDABERG HEALTH SERVICE DISTRICT
EXECUTIVE SERVICES**

Enquiries to: Peter Leck, District Manager
Telephone: 4150 2020
Facsimile: 4150 2029
Our Ref:

Ms Karen Harbus
Intake Officer
Health Rights Commission
GPO Box 3089
BRISBANE Q. 4001



Dear Ms Harbus

I write in response to your letter dated 6 April 2004 concerning the complaint by Mr George Connelly about the health service provide to his late wife, Doreen.

Mrs Doreen Connelly presented to Bundaberg Base Hospital (BBH) at approximately 0450h on 1 December 2003. She had woken at 0330h with chest pain which lasted 30 minutes and completely resolved after she was administered oxygen, aspirin and GTN by QAS paramedics.

Upon arrival at BBH, Mrs Connelly was pain free and assessed by the duty medical practitioner, who noted Mrs Connelly's past history of an acute myocardial infarction and hypothyroidism. The medical practitioner also noted that Mrs Connelly complained of an increasing frequency of chest pain on exertion over the preceding days. Physical examination including vital sign monitoring revealed no major abnormality. Investigations including serial ECGs confirmed the previous myocardial infarction with some lateral 'T' wave changes, the chest x-ray was normal and blood tests showed a raised troponin value.

Mrs Connelly was admitted to a general ward and reviewed by the specialist medical team later in the morning. The medical team made a diagnosis of unstable angina with aspirin, a lipid lowering medication ('Lipitor') and frusemide ('Lasix') added to Mrs Connelly's medication. At that time Mr Connelly explained to the treating medical staff that their general practitioner had referred Mrs Connelly for a (sestamibi) stress test to be performed by North Coast Nuclear Medicine at Mater Hospital Bundaberg, which was booked for 2 December 2003. He explained he had notified the nuclear medicine service that Mrs Connelly was an inpatient at BBH and understood the booking would remain open until approximately 0930h, requiring confirmation from BBH staff before this time. The agreed management plan was that further blood tests be taken and if normal, the stress test occur, as planned. The blood was collected and marked urgent with the result checked by Dr Khan and arrangements begun to transfer Mrs Connelly for her stress test. The nursing staff member rang North Coast Nuclear Medicine to confirm the appointment however it had been reallocated with no further appointments available for one week. Arrangements were made for Mrs Connelly to undergo the test as an outpatient on 8 December 2003.

Office
Queensland Health
Bundaberg Health Service District
Bourbong Street
BUNDABERG 4670

Postal
PO Box 34
BUNDABERG 4670

Phone
4150 2020

Fax
4150 2029

Mrs Connelly was stable throughout her admission, with no further complaints of pain or any requirements for any form of analgesia and was discharged home at 1430hr on 2 December 2003. Tragically Mrs Donnelly died in the early hours of the morning of 3 December 2003. One of Mr Donnelly's responses was to seek out the name of the nurse, who he believed hadn't rung the nuclear medicine service, therefore allegedly contributing to the untimely death of his wife. In a telephone call of 3 December 2003 with Mr Connelly, Ms Beryl Callanan Acting Director of Nursing explained that BHSD would review his concerns, but wouldn't release the name of the nurse to him, because the nurse was employed by BHSD and any complaint should be directed to the employing organisation.

An interview was conducted with the nurse caring for Mrs Connelly, who explained she had contacted North Coast Nuclear Medicine in an attempt to confirm the booking, after receiving confirmation from Dr Khan that Mrs Connelly could attend. However her phone call was made after the required confirmation time and the booking had been reallocated with no emergency appointments available. The timing of the latter booking was checked with the treating medical staff. BHSD believes the nurse performed her duties correctly within her overall workload allocation and can find no fault with her actions. It is noted that this nurse was very upset following Mr Connelly's return to BBH to complain about his wife's cancelled appointment, when he was reported to publicly remonstrate with a number of nursing staff in the ward area.

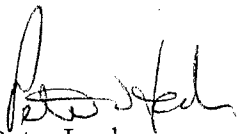
In reviewing this complaint, an internal review of the health care provided to Mrs Connelly was performed by Dr Keating, Director of Medical Services and Dr Peter Miach, Director of Medicine. This review confirms the above information including the ECG changes in Mrs Connelly's initial ECGs (as compared to previous ECGs in 2002), an elevated troponin on arrival which increased in value 8 ½ hours later, but with no rise in creatinine kinase. The raised troponin value is evidence of minor heart muscle damage. The combination of Mrs Connelly's past history, prolonged chest pain, ECG changes and raised troponin values indicates the diagnosis should have been acute coronary syndrome. Accordingly this lady should have remained in hospital for ongoing observation.

Based upon this information, I offer my profound apologies to Mr Connelly for the distress and anxiety relating to the unexpected death of Mrs Connelly. I would like to apologise to Mr Connelly in person and Mr Connelly can contact my office on 4150 2020 to arrange a time convenient to him. I have asked Drs Strahan and Khan to attend this meeting to provide further explanation and answer any questions that Mr Connelly may have.

As a health service, we wish to reduce these circumstances to a minimum and maintain a reputation for high quality care. I have directed Dr Keating and Dr Miach to review the care provided to all patients presenting with acute coronary syndrome to ensure these patients are managed appropriately. BBH has begun involvement with the Collaborative for Healthcare Improvement – Acute Coronary Syndrome, which will provide evidence based guidelines and systematic evaluation of the treatment of this condition in BBH with comparison on a statewide basis. An education session has been conducted at BBH for all medical staff involved in the care of such patients, with senior staff attending continuing education sessions on the specific topic of Acute Coronary Syndrome and the management of patients with raised troponin measurements.

I trust this information is of assistance.

Yours sincerely



Peter Leck

District Manager

01/06/04

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