Bundaberg Hospital Commission of Inquiry

Statement of Gerard FitzGerald

Attachment GF22

Peritoneal Dialysis Catheter Placements - 2003

Patient	Surgeon	Date Catheter Placed	Date of Catheter Problem	Catheter Problem	Outcome	Catheter Position	Infection
E. Ball	Patel	15/08/2003	19/09/2003	Migration	Surgical intervention	upwards	chronic exit-site infection & peritonitis
E. Hillyard	Patel	3/12/2003		Migration	Deceased prior to catheter repair	side-upwards	
R. Marr	Patel	30/09/2003	4/11/2003	Infection Catheter Position	MRSA treated with IV Vancomycin	side-upwards	exit-site infection MRSA
P. Noppe	Patel	19/09/2003		Infection Catheter Position	Peritonitis treated as in-patient with IP AB's	upwards	chronic exit-site infection serratia
E. Nagle	Patel	14/11/2003	16/12/2003	Migration	Surgical intervention - Died	side-ways	
A Weir	Patel	6/10/2003	18/11/2003	Impaired Outflow Drainage	Surgical intervention - Hernia repair performed privately	side-ways	nil to date
x6 Peritoneal Dialysis Catheter Placed 2003							

Dr Jason Jenkins
MBBS, FRACS (Vasc)

VASCULAR SURGEON
Director of Vascular Surgery

JJ:ha

2 November 2004
(Dictated 01.11.2004)

Dr Peter Miach
Renal Unit
Bundaberg Base Hospital
PO Box 34
BUNDABERG QLD 4670

Dear Peter

RE: Marilyn DAISY UR: B669904

Thanks very much for referring this lady to me. Marilyn is a pleasant 43 year old lady who has severe diabetes which is manifest by her renal failure and lower extremity amputation. She is a tricky patient and one which will no doubt have significant problems on dialysis in the future. My concerns are her severe arterial disease with high calcification of her right radial artery and absent left radial pulse. She is unsuitable for radiocephalic fistula's and I think that she is a high risk if we do a brachiocephalic fistula, of developing a steel syndrome and digital ischaemia. I have discussed this with Marilyn. I have organised for her to have duplex scan of her right arm to assess her radial and ulna arteries prior to fistula formation. She has got a good cephalic vein in her right upper arm and hopefully we can maintain this for her dialysis in the future.

I was astounded when I discussed with Marilyn about when did she have her left below knee amputation and I understand she was quite unwell at the time and this was a life saving procedure but this was performed on 20.09.2004, it is now 01.11.2004 and she still has sutures in her amputation stump some six weeks following the procedure. These sutures were heavily buried within the tissue and very difficult and painful to remove. I find it mind boggling that someone could leave sutures in for this long. It either shows a complete lack of understanding of diabetic disease and how to perform an amputation. I also find it strange that a surgeon that does the surgery has not seen the patient since the operation and to monitor the fact that the patient has an area of necrosis in the amputation stump which will require further debridement. Continued saline dressings are not going to heal this lady's amputation stump.

Private Practice Specialist Suite
Royal Brisbane & Women's Hospital Health Service District
Level 1, East Block
Butterfield Street Herston QLD 4029

Ph 07 3636 8346
Fax 07 3636 1784
Provider No 0279327B
Email jason_jenkins@health.qld.gov.au

RE: Marilyn DAISY UR: B669904

I have suggested to her that when she comes to Brisbane that she will require a debridement of this stump and if it fails to heal then she may require an above knee amputation. I think if procedures can't be performed appropriate with the Bundaberg Hospital then they should not be performed at all or if they are performed then they should be followed up appropriate.

I have explained the situation to Marilyn and the fact that ongoing care of her lower extremity peripheral vascular disease should be performed in Brisbane as she is not only has severe disease but also her problems will be difficult in the future. I will organise for Marilyn to be admitted to the Royal Brisbane and Women's Hospital in the next 30 days for her procedure. If you have any questions or queries please do not hesitate to contact me.

Yours sincerely

Jason Jenkins

cc:
Dr Jayant Patel Bundaberg Base Hospital PO Box 34 BUNDABERG QLD 4670

Private Practice Specialist Suite
Royal Brisbane & Women's Hospital Health Service District
Level 1, East Block
Butterfield Street Herston QLD 4029

Ph 07 3636 8346
Fax 07 3636 1784
Provider No 02703279

Bundaberg Hospital Commission of Inquiry

Statement of Gerard FitzGerald

Attachment GF23

GF23

Queensland Government
Queensland Health

RECEIVED
13 APR 2005
SB022534

SUBMISSION TO THE DIRECTOR-GENERAL

DATE:	12 April 2005		
PREPARED BY:	Ruth Reinhard, A/Principal Policy Officer	**Contact No:**	3234 0579
CLEARED BY:	Dr Gerry FitzGerald, Chief Health Officer	**Contact No:**	3234 1137
SUBMITTED THROUGH:	Click, enter Name and Position	**Contact No:**	Click, enter Contact No.
DEADLINE:	13 April 2005	**File Ref:**	Click, enter File Ref.

SUBJECT: Appointment of staff members as Investigators (Health Services Act 1991, Part 6-Administration, Sections 52-57) for a term of appointment from 18 April 2005 – 30 June 2005 for the purpose of the Bundaberg Hospital Services Review

APPROVED/ ~~NOT APPROVED~~

COMMENTS

DR STEVE BUCKLAND
Director-General
14/04/05

PURPOSE:

To seek the Director-General's approval for the appointment of the following officers as investigators pursuant to the Part 6 Sections 52 – 57, *Health Services Act 1991*, for the purpose of the Bundaberg Hospital Services Review—

- Dr Mark Mattiussi, District Manager & District Director of Medical Services, Logan and Beaudesert Health Services
- Dr Peter Woodruff, Consultant Vascular Surgeon, Surgical Expert, Royal College of Surgeons
- Dr John Wakefield, A/Executive Director, Patient Safety Centre
- Ms Leonie Hobbs, Executive Director, Women & Newborn Services, Royal Brisbane and Women's Hospital

BACKGROUND:

The Minister for Health announced on 9 April 2005, a comprehensive review of safety and quality at the Bundaberg Base Hospital as a result of recent allegations regarding a doctor from the Hospital. The Minister also announced that a review panel would be given investigative powers under the *Health Act* by the Director-General.

ISSUES:

Terms of Reference for the review are—

- Examine surgical cases identified by staff to determine if the clinical care is appropriate and if anything further needs to be done and make recommendations in relation to these cases.
- Examine Clinical Risk Management at Bundaberg Base Hospital to determine what systems are in place to ensure safety and quality of services and make recommendations in relation to these.
- Examine the application of the service capability framework to ensure clarity on the scope of services at Bundaberg Base Hospital.
- Examine the clinical outcomes and quality of care at Bundaberg base Hospital and identify any areas requiring further review.
- Produce a report for consideration by the Minister.

ATTACHMENTS:

Instruments of appointment

RECOMMENDATION(S):

That the Director-General approve the appointment of the following officers as Investigators under Part 6, sections 52-57 of the *Health Services Act 1991*—

- Dr Mark Mattiussi
- Dr Peter Woodruff
- Dr John Wakefield
- Ms Leonie Hobbs

Queensland Government
Queensland Health

I, Dr Steve Buckland, Director-General, Queensland Health, hereby appoint:

Dr Mark Mattiussi

as an Investigator, pursuant to Part 6, of the *Health Services Act 1991*
for the period 18 April 2005 until 30 June 2005

Dr Steve Buckland
Director-General
14 /04/ 2005

ATTACHMENT 1

Queensland Government
Queensland Health

I, Dr Steve Buckland, Director-General, Queensland Health, hereby appoint:

Dr John Wakefield

as an Investigator, pursuant to Part 6, of the *Health Services Act 1991*
for the period 18 April 2005 until 30 June 2005

Dr Steve Buckland
Director-General
4 / 4 / 2005

ATTACHMENT 1

Queensland Government
Queensland Health

I, Dr Steve Buckland, Director-General, Queensland Health, hereby appoint:

Dr Peter Woodruff

as an Investigator, pursuant to Part 6, of the *Health Services Act 1991*
for the period 18 April 2005 until 30 June 2005

Dr Steve Buckland
Director-General
/ 2005

ATTACHMENT 1

Queensland Government
Queensland Health

I, Dr Steve Buckland, Director-General, Queensland Health, hereby appoint:
Adjunct Associate Professor Leonie Hobbs
as an Investigator, pursuant to Part 6, of the *Health Services Act 1991*
for the period 18 April 2005 until 30 June 2005

Dr Steve Buckland
Director-General
/aL{/ 2005

ATTACHMENT 1

BUNDABERG HOSPITAL COMMISSION OF INQUIRY

QUEENSLAND HEALTH INITIAL SUBMISSION

16 MAY 2005

TERM OF REFERENCE NO 3

DOCUMENT

"APPOINTMENT OF DR MARK MATTIUSSI, DR PETER WOODRUFF, DR JOHN WAKEFIELD, AND ADJUNCT ASSOCIATE PROFESSOR LEONIE HOBBS RN, UNDER PART 6 *HEALTH SERVICES ACT 1991*"

Bundaberg Hospital Commission of Inquiry

Statement of Gerard FitzGerald

Attachment GF24

GF24

COPY

Queensland Government
Queensland Health

MEMORANDUM

To: Dr Steve Buckland, Director-General

Copies to:

From: Dr Gerry FitzGerald
Chief Health Officer

Contact No: (07) 323 41137
Fax No: (07) 322 17535

Subject: Review of Clinical Services, Bundaberg Hospital

File Ref:

Please find attached the terms of reference for the Review of Clinical Services at Bundaberg Hospital for your consideration and endorsement.

Your authorisation is also sought under section 57 (4) (a)(ii) of the *Health Services Act 1991* for the Chief Health Officer to receive information from the appointed Investigators of the Review of the Clinical Services at Bundaberg Hospital.

My report of the Clinical Audit into the Care of Surgical Patients at Bundaberg Hospital has been reviewed by the Director, LALU, who has advised that there are no FOI exemptions in the report, and as such may be released (attached email). I have no objections to the report being released.

Dr Gerry FitzGerald
Chief Health Officer
18/4/05.

REVIEW OF CLINICAL SERVICES
BUNDABERG BASE HOSPITAL

Background:

Following concerns raised by staff of the Bundaberg Base Hospital the Chief Health Officer Dr Gerry FitzGerald with the assistance of Mrs Susan Jenkins of the Office of the CHO conducted a clinical audit of surgical services at Bundaberg Hospital. Before this audit could be completed, the matter was raised in parliament and the Director of Surgery named as a cause of significant mortality and morbidity. The matter has subsequently been the subject of extensive public attention.

The clinical audit revealed four broad issues of concern.

1. That Dr Patel appeared to practice outside the scope of practice of Bundaberg Hospital. Specifically he undertook operations which the hospital was not in a position to support. Some of these patients did not survive. In addition he appeared to retain patients whose condition deteriorated when they would best be transferred to a hospital with higher capacity.

2. That Dr Patel appeared to have a higher complication rate that other hospital of similar standing.

3. That there appeared to be a lack or failure of systems and structures that would support the quality and safety of health care.

4. That as a result of these issues, there is considerable disharmony at the Bundaberg Hospital.

The Minister and Director-General upon receipt of that advice determined that a further review should occur into the issues raised in the clinical audit so as to ensure that the standard of clinical care at the hospital was consistent with accepted standards.

Purpose:

To ensure that the clinical outcomes at Bundaberg Hospital are in accordance with accepted professional standards.

Authority:

The review has been authorised by the Minister and the Director-General. The Members of the review panel are appointed as Investigators in accordance with Part 6 of the Health Services Act.

Membership:

The review panel shall comprise:

Dr Mark Mattiussi. District Manager and District Director of Medical Services at the Logan-Beaudesert Health Service District.
Dr Peter Woodruff. Vascular Surgeon at the Princess Alexandra Hospital
Dr John Wakefield. A/Executive Director of the Queensland Health Patient Safety Centre.
Adjunct Associate Professor Leonie Hobbs. A/Executive Director for Women's and Newborn Services RBWH.

(Dr Mattiussi will lead the team).

Terms of Reference

1. Examine the circumstances surrounding the appointment, credentialing and management of Dr Patel.

2. Review the clinical cases of Dr Patel where there has been an identified adverse outcome or where issues related to his clinical practice have been raised.
3. Analyse the clinical outcomes and quality of care across all services at Bundaberg Hospital. Compare with benchmarks from other states or other like hospitals and identify any areas requiring further review or improvement.

4. Review the Risk Management framework as it relates to the provision of direct services at Bundaberg Hospital to determine its effectiveness. Make recommendations in relation to improvements to these systems.

5. Examine the way in which the Service Capability Framework has been applied at Bundaberg Hospital to determine that the scope of practice is appropriately supported by clinical services.

6. Consider any other matters concerning clinical services at Bundaberg that may be referred to the review by the Director-General.

7. Should the review team identify other areas on concern outside the scope of these Terms of Reference, the Director-General is to be consulted to extend the Terms of Reference if considered appropriate.

Process:

The panel will commence its considerations by the 18th April 2005 and will provide a report through the Director-General to the Minister by the end of June 2005.

The Panel will work closely with the management and staff of the Bundaberg Hospital.

The Panel will consult with key stakeholders, community representatives and staff in undertaking its consideration and preparing its findings and report.

APPROVED ~~**NOT APPROVED**~~

Dr Steve Buckland
Director-General
18 /04/2005

I, Dr Steve Buckland, Director-General, Queensland Health, hereby authorise:

Dr Gerry FitzGerald, Chief Health Officer

Pursuant to section 57(4)(a)(ii) of the *Health Services Act, 1991*, to receive information from the appointed Investigators of the Review of the Clinical Services at Bundaberg Hospital.

Dr Steve Buckland
Director-General
18 04 /2005

Bundaberg Hospital Commission of Inquiry

Statement of Gerard FitzGerald

Attachment GF25

GF25

From: Gerry FitzGerald
To: Peter Leck
Date: 11/04/2005 14:27:28
Subject: Re: Visit on Wednesday 11 April 2005

Thanks Peter

Happy with the program as outlined

I am happy to meet with the families if that woudl be helpful. In regard to the patient with the possible cancer, I would aprpeciate some detail on the case prior to meeting with the lady.

We should also meet with local press and the Minister asked that I try and give Nita Cunningham a breifing on the situation as well That would need to be done discretly.

Regards

Gerry

>>> Peter Leck 11/04/2005 12:37:03 pm >>>

Hi Gerry,

As per our discussion, I confirm that Wednesday is fine to visit.

It is thought best if you meet with some small groups of staff (eg ICU) prior to a general staff meeting - so we will aim for a general staff meeting at either lunchtime or afternoon tea time This will allow for those staff who expressed the concerns to feel a little special in talking to you prior to a wider audience.

Would be grateful if you could confirm that you are happy to meet with the families of some patients before we make the offer

The ones getting most publicity are the Brammichs (crushed by caravan - case currently subject to coronial enquiry) and P402 (you did not review this case but she has complained that she was wrongly diagnosed with cancer - and has had lots of media attention).

As I mentioned, the local newspaper has reported that a class action lawsuit of patients treated by Dr Patel is to be launched. It seems that a public meeting re same is to be held in Bundaberg on Friday.

Peter

CC: John Wakefield; Susan Jenkins

From: Peter Leck
To: Dooley, Joan
Date: 11/04/2005 15:05:48
Subject: Fwd: Re: Visit on Wednesday 11 April 2005

Joan,

A very discrete meeting will need to be arranged for Gerry Fitzgerald and Nita Cunningham during Gerry's visit on Wednesday as discussed. Would be grateful if you could make confidential arrangements.

Thanks

Peter

Bundaberg Hospital Commission of Inquiry

Statement of Gerard FitzGerald

Attachment GF26

GF26

11

From: Gerry FitzGerald
To: Desmond Hall
Date: 14/04/2005 10:53:23 am
Subject: As attached

OVERVIEW OF CHO REPORT

- This review was conducted in response to concerns raised by staff at Bundaberg Hospital in regard to surgical care offered principally by Dr Jayant Patel the Director of Surgery at Bundaberg Base Hospital.

- The purpose of this review was to examine the clinical outcomes from general surgical services at Bundaberg Hospital to identify issues of concern.

- The review was conducted by Dr Gerry FitzGerald the Chief Health Officer assisted by Mrs Susan Jenkins the Manger of the Clinical Quality Unit within the Office of the Chief Health officer.

- In undertaking the review we interviewed staff at Bundaberg Hospital, collected copies of patient files identified by staff at the hospital, collected data from the hospital and from the Health Information Centre is regard to the rates of complications at the hospital.

- The Key findings of the review are:

    - That Dr Patel was undertaking complex procedures which should not have been undertaken at Bundaberg Hospital as it does not have the facilities and the level of support services to manage complex patients. In addition he appeared to retain seriously ill and injured patients at Bundaberg Hospital when they would have been better cared for at a hospital with a higher level of expertise and facilities.
    - That he appeared to have a higher complication rate from his surgical procedures.
    - That the checks and balances that should be in place to identify and deal with such concerns were not in place or did not function effectively.
    - That as a result there was a high level of distress and disharmony amongst the staff at Bundaberg Hospital.

- The actions taken include:

    - The conduct of Dr Patel has been referred to the Medical Board of Queensland for further investigation.
    - The Minister has established a high level review panel to assist the Bundaberg Hospital staff
        - To undertake a further detailed analysis of the cases identified to determine if further clinical care is necessary or if those cases should be further investigated by an independent authority such as the State Coroner.
        - To provide a means whereby patients of Dr Patel could be reviewed to ensure that they have not suffered any direct

harm.

- To examine the quality and safety structures and systems at the hospital and advise on how those systems may be improved.
- To review the culture and relationships within the hospital and with the professional and general community and to identify mechanisms by which those matters could be improved.
- To provide a report to the Minister through the Chief Health Officer.

Bundaberg Hospital Commission of Inquiry

Statement of Gerard FitzGerald

Attachment GF27

9

From: Gerry FitzGerald
To: Cheryl Brennan; CPCU CPCU; Leanne Patton; Paul Dall'Alba; Susan Jenkins
Date: 15/04/2005 1:51:22 pm
Subject: Ministerial_BriefingBundabergfor Premier

Queensland Government
Queensland Health

MINISTERIAL BRIEFING

Number BR

For Noting

DEADLINE

April 15 2005 **April 15 2005**

BRIEFING NOTE to be limited to two pages only. Where additional information is required, supporting schedules / attachments should be used

SUBJECT:

Bundaberg Health Service District and Dr Patel

PURPOSE:

To provide a brief on the issues surrounding Dr Patel, former Director of Surgery at Bundaberg Base Hospital.

DEPARTMENTAL OFFICER ATTENDING THE MEETING / EVENT: (Optional)

N/A

BACKGROUND:

March 2003- Dr Patel commenced work at Bundaberg Base Hospital after being recruited from overseas (USA).

April 10th, 2003- Patient complaint received regarding incorrect placement of a permacath and need to be transferred to Brisbane for further treatment as a consequence. Investigations made by hospital into the adverse event and hospital executive sent the patient a formal letter of apology and explanation.

May, 2003- Patient complaint received relating to perceived inappropriate topical treatment of condition Patient required major surgery by another surgeon

June 1-11, 2003 Patient complaint received relating to incorrect site surgery on the external ear. Patient threatened legal action but did not proceed after hospital rebooked patient for correct site surgery (removal of skin cancer).

July 2003- Initial informal concerns apparently raised by staff at Bundaberg Base Hospital.

Sept/Nov/Dec 2003- Reports made by nursing staff regarding complications with peritoneal dialysis catheter placements carried out by Dr Patel.

November 2003- Patient complaint received by phone. Patient threatened legal action. Patient received appointment to discuss the matter with Dr Patel.

July 27th 2004- Sentinel Event Report form lodged regarding a patient who had suffered trauma and was being cared for by Dr Patel. Adverse Event Report lodged 3/8/05. Further action taken unknown.

August 20th 2004- Sentinel Event Report form lodged regarding a patient who suffered post-operative complications post surgery by Dr Patel and had to return to theatre same day. Referred to *ErrorMed* for investigation.

October 20th 2004 – A meeting between a senior clinician and two members of the District Executive where concerns about patient safety relating to Dr Patel were raised.

October 22nd 2004- Formal written complaint received from a number of staff. Broadly the concerns were about Dr Patel conducting complex procedures at Bundaberg Hospital and that staff felt that some patients should have been transferred to higher level facilities where complex patients could be better managed. Part of this documented complaint included reference to staff concerns which had been raised soon after Dr Patel started operating at Bundaberg Base relating to Dr Patel's complication rate which appeared to be higher than other surgeons.

October 25th 2004- Three complaints received from staff regarding a number of patients cared for by Dr Patel. These letters raised concerns including possible breach of duty of care and behaviour which was not of an acceptable professional standard

October 29th 2004- Meeting between another senior clinician and two members of the District Executive regarding the complaints presented to the District Executive on 20th October. This clinician confirmed some of the concerns raised at that meeting

October 29th 2004- Sentinel Event Report lodged regarding post-operative complications after routine surgery, need to return to theatre and then need for care in Intensive Care Unit.

November 2nd 2004- Meeting between another clinician and two members of the District Executive. The clinician identified some concerns relating to the transparency of the current surgical audit process.

November 5th 2004- Meeting between VMO and two members of the District Executive. The VMO questioned whether a complex procedure should have been performed in Bundaberg by Dr Patel.

Dec 15th 2004-	District Manager discussed with QH Internal Audit the possibility of conducting an investigation in light of the complaints and concerns raised by staff.
Dec 17th 2004-	Internal Audit confirmed that a review would be better undertaken by clinicians since the matter appeared to involve issues of clinical practice rather than allegations of official misconduct.
January 4th 2005-	Letter of complaint received from a staff member by the Director of Nursing regarding the care provided by Dr Patel to a trauma patient.
January 14th 2005-	Three documented complaints from staff raising concerns about a number of patients
January 19th 2005-	Memorandum from District Manager confirming the involvement of the Office of the Chief Health Officer in a review of outcomes of some complex surgical procedures at Bundaberg Hospital.
Jan-March 2005-	Review conducted by the Chief Health Officer and Sue Jenkins at Bundaberg Hospital including preparations for an onsite visit, data review, data collection and preparation of report.
Feb 14th&15th-	CHO on-site visit
March 22nd 2005-	Questions in Parliament, Mr Messenger tabled in Parliament a letter from a Bundaberg Hospital staff member regarding staff concerns about Dr Patel.
March 22nd 2005-	Question without Notice, Mr Copeland raised questions about the review conducted by the Chief Health Officer into serious allegations made about the serious allegations made about the clinical competence of Dr Patel at Bundaberg Hospital.
March 24th 2005-	Question Without Notice from Mr Messenger to the Minister for Health- "*Is Dr Patel still operating?*" Minister responded that complaints were made to District Manager in late October, the District Manager contacted the CHO to carry out a review and the investigation is almost complete.
March 25th 2005-	Dr Patel resigned from Bundaberg Hospital and left immediately
March 26th 2005-	First report in the *Courier Mail*

<u>SUMMARY</u>

- Chronology of events- detailed above.
- Staff complaints- outlined above.
- Patient complaints- outlined above and where follow-up action known documented
- Outcomes of actions taken- requests from the District Manager for a review to be undertaken by the Office of the Chief Health Officer, this review was undertaken and a report was prepared with recommendations.

KEY ISSUES:
Strategic Key Issues

1. There is a world wide shortage of qualified doctors.
2. In Queensland, we are also experiencing a shortage of doctors and an inability to ensure adequate provision of doctors particularly in remote and rural areas.
3. In Queensland, there are significant numbers of overseas trained doctors.
4. The mechanisms to ensure overseas trained doctors are appropriately qualified and experienced to provide medical care appear to have failed in this instance.

Key issues identified in the review conducted by the CHO

5. The complexity of procedures being undertaken by Dr Patel at Bundaberg Hospital which did not have the level of support services required for such complex procedures
6. Apparent higher complication rates for Dr Patel's patients
7. Dr Patel's apparent reluctance to refer patients with complex conditions to higher level facilities
8. The ongoing effects of Dr Patel's involvement in clinical service delivery at Bundaberg Hospital on patients, staff and the wider community. These effects include a lack of confidence in the Bundaberg Hospital to provide appropriate care and services, concern by patients treated by Dr Patel regarding their long term outcomes and a low level of staff morale at Bundaberg Hospital.

MEDIA IMPLICATIONS:

The issues surrounding Dr Patel at Bundaberg Hospital have already been widely reported by the media. Several patients have spoken to the media and voiced personal concerns regarding treatment provided to them by Dr Patel. At least two law firms are involved with patients and their families in discussions regarding class actions Thursday April 14th, a public meeting was held in Bundaberg where patients of Dr Patel and their families expressed severe displeasure and discussed legal action a system which they feel has failed them.

Key Messages:

1. The processes of registration for medical officers in Queensland need to be reviewed and improved
2. The processes of selection and recruitment for medical officers need to be reviewed and improved
3. There must be an ongoing commitment to improve patient safety in Queensland hospitals and health care facilities.

CONSULTATION:

Dr Gerry Fitzgerald, Chief Health Officer

IS THIS IN ACCORDANCE WITH ANY COMMITMENTS / INITIATIVES:

N/A

RECOMMENDATION:

That the Minister note the contents of this brief.

ATTACHMENTS:

Nil

MEDIA RELEASE: (Optional)

☐ YES ☐ NO

COMMUNICATION STRATEGY / SPEECH: (Optional)

☐ ATTACHED ☐ NOT ATTACHED

Cleared by:
Graeme Kerridge
Manager
Central Zone
(07) 3131 6988

Date: 15/4/05

Cleared by:
Dr John Scott
Senior Executive Director
Health Service Directorate
3234 1078

Date: 15/4/05

(Use both sections if this brief requires clearance from District Manager & Zonal Manager, otherwise please delete one section)

(Please include Contact Officer details below)
Prepared by: Sue Jenkins & Leanne Patton
Unit: Chief Health Officer Office & Central Zone Management Unit
Contact No: 3405 5776 & 3131 6894

RECOMMENDATION:

BRIEFING

Noted: .....

COMMENTS:

GORDON NUTTALL MP
Minister for Health
Member for Sandgate

/ /

Bundaberg Hospital Commission of Inquiry

Statement of Gerard FitzGerald

Attachment GF28

GF28

From: Steve Rashford
To: Deborah Miller; John Scott
Date: 21/01/2005 9:47:10 am
Subject: Death in Transport

Dear John and Deb,

This is a short note regarding this death in transport. I will provide a more detailed report once I have had a chance to investigate the case further. Most participants are not at work as it occurred overnight.

Patient Name: F 36a

Referred by Dr Adam Tanyous / Dr Muzib Abdul-Razak (Hervey Bay Hospital)

Clinical Coordinator - Dr Peter Thomas

The initial coordination occurred at approximately 2230. The patient was presented as a 77 year old lady with a gut obstruction. She had a profound lactic acidosis (Lactate 7.2) but her ABG was fully compensated (PH 7.4). She was alert with mild confusion (background mild alzheimers). She had an IDC / NGT / IV fluids in situ. Her obs were SaO2 96% on 6l/min oxygen. BP 121/53 PR 93.

According to Peter he felt at the time she should be operated on at Hervey Bay and transported post operatively to another hospital once stabilized. Both the anaesthetist and surgeon would not perform the operation without a post-op bed.

Peter Thomas, in consultation with the referring physicians, felt the transport was time critical and utilized the nearest helicopter provider - Energex Maroochydore. An intensive care paramedic level escort was decided on.

Please note that an on call physician was available for retrieval in Brisbane (it was me) but Peter felt given the patient's condition an ICP escort was suitable.

Transport:

The transport was performed in Rescue 513 - a long ranger. The larger Rescue 511 was not utilized.

The paramedic (Darren Sweedman) assessed and loaded the patient in Hervey Bay. Apart from her tachycardia (HR 120) the condition was as stated - her conscious level was ISQ.

En route she became mildly agitated and then started vomiting profusely. The airway became difficult to manage and she suffered a cardiac arrest - I would think most likely due to airway obstruction but this is conjecture. I will need to ascertain if the arrest occurred first or as a result of airway obstruction. She received limited resuscitative efforts in flight due to the limited space available and was dead on arrival at Nambour Hospital.

Nambour:

I understand no medical chart was established as she was declared dead in transport. This lady's body was moved to the hospital morgue and the Queensland Police were called in accordance with the Coroner's act.

I will be seeking formal reports from
1. Peter Thomas
2. ICP Darren Sweedman.

The QCC was not notified until the paramedic rang me at 0750 this morning to debrief the case. This is a major communication breakdown as the patient died at approximately 0300.

Prior to this notification this morning, Peter and I had already had a conversation during our handover

about this case - regarding the decision not to operate at Hervey Bay. I had planned to follow it up after a formal email from Peter.

There are a number of issues that need investigation.

I will also notify QAS management given the implications for the DES and ICP.

Please bear in mind the above details are scant and based on initial telephone conversations.

Regards

Steve

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

CC: Gerry FitzGerald

Bundaberg Hospital Commission of Inquiry

Statement of Gerard FitzGerald

Attachment GF29

9F29

Queensland Government
Queensland Health

EXECUTIVE SERVICES STATE
MIN / DD / GMHS / DDGP&O / FILE
EMAIL / MIN / SDLO / DLO / DXDG
EMAIL / EMAIL / MCM

BR021742

A BRIEFING TO THE SENIOR EXECUTIVE DIRECTOR HEALTH SERVICES DIRECTORATE

BRIEFING NOTE NO: QCC 2005/1

DATE: 23/1/2005

PREPARED BY: Dr Stephen Rashford 0438 398 000

Director Clinical Coordination and Patient Retrieval Services

CONSULTATION WITH: Dr Peter Thomas, IC Paramedic Darren Sweedman, QAS Communications Officer Lisa O'Loughlin

CLEARED BY:

DEADLINE: 24/1/2005

SUBMITTED THROUGH: Dr Gerry Fitzgerald Chief Health Officer

SUBJECT: **Death in transport (21/1/2005) –** P369

COMMENTS SED HEALTH SERVICES:

Noted

→ CHO

It seems there are issues to consider at the Hervey Bay level with clinical decision-making + action, and with team performance. I would appreciate your views on these. I think it is time to clarify the authority of the CCC and I welcome your views on this as well.

DR JOHN SCOTT
Senior Executive Director
Health Services Directorate

30/1/05

PURPOSE:

To provide an overview and background to the events and issues surrounding the clinical coordination and retrieval of P369

BACKGROUND:

P369 suffered an in flight cardiac arrest during an aeromedical transport between Hervey Bay and Nambour Hospitals. The case has been referred to the Queensland Coroner.

Initial Referral Process

Dr Adel Tanious (Anaesthetist) made a call to the QEMS Coordination Centre (QCC) at approximately 2220 hours on January 20th, 2005. The QAS Communications Operator Lisa O'Loughlin answered the call. She immediately referred the call to Dr Peter Thomas, who was the on call clinical coordinator. (Appendix A)

Dr Tanious was the on call anaesthetist at Hervey Bay Hospital. He had been requested to assess P369. Dr Tanious requested that Dr Thomas clinically coordinate the case – finding a destination hospital with intensive care facilities.

P369 had presented earlier in the day with an evolving large gut obstruction. Her condition had deteriorated and it was agreed by the surgical team at Hervey Bay Hospital that urgent operative intervention was indicated. There was no available intensive care bed on site therefore a request for transfer was made. No referral to another institution had been made prior to the first call to the QCC.

P369 was conscious with the following vital signs:

BP 121/53 PR 93 SaO2 96% on 6l/min oxygen.

An arterial blood gas had been performed. (Appendix D) This revealed a compensated primary metabolic acidosis. The serum lactate was 7.2 – which most likely represented acidaemia due to ischaemic gut.

Dr Thomas requested that the patient be operated on at Hervey Bay immediately - with subsequent medical retrieval in the postoperative period. The anaesthetist indicated that the treating team did not want to operate without an ICU bed being available. Dr Thomas then requested the treating surgeon ring him to discuss the case.

Dr Muzib Abdul-Razak (Surgical Registrar) contacted Dr Thomas – via the QCC. In the interim period Dr Abdul-Razak had referred the patient to the Nambour Hospital. Dr Thomas again requested the team operate at Hervey Bay. The surgical registrar indicated that the only reason for not operating at Hervey Bay was the lack of an ICU bed and declined to do so.

Coordination Decision

Aircraft availability at the time of coordination

RFDS Brisbane – paediatric case (not available for 3 – 4 hours)

RFDS Bundaberg – paediatric case (not available for 3 – 4 hours)

RFDS Rockhampton – offline

Queensland Rescue (Brisbane helicopter) – available / medical officer

Energex Rescue (Maroochydore) – available / intensive care paramedic

Energex Rescue (Bundaberg) – available / intensive care paramedic

Given the treating team were unwilling to operate at Hervey Bay Dr Thomas then arranged urgent transfer to Nambour. Dr Thomas indicated that based on the referring details and the need for urgent transfer the closest available helicopter should be utilized and an intensive care paramedic level escort was appropriate.

Retrieval

Energex Rescue was tasked at 2259 hours. The QAS intensive care paramedic was Darren Sweedman who was paged at 2301 hours. The helicopter departed Maroochydore airport at 0107 hours. There was a delay between activation and commencing the task.

The aircraft utilized was Rescue 513 - a Bell 206L Long ranger.

The Energex team arrived at Hervey Bay at 0150 hours.

I interviewed ICP Sweedman on the 21/1/2005: He reported that on arrival at Hervey Bay Hospital the patient appeared unwell. P36 's vital signs were as follows:

GCS 14 BP 115/75 PR 120 SaO2 94% on 15l/min oxygen by non-rebreather mask.

He noted she had been anuric for 3 hours. A naso-gastric tube was in situ but had minimal drainage. P36 obeyed all commands but he did note the treating team in Hervey Bay had administered Valium for agitation prior to his arrival.

At 0230 hours ICP Sweedman notified QCC of his departure and estimated time of arrival for Nambour Hospital. A consultation with the Clinical Coordinator was not undertaken. It is usual procedure to discuss the case with the Clinical Coordinator but on this occasion it was omitted. He was not sure whether this was required as it was an inter-facility flight rather than a scene response. There are no standing written orders/ SOPs as the various helicopter operations have different requirements.

En-route P36 became agitated and pulled at her naso-gastric tube. At 0300 hours she became tachycardic to 160 beats per minute. A massive vomit in excess of 1000ml followed. ICP Sweedman reports overwhelming vomiting occurred resulting in airway obstruction that he was unable to clear. She became bradycardic, with asystole developing shortly there after. Given the confines of the helicopter all airway and advanced cardiac life support interventions were

extremely difficult and problematic. After a period of resuscitation P369 was declared deceased in flight.

The helicopter arrived at Nambour Hospital and as P369 was deceased she was not registered on the emergency department attendance register. The Queensland Police Service was notified in accordance with the Coroner's Act.

The QCC was not notified of this event until 0800 hours – 5 hours after the cardiac arrest.

KEY ISSUES:

1. Decision not to operate at Hervey Bay

   A Surgeon and Anaesthetist were available to operate on the patient at Hervey Bay. Both physicians had identified this lady as a high-risk patient who required urgent surgical intervention. It appears that the only obstacle to this intervention was the lack of a postoperative intensive care bed. The medical retrieval of such patients after the procedure can be facilitated. A balance must be struck between pre and post operative stability.

   The transcripts of the conversation between the medical coordinator and referring physicians indicate it was the preference of the Clinical Coordinator (Thomas) to transfer the patient after an operative intervention.

   Intensive Care bed availability is dynamic in nature. The demand for such resources varies. Parties involved in such decisions must acknowledge all possible options.

   The authority of the Clinical Coordinator and final accountability in this scenario is unclear at present.

2. Clinical Coordination / Escort Level

   The initial observations indicate a conscious haemodynamically stable patient who had a mild oxygen requirement. The biochemical profile suggests a much more perilous situation as evidenced by the serum lactate level.

   The initial clinical coordination discussion covered all relevant vital signs except urine output and renal function.

   It was clear that there was urgency to provide the definitive operative procedure.

   Based on the initial observations and clinical need for urgent transfer the Clinical Coordinator (Thomas) decided on an intensive care paramedic level escort utilizing the closest available helicopter.

   A physician was available and on call in Brisbane should a medical retrieval have been deemed necessary.

   It was anticipated that the patient required on going supplemental oxygen, intravenous fluid therapy and parenteral narcotic analgesia.

   The patient's condition had deteriorated by the time of arrival of the IC paramedic.

3. Aircraft Utilization

The Energex Rescue Helicopter (Rescue 513) was dispatched at approximately 2300 hours. It is anticipated that the aircraft would have been airborne approximately 45 minutes after the activation. The aircrew at Maroochydore require call in after hours.

The helicopter left Maroochydore at approximately 0107am, some 2 hours after initial activation. There appears to have been a communication breakdown between QAS Maroochydore (local tasking agency) and Energex Rescue, which will require investigation.

The aircraft utilized was a Bell Long ranger (206L). This is a single engine visual flight rules aircraft and is the current Queensland Government baseline standard for aeromedical operations. The cabin is relatively cramped and would have contributed to the difficulties the IC paramedic experienced during the attempted resuscitation of P369

4. ICP standard operating procedures

The IC paramedic was dispatched in accordance with standard task specific crewing principles employed by the QCC medical coordination staff.

In general, the paramedics provide feedback from the pre-hospital scene or hospital prior to departure for the destination hospital. This allows consultation with an experienced specialist physician to establish the proposed treatment plan for the aeromedical transport.

There is no formal agreement with any service to do this. The entire retrieval system is still evolving and a number of services have different operational requirements. It is our intention to standardize procedures across the entire system to improve quality and safety.

The paramedic on this occasion did not consult with the Clinical Coordinator after assessing the patient at Hervey Bay Hospital. The paramedic correctly assessed that this patient was extremely unwell – peripherally cool, tachycardic, anuric with an increasing oxygen requirement.

Given this clinical scenario the Clinical Coordinator may have reassessed the transfer but this is a difficult scenario to re-examine in hindsight. The paramedic completed all necessary pre-departure checks including the functionality of the naso-gastric tube.

The paramedic acted at all times within current QAS treatment protocols. He confronted an extremely daunting clinical scenario and despite his best efforts the patient died.

ACTIONS TAKEN/ REQUIRED:

1. Referred case to Chief Health Officer for formal investigation and review
2. Review ICU bed utilization
3. Review of Clinical Coordinator authority
4. Review of Clinical Coordination procedures - including involvement of receiving intensive care unit in the initial coordination assessment.
5. Review of Clinical Coordinator fatigue management
6. Review of current IC Paramedic education requirements for aeromedical transportation
7. Implement standardized operating procedures across all aeromedical services – will require liaison and consultation with stakeholders (DES, Queensland Rescue, Community Helicopter Providers and the QAS)
8. Investigate delay in departure of the helicopter from Maroochydore – refer to QAS
9. Consult with stakeholders regarding the suitability of the various aeromedical aircraft types for specific tasks.

ATTACHMENTS:

Appendix A	Clinical Coordination Transcripts
Appendix B	Clinical Coordination Data Base Record (CCRIS)
Appendix C	QCC Computer Case Log
Appendix D	Arterial Blood Gas Result
Appendix E	Maroochydore Communications Audit Trail
Appendix F	Ambulance Report Form
Appendix G	Email from Dr Peter Thomas

Queensland Government
Queensland Health

Fraser Coast Health Service District.

TO:	*Mr Mike Allsopp.*
FROM:	*Dr Terry Hanelt.*
DATE:	*21/01/2005.*
SUBJECT:	*Notes in relation to Marjorie Tanner DOB 28/02/1927 DOD 21/01/2005.*

- Presented to ED at Maryborough Hospital on 18/01/2005 at ~1645 hours. Patient suffered from dementia. History from husband of abdominal pain and bowels probably had not opened for last few days. Afebrile, normotensive and not tachy or bradycardic. Examination showed only some tenderness in left lower abdomen. Constipation diagnosed and treated with an antispasmodic drug and anti-constipation agent. Discharged home.
- Presented to ED at Maryborough Hospital on 19/01/2005 at ~1510 hours. Husband reported that there had been no bowel motions, the abdominal pain continued and she had vomited three times. Temperature was 37.2, pulse 87 and BP 143/91. Examination revealed a distended abdomen with a palpable bowel and bowel sounds were present. An x-ray showed 2 or 3 fluid levels and faeces +++. An enema was administered with some result and she was discharged home to be reviewed the next day.
- Presented to ED at Maryborough Hospital on 20/01/2005 at ~1055 hours. She was still constipated and a CT of the abdomen was organised for 24/02/2005.
- Husband telephoned the ED at Maryborough Hospital on 20/01/2005 at ~1520 hours stating his wife kept calling out for him, that he could not sleep and that he could no longer cope. Arrangements were made to admit the patient and blood tests were organised. On return to hospital observations were still within normal limits. Blood tests showed renal failure (renal function had been normal 10 months prior), deranged biochemistry and a blood count indicative of acute bacterial infection. At about 1900 hours the patient's condition deteriorated and medical review occurred. She was agitated, clammy and sweaty. Probable sepsis was diagnosed. The origin was unclear. Arrangements were made for transfer to Hervey Bay Hospital.
- The patient arrived at Hervey Bay Hospital on 20/01/2005 at 2030 hours. On arrival her temperature was 36.1, pulse 93 and BP 121/63. Surgical review resulted in a diagnosis of a large bowel obstruction and that a laparotomy was indicated. The case was discussed with the Anaesthetist who was of the opinion that the patient would require post-operative mechanical ventilation. As the ICU ventilatory capacity was full the Anaesthetist advice was that the patient should be transferred to an alternate site for further management.
- The Surgical team member discussed the case with the Surgical registrar at Nambour who agreed to accept the patient.
- QAS transfer was requested with no request for medical/nursing escort.
- A naso-gastric tube was inserted. Patient pulled this out and the tube was re-inserted.
- The patient was transported by the QAS at ~ 0200 on 21/01/2005 and apparently arrested in transit.

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Cnr Nissen St and Urraween Rd
HERVEY BAY Q 4655
Phone 07 41206666 Fax 07 41206799
E-mail: Terry_Hanelt@health.qld.gov.au

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Phone 07 41238355. Fax 07 41231606
E-mail: Terry_Hanelt@health.qld.gov.au

Issues that need to be considered –

1. Was the management at Maryborough Hospital appropriate?
2. Why was no ICU bed available at Hervey Bay?
3. Should the patient have had surgery and then be transported post-operatively?
4. Was the delay from arrival at Hervey Bay until retrievable reasonable and what constituted the delay?
5. Was the level of staff accompanying the patient appropriate in the clinical circumstance?

1. Was the management at Maryborough Hospital appropriate?

There are no factors in the history or examination notes at Maryborough Hospital indicating the patient should have been managed differently.

2. Why was no ICU bed available at Hervey Bay?

Hervey Bay Hospital has the capacity to ventilate two patients on a medium to long term basis. There had been two ventilated patients at HBH since Sunday night (4 days). Staffing these two ventilated patients had required overtime to be worked by existing ICU staff. No other staff were available. The District has a third ventilator which is currently being repaired due to a breakdown and thus had no proper ventilator available. The data over the life of the ICU and the trends of this data does not support having facility or staffing for greater than two ventilator capable beds in the ICU at HBH. It is of note that another patient was flown out from the District on Sunday as no ventilator bed was available. It is also worth noting that one of the currently ventilated patients was transferred to HBH due to lack of ventilated beds at Bundaberg.

3. Should the patient have had surgery and then be transported post-operatively?

This is a matter of debate and expert opinions could be obtained to support either option. I do not have the expertise to give an authoritative opinion on this question and have no doubt others will give opinions.

4. Was the delay from arrival at Hervey Bay until retrievable reasonable and what constituted the delay?

The patient was at Hervey Bay Hospital for approximately 5 to 6 hours and this seems a prolonged period. The reasons for this will be investigated.

5. Was the level of staff accompanying the patient appropriate in the clinical circumstance?

The staff accompanying the patient in transfer was considered appropriate by the managing clinicians and the Clinical Co-ordinator. Until more is known of the mechanism of death, it is not possible to state whether more personnel or personnel with different qualifications would have made any difference.

Dr Terry Hanelt
Director of Medical Services
Fraser Coast Health Service District

From: Steve Rashford
To: Deborah Miller; John Scott
Date: Fri, Jan 21, 2005 9:47 am
Subject: Death in Transport

Dear John and Deb,

This is a short note regarding this death in transport. I will provide a more detailed report once I have had a chance to investigate the case further. Most participants are not at work as it occurred overnight.

Patient Name: P3605

Referred by Dr Adam Tanyous / Dr Muzib Abdul-Razak (Hervey Bay Hospital)

Clinical Coordinator - Dr Peter Thomas

The initial coordination occurred at approximately 2230. The patient was presented as a 77 year old lady with a gut obstruction. She had a profound lactic acidosis (Lactate 7.2) but her ABG was fully compensated (PH 7.4) She was alert with mild confusion (background mild alzheimers). She had an IDC / NGT / IV fluids in situ. Her obs were SaO2 96% on 6l/min oxygen. BP 121/53 PR 93.

According to Peter he felt at the time she should be operated on at Hervey Bay and transported post operatively to another hospital once stabilized. Both the anaesthetist and surgeon would not perform the operation without a post-op bed

Peter Thomas, in consultation with the referring physicians, felt the transport was time critical and utilized the nearest helicopter provider - Energex Maroochydore An intensive care paramedic level escort was decided on.

Please note that an on call physician was available for retrieval in Brisbane (it was me) but Peter felt given the patient's condition an ICP escort was suitable

Transport:

The transport was performed in Rescue 513 - a long ranger. The larger Rescue 511 was not utilized.

The paramedic (Darren Sweedman) assessed and loaded the patient in Hervey Bay. Apart from her tachycardia (HR 120) the condition was as stated - her conscious level was ISQ.

En route she became mildly agitated and then started vomiting profusely. The airway became difficult to manage and she suffered a cardiac arrest - I would think most likely due to airway obstruction but this is conjecture. I will need to ascertain if the arrest occurred first or as a result of airway obstruction. She received limited resuscitative efforts in flight due to the limited space available and was dead on arrival at Nambour Hospital

Nambour:

I understand no medical chart was established as she was declared dead in transport. This lady's body was moved to the hospital morgue and the Queensland Police were called in accordance with the Coroner's act.

I will be seeking formal reports from
1. Peter Thomas
2. ICP Darren Sweedman.

The QCC was not notified until the paramedic rang me at 0750 this morning to debrief the case. This is a major communication breakdown as the patient died at approximately 0300.

Prior to this notification this morning, Peter and I had already had a conversation during our handover

about this case - regarding the decision not to operate at Hervey Bay. I had planned to follow it up after a formal email from Peter.

There are a number of issues that need investigation.

I will also notify QAS management given the implications for the DES and ICP.

Please bear in mind the above details are scant and based on initial telephone conversations

Regards

Steve

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

CC: Gerry FitzGerald

Issues that need to be considered –

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2. Why was no ICU bed available at Hervey Bay?
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The staff accompanying the patient in transfer was considered appropriate by the managing clinicians and the Clinical Co-ordinator. Until more is known of the mechanism of death, it is not possible to state whether more personnel or personnel with different qualifications would have made any difference.

Dr Terry Hanelt
Director of Medical Services
Fraser Coast Health Service District

From: Steve Rashford
To: Gerry FitzGerald; John Scott
Date: Sun, Jan 23, 2005 9:50 pm
Subject: In Flight Death Brief

Dear John and Gerry,

Please see the attached brief regarding the death of Mrs Marjorie Tanner.

The brief and voice transcripts are attached.

I will send a number of emails with other relevant scanned documents (Appendices) - multiple emails due size but easily printed

I would be happy to discuss the case at any time.

Regards

Steve

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

CC: Deborah Miller

Date of conversation: 21/01/05
Time of conversation: Call No 1 – Anaesthetic Consultant

Conversation participants: Dr Peter Thomas (referred to as PT in all following transcripts), Comms Officer Lisa O'Loughlin (referred to as LO in all following transcripts) and HBH on call anaesthetist (referred to as MO1 in all following transcripts).

PT Yeah righto.

LO OK, pt's name P369

PT Yeah

LO Twenty-eight, two, twenty-seven...

PT Yeah

LO She's seventy kilo's, he hasn't found an ICU bed for her at this point. Treating doctor is Adam Tanious

PT Adam what?

LO Tanious I believe he said it was.

PT Ok

LO He has a very thick accent. Um...

PT Yeah

LO Contact number is 4120...

PT Yeah

LO 6981

PT And he's where? Hervey Bay.

LO He's at Hervey Bay.

PT Ok

LO Alright, I'll put you through.

PT Thanks

MO1 Hello ICU *Adel* speaking

LO Yes Adam it's Lisa from the QEMS coordination centre I have Dr Thomas, I'll put him through now.

MO1 Alright, thank you.

LO Go ahead please.

MO1 Hello....hello.

PT Yeah, hello.

MO1 Ah, hi Peter. I'm Adam ??? one of the anaesthetists here, um, er, we have a pt who has a bowel obstruction, er, she's about seventy two years old and, um, she is very acidotic, was, er, *compensated* with lactate seven point two at the moment, ah, fully conscious, ah, ah, we have a ...

PT What's her...what's her Ph?

MO1 pH is 7.4

PT Lactate 7.2 , pH 7.4.

MO1 Yeah

PT Ok... ok

MO1 And, er, CO2 is twenty-seven or twenty-four, can't remember.

PT Ok

MO1 Er.....but we.....I worry that...er. .she will need the ventilation and we don't have beds available here.

PT Do you have a surgeon?

MO1 Er...we have a surgeon

PT Has he seen her?

MO1 Yes, the surgeon's seen her, yeah

PT What...what does he think?

MO1 He said it needs to be operated on immediately.

PT So is he going to operate?

MO1 Ah.....we.....we.....we reckon if we can transfer her and then have an operation so we don't stuck with her with ventilation.

PT Have...have you spoken to a surgeon?

MO1 Yeah, yeah, we trying have them

PT Where? Which hospital?

MO1 Her.....Her....we're Hervey Bay Hospital

PT But have you spoken to a surgeon somewhere else?

MO1 Ah.....they.....they trying to find and um they said ...er...he spoke to Royal Brisbane, they said ICU full.

PT Yeah

MO1 Mmm.....so I don't know. I thought if you can find then a bed for us.

PT Is it large or small gut obstruction?

MO1 Um...I don't know exactly.

PT She's got a bowel obstruction but....

MO1 Yeah

PT But he doesn't want to operate?

MO1 S ...sorry?

PT He wants.....She needs an operation immediately but....

MO1 Yeah

PT But he won't do it?

MO1 Yeah because.....er...we.....er.....we have an ICU problem

PT Yeah but she needs an operation doesn't she?

MO1 Ye ...Yes she does. If sh....if she can have an operation in an hours time, two hours time somewhere else would be good.

PT Alright you want me to find a surgeon and a bed somewhere else for her?

MO1 Yes please...is this alright?

PT Not really, I think she needs an operation in Hervey Bay, doesn't she?

MO1 Ah, yeah, we can, that's alright, can you hold for a second please?... ...He ..hello Adam speaking.....can you hold for a second, a second please?.....Ah yes...ah....then we will...

PT How long has she had the obstruction for?

MO1 Ah, they told me, er, the, since this morning

PT And you don't know if it's large or small?

MO1 Ah, I just been told about her now.. this is the problem actually

PT Er, they've, er.....

MO1 Mmm

PT Who's the surgeon?

MO1 Er, I'll, I'll get you to c ..er ..him to contact you, how is that?

( ) I....I better talk to the surgeon....

MO1 Yeah, fair enough....er....do you have a dial phone number Dr Thomas?

PT Yeah zero four one two....

MO1 Zero four one two ..

PT Um. ..seven two four....

MO1 Seven two four....

PT Zero two five

MO1 Zero two five No worries, I'll get him to contact you immediately

PT Thank you.

MO1 Thank you, bye..

( ) You there? ..You there?...

LO Yes I am Peter

PT Oh Christ!

LO I'm sorry, he didn't explain that part of it to me....

PT No, I mean it' s not for you to know .

LO No...

PT Oh...Fuck me, what's going on here?

LO I don't know....I mean if the surgeon's agreeing that she needs immediate surgery...

PT Immediate surgery and he doesn't want to do it.. You know you operate . and then you worry about a bed ...

LO Why wouldn't you operate, ventilate and then get her out? Er...yeah....

PT That's my point, yeah, if she came in with a ruptured spleen he'd operate.

LO Yeah

PT Alright, I'll hang up and he'll ring me.

LO Alright, no problems.

PT What are we... er... ok, righto.

LO Ah, we actually don't have an aircraft ..

PT We don't have an aircraft, no.

LO ...at the moment anyway

PT We'd have to fly Bund.. we'd have to fly Bundaberg down to go back....

LO Well Bundaberg's actually had some issues with their paediatric patient, they couldn't land at Kingaroy because they couldn't activate the lights, so they're now heading to Wondai but they're going to have to wait for the ambulance to bring the patient from Kingaroy to Wondai.

PT So Bundaberg's out of action, we don't have an aircraft....

LO Os....Yeah, Rockhampton's out of action, Bundaberg will probably be down at Toowoomba an hour to an hour and a half from now... um....and then we'd have to bring.....

PT So Bundaberg will be in Toowoomba an hour and a half from now?

LO Probably yeah and then we'd need to bring them on to Brisbane, or....

PT To get a doctor

LO ah....the Brisbane aircraft is back in Brisbane at quarter to twelve but they need to do a hospital handover so you can add another hour and a half to that.

PT So Brisbane's not ready till early tomorrow....

LO Yup

PT Rocky's not ready at all

LO At all

PT And Bundaberg is....is

LO And Bundaberg, yeah, we'll be looking into Toowoomba probably in about an hour to an hour and a half depending on how quickly the ambulance can get this child from Kingaroy to Wondai.

PT Ok, alright.

LO So, we, yeah, the short answer is we don't have an aircraft immediately available anyway.

PT Ok, alright, ok.

LO Alrighty.

PT Bye.

LO Bye.

Date of conversation: 21/01/05
Time of conversation: Call No 2 – Surgical Registrar:

Conversation participants: Comms Officer Lisa O'Loughlin (referred to as LO in all following transcripts), Switch Operator HBH (referred to as SO in all following transcripts), HBH on call surgeon (referred to as MO2 in all following transcripts) and Dr Peter Thomas (referred to as PT in all following transcripts).

LO QEMS coordination centre, Lisa.

SO Is this Lifeflight?

LO You've come through to the aerial retrieval unit..

SO Ok, I'll just put...this is the Hervey Bay Hospital, Dr *Mujlbe* would like to talk to you, I'll just put you through to him, thank you.

LO Thank you.

MO2 Hello?

LO Yes, hello Dr, it's Lisa from the QEMS coordination centre, were you wishing to speak to the coordinator again?

MO2 Yeah.

LO Ok, I'll put you through

MO2 Thank you.

PT Peter Thomas.

LO Peter, it's Lisa, I have Hervey Bay on the line again, can I put them through?

PT Uhuh, yeah.

LO Go ahead please.

MO2 Hello?

PT Yeah, hello.

MO2 Hello, ah, Good evening, my name is Dr *Mujibe*, the surgical registrar...

Yes...

MO2 ....at Hervey Bay Hospital.

PT Yes. .

MO2 Yeah, ah, I can talk to Mr, Dr Peter Thomas?

PT That's me.

MO2 Yeah, ok there, did ???? speak to you about, ah, a pt to be shifted to...

PT Yeah... yeah keep going.

MO2 Yeah, so actually I've spoken to the surgical registrar at Nambour Hospitals and they've accepted to... receive her.

PT They will take her?

MO2 Yeah, they will take her, yeah..

PT At Nambour?

MO2 ... thankfully.

PT Why can't you operate?

MO2 We are ready to operate, we are willing to operate, we want to operate, the thing is that we don't have a bed with a ventilator.

PT Yes but. .uh... ok.

MO2 That's what... that's what ?????? response

PT What sort of ...what sort of bowel obstruction does she have?

MO2 A large bowel obstruction.

PT Ok...So she's going to Nambour?

MO2 Nambour, yeah.

PT They will take her now...

MO2 Yep, as soon as possible, she's all ready and she's just in the A and E and we just waiting now....

PT What have you done for her?

MO2 Um, we have done the blood *specs,* ???, the works, everything.

PT She got a drip in?

MO2 Yeah, drip in, nasogastric tube in, catheter in.

PT Analgaesia?

MO2 Yep

PT Ok

MO2 She's not particularly painful, the problem is distended, ????????

PT And what are her . do you have her vital signs?

MO2 Yeah, vital signs are fine, her sats a little bit down so she is on supplemental oxygen, arterial blood gas is fine but....

PT What's her pulse and blood pressure? I need all these.

MO2 Ok. Her pulse is ninety three, blood pressure one twenty one by fifty three.

PT And saturations?

MO2 Sats are ninety six on, ah, six litres oxygen.

PT And she's going to Nambour.

MO2 Yeah.

PT Ok, alright. Ok, we'll call you back.

MO2 Ok then, you want me to. .do you want a letter...a letter from me to Nambour isn't it?

PT Well I guess so, yes.

MO2 Ok then, yeah, thank you.

PT Good on you, bye.

MO2 Bye.

PT Lisa.

LO Yes Peter.

PT Ah... Nambour helicopter with a IC Para?

LO Sure.

PT Is that possible? Is that do able?

LO Yeah...yeah...ah it takes about forty to forty five minutes to get them activated though.

PT Well that's alright.

LO Yep ...you're happy with that?

PT It's quicker than what we've got.

LO Yeah, absolutely.

PT Ah... too s... ..it's too slow by road.

LO Yes.

PT Ah... what about Bundaberg helicopter? Whatever is quickest anyway.

( ) Alright.

PT Can you shop around?

LO I will, I'll give Bundaberg a call now.

PT An IC Para can do it, I mean....

LO Yep sure.

PT ...if she.... if she's that fit, it's just a matter of getting her to Nambour and let them operate.

LO Yep, ok.

PT Can you let me know what they, what you come up with?

LO I will.

PT Ok.

( ) I will Peter.

PT Tell them...tell them they... tell them to be as quick as possible and....

LO Yep, for sure.

PT ...save stuffing around. What's the biggest helicopter...it's ..are they ...are they IFR?

LO They're both the same, they're both squirrels.

PT IFR or night VFR?

LO Ah ..

PT Oh well put it....

LO Not sure but I'll put the question to them.

PT ....put it to them.

LO Yep, sure.

PT What's the weather like at the moment?

LO Weather seems fine, I actually had a look at the radar about an hour ago and there was nothing of any significance out there..

PT Ok.. well.....I suppose Nambour is the closest?

LO Mm hm.

PT It's the obvious one, isn't it?

LO Yeah

PT Try them first and otherwise Bundy. Let me know that, will you?

LO Alrighty.

PT Thank you, bye..

LO Thanks, bye.

Date of conversation: 21/01/05
Time of conversation: Call No 3 Retrieval Notification:

Conversation participants: Unidentified male staff member HBH CCU (referred to as UM1 in all following transcripts), Comms Officer Lisa O'Loughlin (referred to as LO in all following transcripts), HBH on call anaesthetist (referred to as MO1 in all following transcripts), unidentified male staff member HBH Theatre (referred to as UM2 in all following transcripts), second unidentified male staff member HBH Theatre (referred to as UM3 in all following transcripts), unidentified female staff member HBH ED (referred to as UF1 in all following transcripts)

UM1 Coronary Care can we help you?

LO Yeah, hi, it's Lisa from QEMS coordination centre, how are you this evening?

UM1 Who sorry?

LO It's Lisa from the QEMS coordination centre.

UM1 Yep

LO I believe you have a Marjorie Tanner in the ward with you at the moment..

UM1 No we don't.

LO You don't?

UM1 No, I assume that's probably might be the person over in theatre....

LO Ah....ok

UM1 ...which is, ah, intubated and we can't, um, as far as ventilation...and we, we're already full, full as far as ventilation, ventilating patients...so I'll put you over to theatre and talk to the anaesthetist who's in charge....that would be in charge of that patient.

LO That'd be great, thank you.

UM1 Just hold on.

MO1 Hello.

LO Yes, hello, it's Lisa from the QEMS coordination centre....

MO1 Yes Lisa.

LO Um, you're looking after P365 at the moment, are you?

MO1 After what sorry?

LO P365

MO1 Ah, no, it is not me anymore. That is doctor, ah *Mujibe*, ah, *Abdul Mujibe*.

LO Ok and where would Dr *Mujibe* be please.

MO1 Alright so we....we.. can you transfer this phone call to the....A and E please?

UM2 A and E?

MO1 Yeah.

UM2 Ok.

MO1 Ah, yeah, can you hold for a second, Lisa?

LO Certainly.

MO1 Thank you.

UM2 Um... I think ..

MO1 Double six, five, four.

UM2 Yeah I know that, I know, I'm just trying to think how to transfer on these phones ... No idea, there is a way of doing it ... Annette, how you doing, it's Ian ... um, one of the doc's just gave me their free set, how do you transfer on a free set over to another phone? ... yep, yep, so you push yes ... You there?

LO Yeah ...

UM2 Yeah, hang on, we're just trying to transfer over at the moment

LO Ok

UM2 Hang on ...

UF1 A and E, hello?

LO Yes, hello, it's Lisa from the QEMS coordination centre.

UF1 Yes.

LO Um, I believe you have P369. with you in the emergency department ...

UF1 Yes, we do.

LO ... is that correct?

UF1 Yes

LO Um ... if you could just let the person looking after her know that she'll be transferred out by chopper tonight

UF1 By chopper, do you know what time roughly?

LO Ah, haven't got a time at this stage, the chopper's just been tasked from Maroochydore, so, ah, they should be up with you shortly.

UF1 Alright then, thank you.

LO Ok, thank you, bye bye.

UF1 Bye.

Bundaberg Hospital Commission of Inquiry

Statement of Gerard FitzGerald

Attachment GF30

GF30

Queensland Government
Queensland Health

Clinical Audit – Fraser Coast

Confidential Audit Report

Prepared by:
Dr Gerry FitzGerald, Chief Health Officer
Mrs Susan Jenkins, Manager-Clinical Quality Unit
Office of the Chief Health Officer

March 2005

Controlled Document Number:

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Acknowledgements

The Chief Health Officer, Dr Gerry FitzGerald, wishes to thank the staff members of Maryborough and Hervey Bay Hospitals and the Queensland Ambulance Service involved in this clinical audit for their assistance, participation, advice and support.

Preamble

Prior to the on-site visit, with the information provided, the audit team had assumed that the scope of the review was to investigate the circumstances surrounding the transfer of a patient from Hervey Bay Hospital to Nambour Hospital.

On arrival at Maryborough Hospital to meet with relatives of the patient, it became apparent that, although there may have been concerns with the transfer, there were also some questions regarding the total episode of care.

For this reason, the background information to Maryborough and Hervey Bay Hospitals has been included in this report.

Introduction

Hervey Bay Hospital is a modern 104-bed facility which was opened in 1997. Since then the hospital has built a reputation for excellence, especially in professional education, and attracts medical and nursing programs in conjunction with the Universities of Queensland, Central Queensland and Southern Queensland and the Queensland University of Technology. Hervey Bay Hospital provides a range of clinical services including the following: operating theatres, 24-hour emergency, intensive and coronary care, paediatrics, obstetrics and gynaecology, midwifery, orthopaedic surgery, ophthalmology, pathology, medical imaging, renal dialysis, cardiac rehabilitation, infection control and needle availability service.
Allied Health services include physiotherapy, occupational therapy, dietetics, diabetes education, speech pathology and social work.

Maryborough Base Hospital is an 88-bed facility and is the site of the district's 14-bed Integrated Mental Health Service's Acute Inpatient Unit. A planned $13.5 million replacement Aged Care facility will also be housed on the site. The hospital underwent a $17 million redevelopment two years ago which was designed to ensure the provision of first class healthcare for the community.
Services provided include: operating theatres, emergency services, intensive and coronary care, paediatrics, obstetrics and gynaecology, orthopaedic surgery, ophthalmology, pathology, medical imaging, mental health unit, infection control and needle availability service.
Allied Health services include physiotherapy, occupational therapy, dietetics, diabetes education, speech pathology and social work.

Background data source: *Queensland Government, February 2005, 'District and Hospital profiles' in the Queensland Health Electronic Publishing System (QHEPS) [Online]. Available at: http://qheps.health.qld.gov.au/*

Background

This clinical audit was undertaken in February 2005 by the Chief Health Officer, Dr Gerry FitzGerald and Mrs Susan Jenkins, Manager of the Clinical Quality Unit in the Office of the Chief Health Officer, both of whom are appointed by the Director-General as Investigators pursuant to Part 6 of the *Health Services Act 1991*, enabling access to relevant clinical data.

Definition of clinical audit

Clinical audit is a systematic review and critical analysis of recognised measures of the quality of clinical care, which enables benchmarking and identifies areas for improvement. Clinical audits are designed to complement accreditation surveys and focus on the outcomes of care rather than structures and processes.

Purpose of the clinical audit

The clinical audit was undertaken to measure the quality and safety of this patient transfer from Hervey Bay Hospital to Nambour Hospital and identify areas for improvement. The Chief Health Officer had been made aware of a sentinel event which occurred during this transfer and was requested to conduct a review of the circumstances surrounding the event.

Scope of the clinical audit

The Chief Health Officer and Manager-Clinical Quality Unit conducted on-site visits at Maryborough and Hervey Bay Hospitals on February 15th 2005, to collect data and interview staff and members of the patient's family in regard to the transfer of the patient. Information was also provided by the Queensland Ambulance Service. During the on-site visit it became apparent that there were concerns about the care provided at Maryborough and Hervey Bay Hospitals, so these issues were included in the review.

Data sources

Data were sourced from the following:

- The patient's clinical record
- Interviews with family and staff members
- Queensland Ambulance Service.

Some information was also provided to the audit team prior to the on-site visits.

Preliminary information

The audit team was in receipt of the following information prior to the on-site survey:

- Briefing from the Director-Clinical Co-ordination and patient Retrieval Services to the Senior Executive Director-Health Services submitted through the Chief Health Officer
- A memorandum from the Director of Medical Services – Fraser Coast to the District Manager – Fraser Coast with details of the care provided to the patient prior to the request for transfer to Nambour
- A memorandum from the Director of Medical Services – Fraser Coast with a summary of the events
- Sentinel event notification report
- Copies of transcripts of conversations between:
    - Call no. 1. The clinical co-ordinator on call, communications officer and the on-call anaesthetist at Hervey Bay Hospital
    - Call no. 2. The communications officer, switch operator, on-call surgeon at Hervey Bay Hospital, the clinical co-ordinator on call
    - Call no. 3. The communications officer, the on-call anaesthetist at Hervey Bay Hospital, staff member (unidentified) – CCU at Hervey Bay Hospital, two staff members (unidentified) – OT at Hervey Bay Hospital, unidentified staff member – ED at Hervey Bay Hospital

Summary of the sentinel event provided to the audit team

- The patient presented to Maryborough Hospital on 18/01/2005 at 1645 hours with abdominal pain and was treated for constipation.
- The patient presented to Maryborough Hospital on 19/01/2005 at 1510 hours with abdominal pain and vomiting and was treated for constipation after x-rays were performed. The patient was advised that a barium enema would be necessary and to return the following day for a referral. The patient was discharged for review the next day.
- The patient's husband presented to Maryborough Hospital on 20/01/2005 at 1055 hours and stated that there was no clinical change. A CT scan was booked for 24/01/2005 and discharged.
- On 20/01/2005 at 1520 hours, a telephone call was received from the patient's husband stating he was unable to cope with the patient. The decision was made to admit the patient for treatment of constipation and Alzheimer's Disease. CT appointment had been changed to 21/01 (error in file entry stating 20/01). Patient presented later and after collection of blood tests was admitted to Maryborough Hospital.
- At about 1800 hours the patient's condition deteriorated and medical review resulted in a diagnosis of sepsis and a bowel obstruction and the decision was made to transfer patient to Hervey Bay Hospital.
- Arrived at Hervey Bay Hospital about 2030 hours and after assessment by the surgical team and the anaesthetic team, the decision was made to transfer the patient to Nambour as it was assessed the patient would require post-operative ventilatory support and there was no available capacity for this at Hervey Bay Hospital.
- Patient was retrieved by helicopter at about 0200 hours and subsequently died during transport.

On-site visit

The audit team visited Maryborough Hospital on Tuesday February 15th 2005, and whilst there, met with two members of the patient's family and one of the Maryborough Hospital doctors who had been involved in the care of the patient. The pattern of events as described by the patient's family is documented below.

Interview with the patient's family – February 15th, 2005

This patient was 77-years of age and lived with her 83-year old husband in their own home in Maryborough.

The patient had been physically well, fully mobile and independent in her personal care. She had been diagnosed previously with early dementia which was exhibited through loss of short term memory, but she had good long term memory and knowledge and recognition of family and friends.

The family provided this account of the care provided at Maryborough Hospital.

Day, date and time	Event
Tuesday January 18, 2005 and Wednesday January 19, 2005	The patient had a sudden onset of 'distended abdomen' which was painful to touch. Because the general practitioner was away, the husband took the patient to the emergency department at Maryborough Hospital. The doctor examined the patient and diagnosed constipation. The patient represented the following day with similar symptoms. The patient had an abdominal x-ray, which showed that she had a 'blockage'. The patient was given an enema which had "some" response. The patient was sent home with instructions to drink 6 glasses of pear juice and take coloxyl (an aperient). The patient was not asked to return.
Thursday January 20, 2005	On Thursday the patient's husband presented to the hospital to pick up a referral for the CT scan. Later that day, the patient's husband rang the doctor in the emergency department requesting admission for his wife since he could not cope at home. The patient was admitted to the hospital, had urine and blood tests. The urine test showed a probable infection. The patient's husband stated during the discussion that he thought this was 'odd from the start' – his wife had complained of being hot and sweating and she was still hot with a fan blowing on her. The decision was made to transfer the patient to Hervey Bay Hospital where there was a CT scanner and surgeons available. The patient was transferred at 8 o'clock that evening. At 11 o'clock that evening the husband received a phone call from Hervey Bay Hospital with the advice that a decision had been made to transfer the patient to Nambour Hospital.
Friday January 21, 2005	At about 3 o'clock in the morning the husband received a phone call from Hervey Bay Hospital to inform him that his wife had died.

The family had the following questions:

- Why was the patient sent home on Tuesday with a suspected blockage?
- Why wasn't the CT scan arranged to be performed at Hervey Bay Hospital?
- Was the patient given any pain relief when she was admitted to Maryborough Hospital?
- Why was the patient sent to Hervey Bay Hospital when there were no beds available with the capacity to ventilate patients?
- What is the role of Maryborough Hospital?
- Why did the air transfer take so long?

Maryborough and Hervey Bay Hospitals

Interviews with staff members

Senior Medical Officer (SMO), Emergency Department, Maryborough Hospital

This SMO has worked at Maryborough Hospital for 28 years. He stated that the patient was first seen at Maryborough Hospital for this episode of care by the emergency department Resident Medical Officer (RMO) on January 18, 2005. The SMO saw the patient on January 19. He discussed the care of the patient using the clinical record as a reference.

Surgical Principal House Officer (PHO), Fraser Coast

This PHO is an overseas trained doctor. In regard to the care of this patient at Hervey Bay Hospital, he stated that he had seen the patient and examined her when she was admitted at 2030hrs on January 20, 2005. He said that it was the decision of the anaesthetist that the patient would need post-operative ventilation. A naso-gastric tube was inserted whilst the patient was in the hospital. There were no episodes of vomiting during her admission.

Anaesthetic Principal House Officer (PHO), Fraser Coast

This PHO is an overseas trained doctor. He stated that the surgical PHO had discussed this patient, and the need for a laparotomy, with him at about 2200hrs on January 20, 2005. Although he had not seen the patient, the anaesthetic RHO had said that the patient would need to be ventilated post-operatively. Because he was concerned that the patient's condition would deteriorate during the procedure, his assessment was that it would be better to transfer the patient pre-operatively, while she was fairly stable. The anaesthetic PHO said he was informed at about 2300hrs on January 20, that the patient was to be transferred to Nambour Hospital.

Director of Medical Services, Fraser Coast

This Director of Medical Services provided the following comments:

- Elective surgical procedures only are carried out at Maryborough Hospital
- Emergency surgical procedures are only carried out if they can be added to an elective list without changing the elective list
- No elective caesarean section procedures are carried out at Maryborough Hospital – emergency caesarean sections only
- There is no after-hours anaesthetic cover at Maryborough Hospital
- Of 38 PHO and RMO positions in the district, 5 are filled by Australian trained doctors and the remaining 33 are filled by overseas trained doctors

Review of the clinical record

Timeline of this episode of care at Maryborough Hospital

Day, date and time	Event
Tuesday January 18, 2005, 1645hrs	The patient presented to the emergency department of the Maryborough Base Hospital complaining of abdominal pain since that morning, without diarrhoea or vomiting.
Tuesday January 18, 2005, 1740hrs	The patient was seen by a resident medical officer who noted that she was complaining of abdominal pain, no history of vomiting, was apyrexial, had some tenderness in the left iliac fossa and wasn't sure whether she had any bowel movements over the last few days. The RMO's impression was noted as 'constipation'. The plan for care was buscopan, coloxyl & senna and oral fluids.
Wednesday January 19, 2005, 1510hrs	The patient re-presented to the emergency department of the Maryborough Base Hospital complaining of continuing abdominal pain and three episodes of vomiting that day. She had been given the aperient that day. It was noted that the patient was not drinking much.
Wednesday January 19, 2005, 1625hrs	The patient was seen by the director of the emergency department (SMO) who noted the previous visit and treatment plan, that the aperient given had not had any effect and that the patient was unsure about how many days since she'd had a bowel movement. On examination, chest was clear, temperature was 37.2°C, blood pressure was 143/91, abdomen distended with palpable bowel with bowel sounds present. An abdominal x-ray was performed which showed 2-3 fluid levels plus faeces +++. Treatment ordered was the administration of a Fleet enema which was given with 'some result' by 1810hrs that evening. The doctor stated that the patient would need a barium enema but in the interim she should take a high fruit content diet including pear juice. It was arranged that the husband would return the following day to collect a referral for the barium enema. The SMO considered at that time that the patient had a partial gut obstruction and he believed that further investigations should occur into the cause of the obstruction.
Thursday, January 20, 2005, 1055hrs	The patient's husband saw the SMO and reported that the patient was still constipated and wouldn't eat. The SMO arranged an abdominal CT scan at a private facility in Maryborough for January 24. The SMO advised that the patient should be given Sustagen and puréed fruit.
Thursday, January 20, 2005, 1520hrs	The SMO received a phone call from the patient's husband, who said he was unable to cope any more, that the patient was distressed, wouldn't eat and kept calling out for her husband. The SMO arranged for the patient to be admitted, with a diagnosis of constipation and Alzheimer's Disease. He noted that there was a need to exclude hyponatraemia and blood tests were to be carried out. The SMO discussed this admission at 1600hrs with the surgical PHO, who was to see the patient on the ward following admission.
Thursday, January 20, 2005, 1615hrs	Nursing observations were taken and an IV cannula inserted with IV fluids commenced to be run at 1litre every 6 hours.

Timeline of this episode of care at Maryborough Hospital (continued)

Day, date and time	Event
Thursday, January 20, 2005, 1800hrs (approx)	The emergency department RMO was called to see the patient at about 1800hrs and noted 'called to see patient because of a rapid decline in the patient's condition', in particular, ↑BP, ↓temperature (35.6°), pale and sweating, tachycardic and distended abdomen. The RMO was told by the patient's husband that she had not had her bowels open for 3 days and that she vomited on January 19 and 20 – the nursing staff advised the RMO that she was vomiting coffee ground vomitus. The RMO's impression was that the patient had sepsis but could not determine the source, that she also had a bowel obstruction that was probably sub-acute and possibly related to the sepsis and noted multiple abnormalities in blood results. He planned to transfer the patient to Hervey Bay Hospital for acute management. The RMO took blood cultures and ordered intravenous broad spectrum antibiotics and arranged for her transfer to Hervey Bay Hospital. An IDC was inserted. At this point the patient had not been seen by the surgical team.
Thursday, January 20, 2005, 2000hrs (approx)	The patient was transferred by QAS to the Hervey Bay Hospital where she arrived at 2030hrs.

Timeline of this episode of care at Hervey Bay Hospital

Day, date and time	Event
Thursday, January 20, 2005, from 2030hrs, Hervey Bay Hospital	It is not possible to explain a significant gap in the patient's care at Hervey Bay Hospital (HBH). Initial observations are recorded by the primary nurse, presumably on arrival at Hervey Bay Hospital. The next observations are recorded at 2330hrs. She was seen by the surgical PHO, although it is not possible to determine the time at which she was seen. The surgical PHO recommended that she should have a laparotomy and discussed it with the surgeon on call who agreed to carry out the laparotomy and asked to be advised when the patient was prepared. The PHO discussed the matter with the anaesthetist who, without seeing the patient, advised that she would need post-operative ICU care. As there was not a bed available in ICU, it was recommended that the patient be transferred to another facility prior to the laparotomy. The surgical PHO then sought to obtain a bed in Brisbane by contacting relevant surgical receiving staff. Staff at Royal Brisbane & Women's Hospital indicated there were no available ICU beds there. Finally the PHO was able to reach agreement with Nambour Hospital to receive the patient. He then called the clinical co-ordination centre. The clinical co-ordinator on-call rang back and spoke to the anaesthetist who was unable to provide details. The clinical co-ordinator attempted to encourage HBH staff that the operation should be carried out at HBH prior to transfer, but as this suggestion was declined, the decision was made to retrieve the patient by helicopter to Nambour Hospital using the Maroochydore-based community helicopter. The clinical co-ordinator determined that a paramedic escort would be appropriate. The helicopter arrived at 0150hrs.

Clinical co-ordination and retrieval of the patient (details taken from the briefing to the Senior Executive Director-Health Services)

Day, date and time	Event
Thursday, January 20, 2005, 2220hrs (approx)	The on-call anaesthetist (HBH) made a call to the Queensland Emergency Medical System (QEMS) Co-ordination Centre (QCC). The Queensland Ambulance Service (QAS) Communications Operator answered the call and immediately referred the call to the on call clinical co-ordinator. The on-call anaesthetist at Hervey Bay Hospital had been requested to assess the patient. This anaesthetist requested that the clinical co-ordinator should co-ordinate the case – finding a destination hospital with intensive care facilities. **Patient history.** The patient had presented earlier in the day with an evolving large gut obstruction. Her condition had deteriorated and it was agreed by the surgical team at Hervey Bay Hospital that urgent operative intervention was indicated. There was no available intensive care bed on site therefore a request for transfer was made. No referral to another institution had been made prior to the first call to the QCC. The patient was conscious with these vital signs: BP 121/53, pulse 93, SaO_2 96% on 6l/min oxygen. An arterial blood gas had been performed. This revealed a compensated primary metabolic acidosis. The serum lactate was 7.2 – which most likely represented acidaemia due to ischaemic gut. The clinical co-ordinator requested that the patient be operated on at Hervey Bay Hospital immediately, with subsequent medical retrieval in the post-operative period. The anaesthetist indicated that the treating team did not want to operate without an ICU bed being available. The clinical co-ordinator then requested the treating surgeon ring him to discuss the case. The surgical registrar contacted the clinical co-ordinator via the QCC. In the interim period, the surgical registrar had referred the patient to Nambour Hospital. The clinical co-ordinator again requested the team operate at Hervey Bay Hospital. The surgical registrar indicated that the only reason for not operating at Hervey Bay Hospital was the lack of an ICU bed. Given the treating team was unwilling to operate at Hervey Bay Hospital, the clinical co-ordinator then arranged urgent transfer to Nambour Hospital. The clinical co-ordinator indicated that, based on the referring details and the need for urgent transfer, the closest available helicopter should be utilised and that an intensive care paramedic level escort was appropriate.

Aircraft availability at the time of coordination

RFDS Brisbane – paediatric case (not available for 3 – 4 hours)
RFDS Bundaberg – paediatric case (not available for 3 – 4 hours)
RFDS Rockhampton – offline
Queensland Rescue (Brisbane helicopter) – available/medical officer
Energex Rescue (Maroochydore) – available/intensive care paramedic
Energex Rescue (Bundaberg) – available/intensive care paramedic

Clinical co-ordination and retrieval of the patient (continued)

Day, date and time	Event
Thursday, January 20, 2005, 2259hrs	Energex Rescue tasked. The aircraft utilised was Rescue 513 - a Bell 206L Long ranger.
Thursday, January 20, 2005, 2301hrs	The QAS intensive care paramedic was paged.
Friday, January 21, 2005, 0107hrs	The helicopter departed Maroochydore Airport. **There was a delay between activation and commencing the task. The reason for this delay appeared to relate to a failure to activate the pilot. A second call had to be made, thus delaying departure.**
Friday, January 21, 2005, 0150hrs	The Energex team arrived at Hervey Bay Hospital. The QAS intensive care paramedic has reported that on arrival at Hervey Bay Hospital, the patient appeared unwell and her vital signs were as follows: GCS 14, BP 115/75, PR 120, SaO_2 94% on 15l/min oxygen by non-rebreather mask. He noted she had been anuric for 3 hours. A naso-gastric tube was in-situ but had minimal drainage. The patient obeyed all commands but he did note the treating team in Hervey Bay had administered Valium for agitation prior to his arrival.
Friday, January 21, 2005, 0230hrs	The QAS intensive care paramedic notified QCC of his departure and estimated time of arrival for Nambour Hospital. En-route the patient became agitated and pulled at her naso-gastric tube.
Friday, January 21, 2005, 0300hrs	The patient became tachycardic to 160 beats per minute. A massive vomit in excess of 1000ml followed. The QAS intensive care paramedic later reported overwhelming vomiting occurred resulting in airway obstruction that he was unable to clear. The patient became bradycardic, with asystole developing shortly thereafter. After a period of resuscitation the patient was declared deceased in flight.
Friday, January 21, 2005, 0320hrs	The helicopter arrived at Nambour Hospital and, as the patient was deceased, she was not registered on the emergency department attendance register. The Queensland Police Service was notified in accordance with the Coroner's Act.

Additional factors

A post-mortem was carried out at the John Tonge Centre, Brisbane. A copy of the report is attached. Findings detailed in the report include: **thoracic cavity** → severe atheroma of the coronary arteries: left anterior descending artery shows 80% stenosis of the proximal and middle thirds: the right coronary artery shows 30% stenosis of the middle third and 50% stenosis of the distal third: no coronary artery thrombi identified: **abdominal and peritoneal cavity** → approximately 220cm from the gastro-oesophageal junction there is a segment of ischaemic appearing small bowel, but no evidence of frank infarction: the mucosal surface shows heavy congestion, the lumen contains brown/green fluid – no cause for these changes is identified. There is no evidence of adhesions, other obstructing lesions, volvulus or intussusception: **brain** → Alzheimer's Disease is confirmed. Cause of death: Coronary atherosclerosis. Other significant conditions: Ischaemic small bowel, Alzheimer's Disease.

Key issues – Maryborough Hospital and Hervey Bay Hospital

1. An elderly woman with early dementia and with gut obstruction was seen on two occasions at Maryborough Hospital and sent home in the care of her elderly husband. There appeared to be a reluctance to admit the patient, despite obvious distress. The reason for this reluctance appears to have been a concern regarding the resources available at Maryborough Hospital.
2. The patient was diagnosed with constipation and treated accordingly. Later evidence suggested the patient had a gut obstruction.
3. In re-presentation, further investigations, including a CT scan, were arranged by the SMO of the emergency department.
4. The scan was arranged at a private facility as the SMO was unable to obtain an appointment for an earlier scan at Hervey Bay Hospital. There is no CT scanner at Maryborough Hospital. The SMO considered that the private scanner at Maryborough may be more convenient for the patient. There must be mechanisms whereby an urgent scan could be obtained at Hervey Bay if required.
5. When the patient was admitted to Maryborough Hospital, she was not seen by anyone for several hours. This would appear to be a significant flaw in the normal medical process. It is unclear if the emergency department SMO saw the patient in the emergency department. If he did so, then no records were made of the examination. It would appear that the patient was not admitted by the surgical team as had been planned and, apart from IV fluids, no analgesia was offered and no other treatment ordered and given.
6. Despite maintenance of her blood pressure, the patient became increasingly shocked until an RMO from the emergency department was called to see her. He initiated treatment including antibiotics, believing she was suffering from septicaemia. He also arranged her transfer to Hervey Bay Hospital. However, he does not appear to have initiated any further resuscitation.
7. The initial call for ambulance transport was made at 1836hrs. Because of competing demands for urgent cases, an ambulance was not immediately available. An ambulance was dispatched at 1930hrs and completed the transfer by 2034hrs.
8. There was a failure of clinical documentation at Hervey Bay Hospital. After initial observations by the primary nurse, presumably on arrival, no further observations are recorded in the clinical record until 2330hrs. No additional treatment was offered. There was no further resuscitation of this patient, despite no urine output.
9. A decision was made to undertake a laparotomy. This decision was potentially flawed. A better clinical decision may have been to resuscitate the patient, insert a naso-gastric tube with suction and ensure appropriate IV fluids until her condition stabilised. She had evident metabolic acidosis compensated by hyperventilation and would appear to have been at high risk for urgent surgery. She was apparently offered no analgesia.
10. The fact that she vomited up to one litre of fluid raises questions about the effectiveness of the nasogastric tube.

Key issues – clinical co-ordination and patient transfers

1. Clinical co-ordination.

The surgical PHO did not appear to be aware of the mechanisms for obtaining medical retrieval by calling the Clinical Co-ordination centre. As a result the patient had been accepted at Nambour before a call was made to the QCC. Despite this, the clinical co-ordinator tried to propose alternative strategies but without success.

The initial observations indicate a conscious haemo-dynamically stable patient who had a mild oxygen requirement. However, the other evidence including biochemical profile suggests a much more perilous situation. She was evidently in renal shutdown associated with severe dehydration.

Based on the initial observations and clinical need for urgent transfer, the clinical co-ordinator decided to utilise the closest available helicopter at Maroochydore. As no doctor was available at Nambour to retrieve the patient, an intensive care paramedic was dispatched. A physician was available and on-call in Brisbane should a medical retrieval have been deemed necessary. The patient's condition had deteriorated by the time of arrival of the intensive care paramedic.

2. Aircraft utilisation

The Energex Rescue Helicopter (Rescue 513) was dispatched at approximately 2300hrs. It is anticipated that the aircraft would have been airborne approximately 45 minutes after the activation. The aircrew at Maroochydore requires call-in after hours. The helicopter left Maroochydore at approximately 0107hrs, some 2-hours after the initial activation. There appears to have been a communication breakdown between QAS Maroochydore (local tasking agency) and Energex Rescue, which will require further investigation to ensure that systems are improved to avoid a repeat of this problem.

The aircraft utilised was a Bell Long ranger (206L). This is a single engine visual flight rules aircraft and is the current Queensland Government baseline standard for aero-medical operations. The cabin is relatively cramped and would have contributed to the difficulties the intensive care paramedic experienced during the attempted resuscitation.

3. ICP standard operating procedures

The intensive care paramedic was dispatched in accordance with standard task specific crewing principles employed by the QCC medical co-ordination staff.

In general, the paramedics provide feedback from the pre-hospital scene or hospital prior to departure for the destination hospital. This allows consultation with an experienced specialist physician to establish the proposed treatment plan for the aero-medical transport. There is no formal agreement with any service to do this. The entire retrieval system is still evolving and a number of services have different operational requirements.

The paramedic on this occasion did not consult with the clinical co-ordinator after assessing the patient at Hervey Bay Hospital. The paramedic correctly assessed that this patient was extremely unwell – peripherally cool, tachycardic, anuric with an increasing oxygen requirement.

Given this clinical picture, the clinical co-ordinator may have re-assessed the transfer but this is a difficult scenario to re-examine in hindsight. The paramedic completed all necessary pre-departure checks including the functionality of the naso-gastric tube.

The paramedic acted at all times within current QAS treatment protocols. He confronted an extremely daunting clinical scenario and, despite his best efforts, the patient died.

Discussion

A series of errors occurred in the management of this patient, which together led to an unacceptable outcome. However, no single error was of such significance that it should be the subject of disciplinary action against any individual. The errors reflect systemic issues and remedial action should be directed towards improvement of these issues.

The errors may be described as follows:

1. The patient presented with evidence of gut obstruction but was diagnosed as 'constipation'.
2. The patient was not admitted to hospital when diagnosed with gut obstruction.
3. When admitted to hospital, the patient was not formally 'admitted' by medical staff and not reviewed by the surgical staff.
4. Upon her collapse, the RMO intervened but failed to recognise the seriousness of her condition and the need for resuscitation.
5. There was a short delay in transfer of the patient to Hervey Bay Hospital due to competing demands for ambulance services.
6. Upon transfer to Hervey Bay Hospital, the patient does not appear to have been closely observed.
7. There are few clinical notes that outline the interventions taken at Hervey Bay.
8. A decision was made to undertake a laparotomy. Expert advice may suggest that the appropriate intervention in circumstances such as this would be to rehydrate the patient with IV fluids and to decompress the stomach contents with a nasogastric tube and suction. However, I would note that by this time the patient was acidotic and anuric and therefore may still have required intensive care.
9. The anaesthetic PHO declined to provide an anaesthetic because of the absence of an ICU bed. However, he did not see the patient and therefore did not have an opportunity to assess the resuscitation status of the patient.
10. The surgeon on-call agreed to undertake a laparotomy without physically examining the patient.
11. The transfer to another hospital was undertaken without first contact with the QEMS Co-ordination centre.
12. There was a delay is dispatching the aircraft due to an error in contact.
13. A decision was taken to enable paramedic escort of the patient when the patient's condition was becoming critical.
14. A small helicopter was used which limited the ability of the paramedic to secure an airway when the patient vomited.

Many of these issues appear to reflect a lack of proper patient care processes that need to be remedied. The errors also appear to reflect more systemic issues of concern that need to be addressed to ensure that standards of patient care are maintained. These systemic issues include:

1. The medical staffing of both hospitals is heavily reliant on overseas trained doctors who may be unfamiliar with the Australian healthcare system. There is a high turnover of junior staff particularly and this places a higher level of responsibility on the specialist level staff to ensure patient safety and quality of health services. Systems of quality review and adequate supervision are necessary.

2. The role of Maryborough Hospital is unclear in regard to acute admissions. Concerns have been expressed by the local community that their local hospital is being downgraded. However, it is not possible with the current workforce shortages to provide the full range of services at both facilities. A better solution would be to consider each hospital as a campus of one integrated health service. Services provided by each facility should be clearly defined.

   Under such an arrangement, Hervey Bay Hospital would be the acute hospital and all acute admissions should be admitted to Hervey Bay Hospital. This could occur either by direct transfer by the QAS of acutely ill patients under protocols to be agreed with Queensland Health, or by the secondary transfer of patients requiring acute admission. This would enable the resources for acute care to be concentrated at Hervey Bay Hospital. The emergency service at Maryborough would then provide initial triage of acutely ill patients and definitive care for patients with less severe illnesses. Maryborough Hospital could also become the site of non-urgent surgery and day procedures as well as convalescence and rehabilitation.

3. There appears to be a lack of understanding of the protocols around the centralised clinical co-ordination and the capacity and responsibility of the Clinical Co-ordinator. Recent extension of the system of clinical co-ordination will enable a clearer instruction to be offered with a single phone number. The QEMS Co-ordination Centre Directors should ensure this clear message is offered to health services across the state.

Recommendations – Fraser Coast Health Service District

1. Review and clarify the roles of Maryborough and Hervey Bay Hospitals to ensure the provision of appropriate services at each facility. Ensure that these roles are clear and communicated to the community and supporting services including the QAS.

3. Review procedures for patient access to specialist services (for example, CT scanning) provided at Hervey Bay Hospital to ensure appropriate, equitable access.

4. Review all clinical policies and procedures to ensure they are based on best evidence and implement a process to make certain that staff know about and comply with all policies and procedures.

5. Implement and/or ensure the ongoing process of credentialling and granting of clinical privileges to medical staff which clearly outlines the scope of practice.

6. Review staff recruitment, selection and retention strategies in an effort to attract and retain clinical staff and improve continuity of service.

7. Review the mechanisms in place which provide support to junior clinical staff to ensure they are appropriate and functioning.

8. Ensure the development and implementation of a policy (which is based on best evidence) and education programme for clinical documentation.

9. Encourage all clinical units/divisions to be involved in an ongoing process of multi-disciplinary clinical audit, which is used to evaluate and improve patient care. This process should embrace performance indicators relevant to the clinical service, for example the ACHS clinical indicators. In particular there should be a facilitated multidisciplinary review of this case to ensure all staff learn from this experience.

10. Develop and implement policies and procedures, which are based on best practice for the following:
    - Multi-disciplinary management of patients
    - Transfer of patients to a higher level facility
    - Multi-specialty and multi-disciplinary involvement in patient care
    - Multi-disciplinary ward rounds, case conferences and meetings to ensure continuity of appropriate care for all patients

11. Review the application of the Queensland Health Service Capability Framework to ensure appropriate levels are applied to each service.

12. Review processes to enable equitable access to ongoing professional development and training programmes.

13 The Director of Nursing Services to review the process of taking and documenting observations to ensure regular observations are taken and recorded.

Recommendations – Clinical Co-ordination and Patient Retrieval Services

1. Review the role of the QCC in ICU bed availability and utilisation. Consider the development of a centralised bed monitoring service within the QCC.
2. Review clinical co-coordinator's role/authority. Ensure the inclusion in CC procedures that where concern is raised regarding the management of a case, the CC reserves the right to speak directly to the consultant responsible for the patient or to the Medical Superintendent if necessary.
3. Review clinical co-ordination procedures to ensure clarity and publicise those procedures to all health services.
4. Review current IC Paramedic education requirements for aero-medical transportation and ensure paramedics have the authority to contact clinical coordinators with any concerns.
6. Review and implement standardised operating procedures across all aero-medical services. This will require liaison and consultation with stakeholders (DES, Queensland Rescue, Community Helicopter Providers and the QAS).
7. Refer to Zonal QEMS to investigate the cause of the delay in dispatch of the helicopter and the decision to use the smaller helicopter.

General recommendations:

1. The Director of Medical Services (DMS) should conduct a detailed debrief of this case with the family. I would recommend that this debrief should frankly admit the many failures that occurred in the management of this patient and indicate a preparedness to address the system issues that underlie the sad events.
2. A detailed and facilitated debrief of this case occur for all the participants so that collective learnings may be determined and applied. This could be conducted under the auspices of the District EMS committee.
3. That a copy of this report be forwarded to the Health Rights Commissioner for consideration and comment.

Bundaberg Hospital Commission of Inquiry

Statement of Gerard FitzGerald

Attachment GF31