Bundaberg Hospital Commission of Inquiry

Statement of Michael Ian Cleary

Attachment MIC-11

01-01-04

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Queensland Government
Queensland Health

A BRIEFING TO THE A/GENERAL MANAGER HEALTH SERVICES

BRIEFING NOTE NO: N/A

REQUESTED BY: Mr D Bergin – Zonal Manager, Central Zone, contact (07) 3234 0825

DATE: 15 January 2004

PREPARED BY: Dr S Phillips – A/Executive Director Medical Services The Prince Charles Hospital Health Service District (TPCHHSD) contact (07) 3350 8226

CONSULTATION WITH: Dr Andrew Galbraith, Director of Cardiology, Cardiology Program TPCHHSD, contact 3212 5566

Ms C Burns, Cardiology Sponsor, District Director Nursing Services TPCHHSD contact (07) 3350 8217

Mr Jon Roberts, Executive Director Finance & Information TPCHHSD, contact (07) 3350 8900

CLEARED BY: Dr M Cleary, A/District Manager TPCHHSD, contact (07) 3350 8224

DEADLINE: N/A

SUBMITTED THROUGH: Mr D Bergin, Zonal Manager, Central Zone

SUBJECT: **Cardiac Services – Update**

A/GMHS'S COMMENTS:

Dr John Scott
A/General Manager Health Services
/ /

PURPOSE:

To provide background information relating to correspondence and comments made in the media by Associate Professor Constantine Aroney Chairman, Queensland Branch, Cardiac Society of Australia and New Zealand and Chairman and which were published in the Courier Mail on Tuesday 6 January 2004.

BACKGROUND:

Associate Professor Aroney as Chair of the Queensland Branch of the Cardiac Society of Australia and New Zealand wrote to the Premier on 16 December 2003 outlining areas of concern relating to statewide cardiology services.

The issues that he raised were as follows:

1. ***Inadequate response to increased demand arising from new guidelines in managing heart attack and unstable angina (acute coronary syndrome):***

   - Prior to the introduction of the "Australian Management of Unstable Angina Guidelines – 2000" by the National Heart Foundation (NHF) and The Cardiac Society of Australia and New Zealand (CSANZ) for managing Acute Coronary Syndrome, this condition was managed by the administration of thrombolytic therapy (drug therapy). If patients remained unstable or failed to respond to drug treatment they were transferred to a major centre for coronary angiography. Following angiography, patients were treated with medical therapy, or placed on a waiting list for angioplasty, coronary stenting or coronary artery bypass surgery. This model of care involved multiple admissions and staged procedures.

   - At the time the Guidelines were released, the Cardiology Department at TPCH advised that they did not believe that the new guidelines would result in increased activity as patients would simply be receiving treatment at an earlier stage. They further indicated that they did not believe that there would be an increase in overall activity.

   - In September 2003, TPCHHSD analysed interventional cardiology activity and identified an increased demand on the service that had resulted from increased referrals from peripheral centres. A Submission outlining this analysis was forwarded to the Central Zone Management Unit for consideration in November 2003.

   - The Prince Charles Hospital (TPCH) now uses a risk stratification methodology to manage all patients with unstable angina and myocardial infarction. All patients are given a Risk Assessment Score (TIMI Score). Based on this Score, patients are then transferred to a tertiary cardiac centre on a priority basis for diagnostic coronary angiography and early revasculisation. This stratification has enabled TPCH Cardiology Department to prioritise admissions on the basis of urgency.

   - Since the release of the Guidelines in 2000 the number of inter hospital transfers has increased. It is estimated that in 2003/2004 this could result in an additional 188 patients requiring care.

   - The patient from Hervey Bay, identified in the correspondence, was awaiting transfer to TPCH and had been risk stratified according to protocols. During that time there was a significant increased demand in inter hospital transfers due to patients with higher risk stratification score requiring immediate care. The patient suffered an in hospital cardiac arrest when the transfer was being organised.

2. ***Despite these increasing demands, there has been a concerted effort to reduce cardiology services, in the knowledge that this will result in adverse outcomes for Queenslanders...***

- To meet the increased demand for the inter hospital transfers, TPCH Executive and the Cardiology Program Management Team agreed in November 2003 to reduce the elective diagnostic and interventional procedures to accommodate the increase in the emergency demand. The waiting list was subsequently audited, elective patients who were scheduled received their treatment, with a commitment that no patients were to be put at risk. This strategy commenced on 1 January 2004 and is to be closely monitored.

As of 31 December 2003, Cardiology diagnostic and interventional waiting list status is:

Procedure	**Category 1 (within 30 days)**	**Category 2 (within 90 days)**	**Category 3 (within 120 days)**	**Total Number Waiting (all categories)**
Coronary Angiography** *	229 Average wait - 34.6 days*	78 Average wait - 93.5 days	7 Average wait – 124.1	314
PTCA/Stent**	21 Average wait – 31.2 days	2 Average wait – 72.5	1 Average wait – 28	24
RF Ablation	6 Average wait – 101.2 days	18 Average wait – 204.1	120 Average wait 434.2	144
Implantable Defibrillator	49 Average wait – 48.6 days	2 Average wait – 9.5 days	1 Average wait – 54 days	52

*Best Practice stated by the Cardiac Society of Australia and New Zealand is that access to Diagnostic Angiography is a maximum of 20 working days

** Since the introduction of the National Guidelines, the elective waiting list data is skewed as many of the patients now having their treatment urgently were previously placed on the waiting list and treated electively.

- The patient from Ballina, who had been scheduled for a procedure, and who was referred to in the correspondence, was followed up by TPCH when he failed to attend at his procedure pre admission appointment. TPCH booking office contacted the patient's home and were advised the patient had died two weeks earlier.

- When there has been a significant increase in demand for access for this service, the Cardiology Program Team (Medical Director, Nursing Director and Business Manager) District Manager, Executive Director Medical Services and Executive Director Nursing Services closely monitored the demand on a daily basis to ensure that the risk stratification process is followed.

Interventional Cardiology Atrial Septal Defect (ASD) procedure on children and adults:

Waiting List Update as at 31 December 2003 for ASD for Paediatric and Adults is as follows:

Procedure	Number Waiting
Percutaneous ASD Closure – Paediatrics	16
Percutaneous ASD Closure – Adults*	20

TPCH has an annual allocation that allows for 15 patients (adults and children) to be treated with ASD devices. Activity in the early 2003/2004 was higher than anticipated. A strategy to control this level of activity while managing any clinical risk was put in place in November 2003. It is noteworthy that the majority of ASD's do not require urgent closure.

A Brief was forwarded to the Central Zone Management Unit in November 2003 outlining this clinical situation and the proposed management.

3. ***Implantable Cardioverter Defibrillators (ICDs):***

- Queensland Health recognised the increased demands for ICDs and have provided additional $400,000 funding this year. This will allow TPCH to undertake an additional 16 procedures this financial year (2003/2004).
- TPCH patient selection criteria are based on the American Heart Association 2002 Guidelines. Sixty-three percent (63%) of the patients waiting have Class 1 indications and 37% have Class 2 indications.
- A Submission was forwarded to the Central Zone Management Unit in November 2003 outlining this clinical situation and the proposed management.

4. ***Dangerously long waiting lists for cardiology outpatients***

- The planned closure of the Outpatient Department during the Christmas period is undertaken annually. Patients requiring urgent outpatient appointments are managed through alternative arrangements.
- Cardiologists were advised that during the Christmas New Year period if clinics were required, special arrangements would be made.
- TPCH has identified increased an increase in waiting times for public outpatient appointments within the cardiology service. The District plans to review outpatient services in 2004 as part of a process redesign activity.
- The recent recruitment of an additional cardiologist will assist with the management of the Outpatient activity.

5. ***Crisis in North Queensland***

- An arrangement is in place for any urgent patients requiring coronary artery stenting to be transferred to TPCH according to clinical priority. Townsville provides funding (at marginal cost) for those procedures.
- Specialist staff from TPCH have been travelling to Townsville to support their service on a regular basis (monthly).

6. *Paediatric Cardiac Services*

- Issues relating to paediatric intensive care are being addressed through the establishment of a joint service between TPCH and Royal Children's Hospital (RCH). Recruitment of a joint Director has resulted in an offer being made to an eminent interstate paediatric intensivist.

- Paediatric anaesthetic cover has been addressed and a roster is in place that ensures that the service is appropriately supported.

7. *Heart Failure*

- TPCH has established a Heart Failure and Heart Transplant Service that has provided heart failure management for patients with chronic and/or complex heart disease.

KEY ISSUES:

Activity levels at The Prince Charles Hospital (TPCH):

1. **Coronary Care Beds**

The Coronary Care Unit (CCU) at The Prince Charles Hospital has sixteen physical beds. The occupied bed days (OBDs) used in 2002/2003 were 4,744 (Figure 1). This equates to requirement for an average of thirteen beds.

Staffing in the Unit was reviewed in 2003. This review identified that the requirement of the clinical service could be met if the District staffed the Unit at a maximum of fifteen beds. This provided flexibility to meet the demands of the service.

There have been significant improvements made to the model of care provided in the Unit. This included the establishment of a "Chest Pain Assessment Service" which has reduced the length of stay for selected patients presenting with chest pain from three days to one day. This model is recognised nationally.

Figure 1:

Year	Occupied Bed Day
2001	4,904
2002	5,015
2003	4,744
2004 (Planned)	4,802

2. **Cardiac Catheterisation Service:**

The Prince Charles Hospital operates two angiography theatres. There has been no change in the hours of operation of the theatres.

There has been a slight decrease in the number of angiopgraphy cases. This has been the result of improvements in clinical care. Patients now have angiography together with angioplasties or stent procedures in a single admission where as previously these were undertaken as a two stage procedure ie required two

admissions. In 2001, 43% of patients had a two stage procedure compared with 23% in 2004 (Figure 2). This equates to a reduction of approximately 160 angiograms.

Figure 2

Year	% of cases having two stage procedures
2001	43.2
2002	39.2
2003	33.2
2004 (Planned)	28.8

It should be noted that because not all cardiologists are able to undertake stent procedures, there will always be a number of cases that require two admissions.

Overall activity within the Unit as it relates to adult cardiology is outlined below (Figure 3).

Figure 3

Year	Angiogram	Angioplasty/Stent	ASD Devices	Other Specialist Procedures
2001	2,883	526	11	33
2002	2,774	631	14	82
2003	2,703	616	12	68
2004 (Planned)	2,660	598*	11	72

*Given the current demands, this is expected to increase to 700.

Overall, if you adjust for the changes in clinical practice that have occurred, the changes in the levels of activity can be seen below for the period 2001 to 2004.

Figure 4

Procedure	2001	2004 (Planned)
Angiogram	2,883	2,820
Angioplasty/Stent	526	598*
ASD Devices	11	11
Other specialised Procedures	33	72

*Given the current demands this is expected to increase to 700

3. Inpatient Beds

There has been a decrease in the total number of adult cardiology separations from 7,191 in 2001 to 6,700 in 2004 (planned), (Figure 5).

Figure 5

Year	Adult Cardiology Separations	Adult Cardiology OBD's
2001	7,191	25,214
2002	7,115	23,857
2003	6,644	21,757
2004 (Planned)	6,700	21,770

The changes in OBD's have been the direct result of changes in clinical practices, for example, there has been a 13.7% reduction in Average Length of Stay (ALOS) in Cardiology. This has brought ALOS in line with the National benchmarks in Cardiology. This has saved approximately 3,440 OBD's

Figure 6

Year	Cardiology ALOS	National ALOS
2001	3.51	3.10
2002	3.35	3.26
2003	3.27	N/A
2004	3.25	N/A

The change in separations has been the direct result of changes in models of care and referral patterns. This includes the increasing number of patients treated as outpatients.

The changes in 2001 to 2002 also included the transfer of some cardiology activity to Princess Alexandra Hospital.

Areas where clinical practice changes have occurred are outlined below.

Figure 7

Year	Arrythmia Management	Angina Management	Chest Pain Management
2001	656	491	912
2002	522	436	928
2003	484	285	839
2004	N/A	N/A	N/A

Investigation Report

The Report draws the following conclusions.

It would appear from the clinical information available these three patients had advanced and/or well established disease, with major co-morbidities which contributed adversely. They were all living remote from any centre which could have possibly prolonged their life.

We conclude that in the case of Patient 1 there was no recognition of the need for early transfer of the patient. We note that an essential communication between Hervey Bay Hospital and The Prince Charles Hospital was not acted on for 4 days. No reason for the delay could be elucidated. There was subsequent deterioration in the patient's condition and death occurred 3 days after the communication was made. The link between lack of resources as alleged and this patient's death could not be made.

In the Case of patient 2, a resident of NSW, we believe that the failure to communicate the long wait for access to treatment with the responsible clinician prevented he clinician from making alternative arrangements for the patient. The link between reduction of services and this patient's death was not clear. The issue here appears to have been communication between booking staff and the responsible clinician. There is increased pressure on the service from emergency patients as noted in a previous submission to A/General Manager Health Services. It would appear that at times this impacts on the category 1 waiting times for angiography.

Patient 3 was unable to access the implantation of an ICD in a timely fashion which may have prevented his death from a ventricular arrhythmia.

The District is currently developing a plan to address the procedural anomalies identified in the report.

The Report makes the following recommendations:

Interhospital Referral Process
It is recommended that a review of the interhospital referral process be undertaken to ensure appropriate recording of transfer requests promoting the central coordination and prioritisation of these. Staff at TPCH and referral hospitals should be made aware of this process.

Procedure Booking
Staff undertaking the booking of procedures outside the clinician requested time should advise the clinician accordingly allowing the clinician to make alternative arrangements where the clinician believes the waiting time to be inappropriate.

ICD Waiting List
A review of the ICD waiting list criteria be undertaken in collaboration with other public providers to ensure consistency between sites providing this service. Movement of patients between lists should be expedited where clinical situations indicate the need for early intervention.

BENEFITS AND COSTS

Additional funding has been added to The Prince Charles Hospital Cardiology Service in the 2003/2004 financial year. This includes:

1. $1.0million to support the transfer of cardiac services to Princess Alexandra Hospital (PAH)

300 cardiac surgical procedures will be transferred to PAH in July 2003. Planning for this transfer is in progress at present. The transfer will include cardiac surgical as well as cardiac medical procedures such as angiograms.

$1.0million was allocated by Queensland Health to support this transfer. This funding is recurrent.

For the 2003/2004 financial year the funding was held in TPCHHSD budget until its allocation could be finalised. Following a recent meeting with the Zonal Managers from Southern and Central Zone and the District Managers from PAHHSD and TPCHHSD it was agreed that the funds would be allocated as follows:

- $750,000 to support the purchase of cardiac surgical and related equipment at PAH. These funds are in the process of being transferred to PAHHSD.
- $250,000 to support the clinical services at TPCH during the transition period. This will principally be used to support cardiac surgery.

From 2004/2005 the funding will be allocated to PAH on a recurrent basis (it will not be in the TPCHHSD budget). It will be used to support the provision of cardiac services at PAH.

2. $800,000 to support cardiac services in general

An additional $800,000 was allocated in the 2003/2004 financial year to TPCH to support the ongoing provision of cardiac services. These funds are being applied to allow the District to maintain cardiac services at the levels that existed in 2002/2003. The funds have been allocated to the Cardiology Program.

3. $400,000 for ICD Services

In December 2003 Queensland Health allocated an additional $400,000 to support the Implantable Cardioverter Defibrillator (ICD) service. This funding is recurrent.

Note: In the prior financial year (2002/2003) the District received an additional $1.0million for ICD services. This funding was recurrent and has allowed additional ICD procedures to be performed.

4. $300,000 to support intensive care services

An additional $300,000 was allocated in the 2003/2004 financial year to TPCH to support the ongoing provision of cardiac intensive care and general intensive care services. These funds are being applied to allow the District to maintain these specialised services including paediatric intensive care. The funds have been allocated to the Critical Care Program.

5. $145,000 to support linking clinical services between Royal Brisbane & Women's Hospital and The Prince Charles Hospital

The funds have been allocated to the Cardiology Program.

6. $579,000 to support the use of single use items in the Cardiac Electrophysiology Service

A claim for $579,000 was submitted this year (2003/2004 for these funds. This is yet to be finalised. These funds have been allocated to the Cardiac Services Program to support the use of single items in the Electrophysiology Service.

Note: In the prior financial year (2002/2003) $242,000 (recurrent funding) was allocated to support the use of single use items within this service. The additional funding identified above represents the full year effect of changing to a single use policy within the Electrophysiology Service.

ACTIONS TAKEN/REQUIRED

That the Acting General Manager Health Services note the contents of this Brief.

ATTACHMENTS:

1. Investigation Report regarding Allegations regarding allegations relating to cardiac services.

DRAFT MEDIA RELEASE:

[X] ATTACHED – Talking Points

[ ] NOT ATTACHED

Background points

An independent investigation was undertaken following the death of three cardiac patients waiting for treatment at The Prince Charles Hospital.

The cases were reviewed and it was concluded that all three patients had severe medical conditions.

The investigation revealed that in two of the three patients, deviation from standard clinical procedures contributed to the patients not receiving timely treatment.

The investigation identified specific areas where clinical processes could be enhanced to improve the outcome for patients.

The Prince Charles Hospital is currently reviewing these areas as a priority.

In the first two patients, there was no evidence to suggest that resource constraints impacted upon the patients not receiving timely treatment.

In the third patient, resource constraints may have contributed to the patient not receiving the required procedure.

I note however that in December 2003, Queensland Health contributed an additional $400,000 to The Prince Charles Hospital to allow additional patients requiring this procedure to be treated.

The Prince Charles Hospital is constantly improving the way in which it manages its cardiac patients.

The length of time that cardiac patients need to stay in hospital has been reduced 13% over the last two years which is now in line with the national average.

The number of people who have a coronary angiograms has remained unchanged from 2,883 in 2001 to 2,820 in 2004.

The number of people having specialised procedures has increased over this period. This has included an increase in angioplasty and stenting procedures from 526 to 598. Other specialised procedures have increased from 33 to 72 per year.

The hospital has introduced a range of specialised cardiac services to improve the care provided to cardiac patients.

These include a specialised liaison service for elderly people, and a Chest Pain Assessment Service. The Chest Pain Assessment service enables people admitted to TPCH to receive more rapid diagnosis and treatment for their condition and to spend a shorter period in hospital.

Queensland Government
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INVESTIGATION REPORT REGARDING
ALLEGATIONS RELATING TO CARDIOLOGY SERVICES

Investigation Officer: Dr P Thomas, Principal Clinical Coordinator, Southern Zone, PAH
Dr S Ayre, Deputy Executive Director, Medical Services, RBWH

Contact Number: 07 3636 8313

Period of Investigation: 8/1/04 – 12/11/04

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1.0 BACKGROUND TO INVESTIGATION

1.1 Events Leading to Investigation

Associate Professor C Aroney, Chairman, Queensland Branch, Cardiac Society of Australia and New Zealand wrote to the Premier outlining concerns with regard to Cardiac Services in Queensland. In particular he raised the cases of three patients whose care had been compromised because of access difficulties to cardiology intervention services at The Prince Charles Hospital (TPCH) which is a facility managed through The Prince Charles Hospital Health Service District (TPCHHSD).

1.2 Key Dates

Patient 1 referred 10/11/03, died 13/11/03.
Patient 2 referred 30/09/03, died 28/10/03.
Patient 3 referred 23/09/03, died 29/11/03.

1.3 Key People

Dr Michael Cleary, A/District Manager, TPCHHSD
Assoc Professor Constantine Aroney, Visiting Cardiologist, TPCH and Chairman, Queensland Branch, Cardiac Society of Australia and New Zealand
Dr Andrew Galbraith, Clinical Director, Cardiology Program, TPCH
Dr Matthew Marrinan, Registrar, Cardiology, TPCH
Ms Cheryl Burns, Executive Sponsor Cardiology Program (and Executive Director Medical Services TPCHHSD)
Ms Margaret Dahl, Clinical Nurse Manager, Catheter Laboratory, TPCH

1.4 Investigation Terms of Reference

INVESTIGATION INTO ALLEGATIONS RELATING TO CARDIOLOGY SERVICES

Associate Professor Constantine Aroney is State Chairman of the Cardiac Society of Australia and New Zealand.

A complaint has been received from Associate Professor Aroney, in his capacity as State Chairman of the Cardiac Society of Australia and New Zealand, alleging that:

1. Queensland Health "...has provided an inadequate response to increased demand arising from new guidelines in managing heart attack and unstable angina". Specifically;

   - "for example, most recently, a patient died in Hervey Bay Hospital, in November 2003 whilst awaiting transfer to Prince Charles Hospital for coronary angiography."

2. "...there has been a concerted effort to reduce cardiology services, in the knowledge that this will result in adverse outcomes for Queenslanders". Specifically;

   - "A Category 1 patient from Lismore, unable to access the Princess Alexandra Hospital, died after waiting 27 days on the Prince Charles Hospital list."

3. "Major restrictions are placed on the implantation of life-saving cardiac defibrillators." Specifically:

   - "...only last week a patient on the waiting list died suddenly at home." (date not provided)

Where any further issues arise during the course of the investigation, I am to be advised of the specifics of those issues. Where I am of the view that the additional issues are relevant to this investigation, I may choose to amend these terms of reference to include the investigation of such issues.

I have appointed Dr Stephen Ayre, Deputy Executive Director of Medical Services, of the Royal Brisbane and Women's Hospital and Health Service District and Dr Peter Thomas, Principal Clinical Co-ordinator, of the Princess Alexandra Hospital Health Service District, under section 52 (1) of the *Health Services Act 1991* (the Act), to ascertain whether there is evidence to support or deny the allegations made by Associate Professor Aroney.

The investigation is to proceed in accordance with the principles of natural justice.

The Investigation Officers have the authority under section 56 and section 63 (2) (f) of the Act to access any evidence under the control of the Health Service District, which either proves or disproves the allegations that have been made. The Investigation Officers should also make a reasonable attempt to obtain any other relevant evidence that either proves or disproves the allegations that have been made.

The Investigation Officers have the authority under the Act to interview any person who may be able to provide further evidence, which either proves or disproves the allegations that have been made. Investigation Officers may seek to interview persons who are not employees of Queensland Health who may be able to assist with the investigation. Where this will incur a cost to the District, approval must first be sought from myself.

The Investigation Officers need only interview persons who can provide information that is credible, relevant and significant to the matter under investigation.

The Investigation Officers must provide relevant officers of the Department with the opportunity to attend an interview and the opportunity to respond verbally to the matters under investigation.

Material, which is adverse to any person, and credible, relevant and significant to the findings to be made by the Investigation Officers, is to be released to that person during the course of the investigation. This can be released verbally at interview.

The Investigation Officers shall provide to myself a report. This report should specifically address the allegations outlined above, and assess the evidence as to whether the evidence either supports or does not support the allegations on the balance of probabilities. The investigation should also examine whether further inquiries are required.

The Investigation Officers are to provide in the body of their report, an assessment in relation to the above paragraph and reasons for these conclusions. Any inferences, which are derived from hearsay, should also be clearly identified. All evidence, including signed records of interview / statements should be appended to the report. Excerpts from records of interview / statements that are credible, relevant and significant to the findings made by the Investigation Officers are to be quoted in the body of the report under the heading "Assessment of Evidence".

The report is to be finalised by 12 January 2004, unless otherwise agreed with myself.

The Investigation Officers are delegated the authority to give any appropriate lawful directions which may be required during the course of the investigation. For example to provide a lawful direction to an employee to maintain confidentiality, to attend an interview, or to provide copies of Health Service District documents etc.

If necessary, the Investigation Officers should report back to me for further instructions during the course of the investigation.

Dr Michael Cleary
Acting District Manager
The Prince Charles Hospital Health Service District

__ / __ / 2004

2.0 PROCESS OF INVESTIGATION AND EVIDENCE

2.1 Key Dates

The investigators commenced on site at TPCH on Thursday 8th January, 2004. After discussion with the District Manager and Executive Director of Medical Services, the patient's records were reviewed. Patient records were obtained from the Hervey Bay Hospital and searches for records and information conducted at the Princess Alexandra Hospital. On the 9th of January 2004 interviews were conducted with Drs Galbraith, Aroney, Marrinan and with Ms Burns and Ms Dahl. Telephone advice was obtained from the following clinicians with regard to patient treatment issues: Dr R Denman, Cardiologist TPCH, Ms Rita Forni, Manager, Patient Services Unit: PAH, Dr Tom Marwick, Cardiologist and Professor of Medicine PAH: Dr S Wahi, Cardiologist PAH: On duty officer, Aviation desk, Ambulance and Fire Communications Centre, Spring Hill, Qld. Dr. Darren Walters was unavailable for discussion as he was on leave.

2.2 Summary of Allegations/Alleged Incidents

Prof Aroney alleged that:

1. Queensland Health "...has provided an inadequate response to increased demand arising from new guidelines in managing heart attack and unstable angina". Specifically;

   "for example, most recently, a patent died in Hervey Bay Hospital, in November 2003 whilst awaiting transfer to Prince Charles Hospital for coronary angiography." *(Patient 1)*

2. "...there has been a concerted effort to reduce cardiology services, in the knowledge that this will result in adverse outcomes for Queenslanders". Specifically;

   "A Category 1 patient from Lismore, unable to access the Princess Alexandra Hospital, died after waiting 27 days on the Prince Charles Hospital list." *(Patient 2)*

3. "Major restrictions are placed on the implantation of life-saving cardiac defibrillators." Specifically:

   "...only last week a patient on the waiting list died suddenly at home." (date not provided) *(Patient 3)*

2.3 People Interviewed

Dr M Cleary, A/ District Manager, TPCHHSD
Assoc Professor Constantine Aroney, Visiting Cardiologist, TPCH and Chairman, Queensland Branch, Cardiac Society of Australia and New Zealand
Dr Andrew Galbraith, Clinical Director, Cardiology Program, TPCH
Dr Matthew Marrinan, Registrar, Cardiology, TPCH
Ms Cheryl Burns, Executive Sponsor Cardiology Program (and Executive Director Medical Services TPCHHSD)
Ms Margaret Dahl, Clinical Nurse Manager, Catheter Laboratory, TPCH
Dr R Denman, Staff Cardiologist, TPCH
Dr P Garrahy, Director Cardiology, PAH

No written statements were received other than the original correspondence to the Premier from A/Prof Aroney. This is attached as appendix 1.

2.4 Techniques Used During Investigation

Notes were taken by the investigators of the interviews. Medical records were perused and used during the interviews to clarify issues. Records of patient referral and interhospital transfers were available and reviewed.

3.0 ASSESSMENT OF EVIDENCE

3.1 Allegations

3.1.1 Allegation 1

Queensland Health "...has provided an inadequate response to increased demand arising from new guidelines in managing heart attack and unstable angina". Specifically;

"for example, most recently, a patent died in Hervey Bay Hospital, in November 2003 whilst awaiting transfer to Prince Charles Hospital for coronary angiography." *(Patient 1)*

Patient 1, P426, a 72 year old Tasmanian resident on holidays in Queensland was admitted to Hervey Bay Hospital at 0921 hrs on 8 November 2003 following chest pain of three to four days duration.

Patient had diabetes mellitus, chronic renal impairment, ischaemic heart disease with past myocardial infarction, peripheral vascular disease, steroid dependency, hypercholesterolaemia, diabetic retinopathy, and an above knee amputation.

Tropinin levels done at admission indicated myocardial infarction.

Following admission to Coronary Care, Hervey Bay Hospital, Patient 1 was commenced on a clinical pathway for myocardial infarction but continued to experience chest and abdominal pain despite maximum medical therapy.

At 2230 hours on the 8th November 2003, he remained acutely ill with hypotension, no urine output and ongoing chest pain.

On the 9th November 2003, discussion occurred with the Registrar at The Prince Charles Hospital. He advised Hervey Bay staff to obtain previous angiograms and other history from Royal Hobart Hospital. These arrive later that day.

Seen by consultant physician in Hervey Bay, who noted that patient 1 continued with chest pain and shortness of breath. Consultant notes....

> "not a good candidate for angiography because of renal impairment, enzymes consistent with STEMI".

10th November 2003, patient continues with chest pain and remains acutely unwell. Medical treatment continues.

11th November 2003, patient acutely unwell.
"BLEAK prognosis". - Consultant Physician, Hervey Bay Hospital

Patient expresses a wish to be not resuscitated in event of cardiac arrest. This fact is recorded in the chart.

12th November 2003, chest pain continues despite therapy.

13th November 2003, 0500 hours, patient 1 found pulseless and not breathing in Hervey Bay Hospital and declared deceased

DISCUSSION

The original referral letter from the Hervey Bay Hospital to The Prince Charles Hospital is missing. This would have carried the TIMI Score done by the Prince Charles Registrar at the time of receipt of the referral. However a copy of this original referral letter is to be found in the Hervey Bay record and indicates that it was faxed to the booking office The Prince Charles Hospital on 10 November 2003. The Prince Charles Hospital form for Admissions and Potential Admissions gives the initial referral date as 14 November 2003 with a planned date of admission of 17th November 2003.

We note that the patient deceased at the Hervey Bay Hospital on 13th November 2003.

At interview, the Cardiology Registrar did not recall the patient or the discussion between himself and the resident medical officer at the Hervey Bay Hospital on 9th November 2003. This discussion is noted in the Hervey Bay file.

To enable completion of information for this investigation, a copy of the original referral was sent from Hervey Bay to the Prince Charles Hospital and received on 6 January 2004. The Cardiology Registrar has retrospectively repeated the TIMI Score (used to triage patient referrals) from information in this letter, post- dated the score and attached it to the copy.

Essentially, we find that the Hervey Bay Hospital referred the patient to The Prince Charles Hospital on 10 November 2003. There appears to have been no action from The Prince Charles Hospital until 14 November 2003 when it was found that the patient had died the day before. In this time, the patient's

condition deteriorated, a "bleak" outcome was prognosticated and the patient himself requested no resuscitation. It could be postulated that, over time, the Hervey Bay staff became aware of his parlous clinical state and chose not to pursue the transfer issue.

The Director of Cardiology and the Clinical Nurse Manager, Catheter Lab both separately commented that the patient's clinical condition as outlined on the referral letter would indicate the need for immediate transfer to a tertiary centre for ongoing care.

There is no record of a request for transfer of the patient in the files of the Ambulance and Fire Communications Centre in Brisbane.

3.1.2 Allegation 2

"...there has been a concerted effort to reduce cardiology services, in the knowledge that this will result in adverse outcomes for Queenslanders". Specifically;

"A Category 1 patient from Lismore, unable to access the Princess Alexandra Hospital, died after waiting 27 days on the Prince Charles Hospital list." *(Patient 2)*

Patient 2, [redacted] a 68-year-old resident of Evans Head NSW, was admitted to Lismore Hospital on 19th August 2003 with a diagnosis of acute coronary syndrome.

He was noted to weigh 175 kilograms, was a smoker with hypertension and hypercholesterolaemia. A stress ECG as an outpatient following discharge was positive for myocardial ischaemia.

Patient 2 continued to experience ongoing chest pain as an outpatient.

His Lismore cardiologist sent a letter dated 16 September 2003 and addressed to a specific Cardiologist at TPCH. This letter was faxed on 30th September 2003 and received at The Prince Charles Hospital on that date. The Cardiologist assessed the letter the same day and gave the patient a Category 1 listing. He was booked for Pre-Admission Clinic on 26th November 2003 and the procedure on 27th November 2003. He was booked as a Private Patient.

Patient 2 subsequently died on 28th October 2003. There is no information available as to the cause or circumstances surrounding the death.

DISCUSSION

This patient was under the care of a Lismore cardiologist who referred the patient directly to a Cardiologist at The Prince Charles Hospital.

Appropriate triaging by the Prince Charles Cardiologist was undertaken in a timely fashion, on immediate receipt of the referral. Despite being made a Category 1 (ideal treatment less than 30 days), patient 2 was booked for angiogram as an outpatient fifty six days later

There is no information to indicate that this booking was discussed with the triaging clinician. He was unavailable for this to be verified.

Despite extensive enquiries and search of records at the Princess Alexandra Hospital, there is no evidence to suggest that the patient was referred to the

Princess Alexandra Hospital for assessment at any time. He does not have a PAH chart from any previous attendances.

The fifty six day wait booking is inappropriate for this patient and there appeared to be no clinician involvement in re-assessing the situation. Discussion with the clinician would have allowed him to decide on the need for or actually seek earlier treatment for Patient 2. The mitigating circumstances in this situation were that the patient was booked as a private patient and the TPCH Cardiologist was on leave for 2 weeks during this time (according to Clinical Nurse Manager).

3.1.3 Allegation 3

"Major restrictions are placed on the implantation of life-saving cardiac defibrillators." Specifically:

"... only last week a patient on the waiting list died suddenly at home." (date not provided) *(Patient 3)*

Patient 3, P428 was a 53-year-old resident of Yeppoon admitted to The Prince Charles Hospital on 15th September 2003 with known cardiomyopathy, for a heart transplantation work-up.

He presented with deterioration in functional status over the previous six weeks. History includes myocardial infarction secondary to ischaemic heart disease, coronary artery bypass grafting x 2 in 1990 and 1995, Type 2 diabetes with diabetic neuropathy, chronic atrial fibrillation, hyperlipidemia, obstructive sleep apnoea requiring CPAP, asthma, gastroesophageal reflux disease, gout and arthritis.

He was treated for cardiac failure and symptomatic improvement in his condition occurred. He remained an in-patient for two weeks.

During admission, episodes of non-sustained ventricle tachycardia were noted on cardiac monitoring. Hard copies of these episodes are attached to the record. A cardiologist assessed patient 3 on 22nd September 2003 with regard to insertion of an ICD. He was placed on the ICD waiting list on 23rd September 2003.

Patient 3 was discharged on 30th September 2003 after discussion at the transplantation meeting.

A TPCH form letter was sent to patient 3 requesting him to indicate his availability for the procedure of ICD implantation. He acknowledged in writing on 2nd October 2003 noting he would require two weeks notice for the procedure.

Letter received 29th November 2003 from Rockhampton Base Hospital informing of the death of Patient 3 from ventricle fibrillation arrest.

DISCUSSION

Patient 3, during admission at The Prince Charles Hospital, showed evidence of the need for the implantation of an ICD through repeated episodes of recorded ventricular ectopic beats and episodes of non-sustained ventricular tachycardia.

This was acknowledged by a consultant cardiologist during the patient's admission. This cardiologist noted that the earliest the procedure could be performed was three to four months and commented in the patient record "on budgetary restrictions which prevented an earlier procedure".

There is no indication of an approach to management to expedite an earlier implantation of the device. Neither is there evidence to suggest that treatment was sought elsewhere to provide earlier access to the procedure for the patient. Anecdotal evidence supplied by the TPCH Director of Cardiology would indicate that the waiting list for ICDs is shorter at PAH. The Cardiologist involved confirmed this. Patient 3 did not fall into the most urgent category for placement of an ICD. It is recognised that there is a risk of sudden death where patients are managed in the community while awaiting ICD placement.

In discussion with the Executive Sponsor for Cardiology, it is understood that clinicians can approach the Executive Sponsor or Executive Director Medical Services to perform earlier implantation where there are clinical indications for this. However there are restrictions on the numbers of ICDs that can be implanted at TPCH. Patients with pre-existing ICDs are re-entering the system when they require renewal or replacement of their devices, so further adding stress to the waiting list. It is noted that avenues to circumvent waiting lists when the clinical need is necessary do exist in times of particular clinical need but these were not utilised for patient 3.

We note that Patient 3 appeared not to appreciate the urgent need for an ICD implantation as evidenced in his reply of two weeks to the booking availability request.

4.0 CONCLUSION

It would appear from the clinical information available these three patients had advanced and/or well established disease, with major co-morbidities, which contributed adversely. They were all living remote from any centre which could have possibly prolonged their life.

We conclude that in the case of Patient 1 there was no recognition of the need for early transfer of the patient. We note that an essential communication between Hervey Bay Hosp and TPCH was not acted on for 4 days. No reason for the delay could be elucidated. There was subsequent deterioration in the patient's condition and death occurred 3 days after the communication was made. The link between lack of resources as alleged and this patient's death could not be made.

In the Case of patient 2, a resident of NSW, we believe that the failure to communicate the long wait for access to treatment with the responsible clinician prevented the clinician from making alternative arrangements for the patient. The link between reduction of services and this patient's death was not clear. The issue here appears to have been communication between booking staff and the responsible clinician. There is increased pressure on the service from emergency patients as noted in a previous submission to A/General Manager Health Services. It would appear that at times this impacts on the category 1 waiting times for angiography.

Patient 3 was unable to access the implantation of an ICD in a timely fashion which may have prevented his death from a ventricular arrhythmia.

5.0 RECOMMENDATIONS

5.3 Interhospital Referral Process

It is recommended that a review of the interhospital referral process be undertaken to ensure appropriate recording of transfer requests promoting the central coordination and prioritisation of these. Staff at TPCH and referral hospitals should be made aware of this process.

5.2 Procedure Booking

Staff undertaking the booking of procedures outside the clinician requested time should advise the clinician accordingly allowing the clinician to make alternative arrangements where the clinician believes the waiting time to be inappropriate.

5.3 ICD Waiting List

A review of the ICD waiting list criteria be undertaken in collaboration with other public providers to ensure consistency between sites providing this service. Movement of patients between lists should be expedited where clinical situations indicate the need for early intervention.

Dr P Thomas **Date**

Dr S Ayre **Date**

APPENDICES

LIST OF APPENDICES

NUMBER	CONTENT
1	Correspondence from A/Prof Aroney to Premier Peter Beattie
2	Submission to A/General Manager, Health Services 24/11/03
3	Management of Unstable Angina Guidelines – 2000 National Heart Foundation of Australia & The Cardiac Society of Australia and New Zealand

Bundaberg Hospital Commission of Inquiry

Statement of Michael Ian Cleary

Attachment MIC-12

Queensland Government
Queensland Health

MEMORANDUM

To: District Manager, The Prince Charles Hospital
District Manager, Princess Alexandra Hospital

Copies to: Dr J Scott, Acting General Manager Health Services
Dr A Galbraith, Director of Cardiology, The Prince Charles Hospital
Dr P Garrahy, Director of Cardiology, Princess Alexandra Hospital

From: Dr Steve Buckland, Acting Director-General, Queensland Health
Contact No: 07 323 41171
Fax No: 07 323 41482

Subject: CARDIAC SERVICES AT THE PRINCE CHARLES HOSPITAL

File Ref: DG:dg1

The Acting General Manager, Health Services, Dr J Scott met with the President of the Cardiac Society, Dr Aroney on 8 January 2004 to discuss emergent issues in cardiac services raised by Dr Aroney. This was the first time such issues had been raised with Dr Scott.

This memorandum is specifically in relation to the situation at The Prince Charles Hospital. Other issues raised by Dr Aroney will be dealt with separately by the General Manager, Health Services. In particular I wish to address the following:

- Septal defects;
- 3 deaths allegedly as a result of resource constraints;
- Separate procedures for diagnosis and treatment (particularly as it relates to angioplasty and stents);
- Access to Automatic Implantable Cardiac Defibrillators; and
- Inappropriate waiting times for angiography.

As part of my consideration of these issues I have consulted with the District Manager, Princess Alexandra Hospital, Dr J Young, Executive Director of Medical Services, Princess Alexandra Hospital and Dr P Garrahy. The waiting list for Princess Alexandra Hospital angiography reveals **no** *Category 1 patients waiting* and only **2** *Category 2 patients waiting*. On the other hand The Prince Charles Hospital angiography waiting list reveals **229** *Category 1 patients* and **78** *Category 2 patients waiting*. Executive Management at PAH advise they have immediate capacity to address patients on The Prince Charles Hospital angiography waiting list.

My primary concern as Director General and a medical practitioner is the welfare of patients. In addition, I am concerned that despite Queensland Health's best efforts to foster clinical collaboration by cardiac services at The Prince Charles Hospital with other providers such as Princess Alexandra Hospital so that there is equitable access to urgent patients.

This has failed to occur in relation to angiography at The Prince Charles Hospital. I am further concerned that the discrepancy between The Prince Charles Hospital data and that of Princess Alexandra Hospital is so great that it requires formal investigation.

I am no longer prepared to rely on voluntary collaboration to resolve the issues, as this has clearly failed.

Therefore I instruct the following:

- District Manager, The Prince Charles Hospital and Health Service District to review waiting lists for septal defects and advise the General Manager Health Services of The Prince Charles Hospital strategy to treat patients in a clinically appropriate timeframe. Identified cases that require procedures will be funded on a claims basis. A comprehensive strategy for future management of cases is also to be forwarded;

- General Manager Health Services to investigate and report to the Director General on the allegations of 3 deaths due to resource constraints;

- General Manager Health Services to investigate the allegations of separate diagnostic and treatment interventions;

- The District Managers of The Prince Charles Hospital and Princess Alexandra Hospital together with the Directors of Cardiology to immediately collaborate to transfer the most urgent clinically appropriate patients from The Prince Charles Hospital to Princess Alexandra Hospital for angiography. In cases where clinical urgency is the same, preference is to be given to patients in the Southern Zone and Northern New South Wales;

- General Manager Health Services to conduct a formal review of the triage of angiography patients to ensure equity of access based on clinical urgency using a consistent clinical risk evaluation methodology, regardless of patient's place of residence; and

- General Manager Health Services to formalise a collaboration framework for cardiac services.

In closing I offer the following comments. The Prince Charles Hospital and Health Service District in 03-04 has received an extra $800,000 to recognise increasing costs of existing cardiac services, $400,000 for Implantable Defibrillators, $500,000 for single use EP catheters, $300,000 for paediatric ICU and $145, 000 for cardiac service integration between The Prince Charles Hospital and Royal Brisbane &Women's Hospital.

It is also worthy of note that Queensland Health corporately facilitated the first triple organ transplant in Australia on a New South Wales patient and flew the World's leading surgeon from Canada to perform cryoablation on a child and adolescent. These are but two of numerous instances which demonstrate Queensland Health's commitment to providing high quality health services to the community of Queensland, despite uninformed assertions to the contrary.

Dr Steve Buckland
Acting Director-General
22 / 04

Bundaberg Hospital Commission of Inquiry

Statement of Michael Ian Cleary

Attachment MIC-13

Michael Cleary - Cardiac Issue

From: Michael Cleary
To: Bergin, Dan
Date: 23/01/2004 11:19 AM
Subject: Cardiac Issue

Dear Dan,

Following the correspondence from the Director General the following actions occurred on 22/1/04:
1. 1:30pm - Correspondence received
2. 2:30pm - The Acting District Managers at TPCHHSD and PAHHSD discussed a strategy.
3. 2:30pm - The TPCH Cardiology Program Management Team (Director, Deputy Director, Nursing Director, Catheter Lab CNM) met with the A/Executive Director Medical Services, Executive Director Nursing Services and A/District Manager to go through the actions required. These included;

- The Cardiology Program will review the waiting list for ASD closure devices. This will include an audit of the current patients to ensure that the data relating to the patients is correct. Dr Galbraith will review the adult cases and Dr Radford the paediatric cases. This will be completed COB Friday.
- The Director of Cardiology will clarify the booking process for patients following the Christmas Closure period. Formal (written) advice will be provided to clarify the arrangements for the staff involved.
- A plan to review the waiting list to determine which cases could be transferred to PAH will be developed with staff from PAH.

4. 3:30pm - The TPCH Cardiology Program Management Team (Director, Nursing Director), A/Executive Director Medical Services, Executive Director Nursing Services and A/District Manager teleconference with PAH staff including the A/DM and Director of Cardiology. This meeting agreed to a core set of principles:

- Patient transfers would start next week and be between 10 and 20 cases a week depending on the ability of PAH to provide services.
- Inter-hospital transfers from the Southern Zone and NSW would be referred to PAH in the first instance.
- Patients who would be excluded from the process include: children, heart failure/heart transplant patients, complex congenital heart disease patients, patients with a booking at TPCH for a procedure in the next 2 weeks.
- Category 1 Long wait patients from Southern Zone and NSW would be first priority for transfer.
- Category 1 Long wait patients from Central Zone would be second priority for transfer.
- Category 1 in time patients from Southern Zone and NSW would be third priority for transfer.
- The transfer arrangements would be reviewed through the process to ensure that they were clinically appropiate.

The agreed actions included:

- TPCH to review the waiting list in light of the above principles and identify cases that can be transferred (by COB 22/1/04).
- All patients from Southern Zone and NSW will have their charts retrieved and be available for review by PAH staff (by 11:00am 23/1/04).
- Director of Cardiology from PAH and TPCH and Nursing staff from PAH and TPCH to meet at TPCH at 2:00pm 23/1/04 to review charts and cases.
- Following the above meeting between the clinical staff from the two hospitals arrangements will be put in place to contact patients with a view to additional cases being undertaken at PAH next week.
- Ongoing management arrangements will be established to monitor progress.

Detailed minutes of the meetings will be available.

Attached is an e-mail from Jeannette Young confirming the agreed strategy and principles.

Would you be happy for this to be forwarded to Dr Scott (A/GMHS) and Deb Miller for their information.

Kind regards
Michael

Dr Michael Cleary
Associate Professor of Medicine
Acting District Manager
The Prince Charles Hospital and Health Service District
Rode Road
Chermside 4032
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Ph: + (61) 07 33508226
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Exec Support Officer

Bundaberg Hospital Commission of Inquiry

Statement of Michael Ian Cleary

Attachment MIC-14

MEMORANDUM

Queensland Government
Queensland Health

The Prince Charles Hospital
Health Service District
Rode Road, Chermside Q 4032

To: Dr Andrew Galbraith,
Clinical Director, Cardiology Program
Ms Jenny Walsh
Nursing Director, Cardiology Program

Copies To: Mr Dan Bergin,
Zonal Manager, Central Zone
Dr Sue Phillips
Acting Executive Director Medical Services
Ms Cheryl Burns
Executive Director Nursing Services
Dr Darren Walters,
Director, Catheter Laboratory
Ms Margaret Dahl
Clinical Nurse Manager, Catheter Laboratory

From: Dr Michael Cleary
Acting District Manager

Tel No 3350 8224

Fax No.: 3350 8825

Date: 27 January 2004

File Ref: MC:jg

Subject: **Ongoing Management of Cardiac Services within The Prince Charles Hospital**

I refer to recent discussion, and subsequent decisions, in relating to the provision of cardiac services at The Prince Charles Hospital.

The purpose of this memorandum is to provide you with clear instruction relating to the outcomes expected by both the Acting Director General, Queensland Health, and myself.

General Issues

- I require an immediate review of waiting lists within the Cardiology Program and confirmation of their accuracy by close of business 30 January 2004.
- Further, I require your written advice relating to the criteria used to categorise patients on the Cardiology Program waiting lists by close of business on 30 January 2004.

- Effective immediately, I require you to ensure that all categorisation decisions and changes in categorisation for patients on the Cardiology Program waiting lists are accurately recorded in the medical record.

- I also request that you undertake a review of waiting list management within the Program using process redesign methodologies and advise on a revised management system by 9 February 2004.

Issues Relating to Recent Investigation

As a direct outcome of the recent investigation concerning allegations relating to cardiology services within the District, the following actions require your immediate attention:

- That you initiate a review of the inter-hospital referral process to ensure appropriate documentation of transfer requests. As part of this review, you are requested to develop a system that allows a central coordinated priority response and ensure that staff at TPCH and referral hospitals are aware of the process to be used.

- That you establish a process to ensure that staff undertaking the booking of procedures outside the clinician's requested time advise the clinician accordingly to allow alternative arrangements to be made where the clinician believes the waiting time to be inappropriate.

- That you ensure that the movement of patients between lists at TPCH and PAH is expedited where the clinical situation indicates the need for early intervention.

Once you have had an opportunity to consider these issues I require a project management plan to be submitted for my approval prior to any changes being introduced.

Current Waiting List Management

In order to address the immediate concerns raised by the Acting Director General, a meeting was held on 22 January 2004 to establish the following core set of principles:

- Transfer of long wait Category 1 patients from TPCHHSD to PAH will commence from 27 January 2004, with between ten and twenty cases per week, depending on the capacity of PAH to provide services.

- Inter-hospital transfers from Southern Zone and New South Wales will be referred to PAH in the first instance.

- Patients who are excluded from the process include children, heart failure/heart transplant patients, complex congenital heart disease patients, and patients with booking at TPCH for a procedure in the next two weeks.

- Category 1 long wait patients from Southern Zone and New South Wales will be first priority for transfer.

- Category 1 long wait patients from Central Zone will be second priority for transfer.

- Category 1 in time patients from Southern Zone and New South Wales will be third priority for transfer.

- The transfer arrangements will be reviewed through the process to ensure that they are clinically appropriate.

To implement these core set of principles, I require that the following process be implemented, effective immediately:

- That a weekly waiting list report be developed for the Program in consultation with key stakeholders and which is based on the principles detailed above.

- That the weekly waiting list report be provided to the Acting Executive Director Medical Services (EDMS) by close of business on Tuesday of each week, together with the relevant patient charts.

- That the Acting EDMS confirm with patients that they are agreeable to be transferred into the care of Cardiologists at PAH.

- That, following consideration by the Acting EDMS, a revised waiting list is finalised by 10.00am the following day (Wednesday) in preparation for the weekly case meeting between TPCH and PAH Cardiology staff, to be held at TPCH each Wednesday at 5.00pm. This meeting is to be chaired by the Executive Director Nursing Services.

- The Executive Director Nursing Services, after consultation with myself, may revise these arrangements to ensure that the transfer of these patients proceeds in a clinically appropriate and efficient manner.

These arrangements will continue until further notice.

I have also directed that the Executive Director Nursing Services come off line for a two week period to support the Program.

It is my expectation that staff involved in managing the requirements outlined in this memorandum will conduct themselves in a professional, proactive and supportive manner to ensure high quality Cardiology Services continue to be provided by this District.

Should you have any queries or concerns in relation to these instructions please contact me.

Dr Michael Cleary
Acting District Manager

Bundaberg Hospital Commission of Inquiry

Statement of Michael Ian Cleary

Attachment MIC-15

Queensland Government
Queensland Health

AMENDED COPY SENT MC2 MC2 2/3/04 MP

A BRIEFING TO THE SENIOR EXECUTIVE DIRECTOR HEALTH SERVICES DIRECTORATE

BRIEFING NOTE NO:	
REQUESTED BY:	Terry Mehan A/SEDHS
DATE:	24th February 2005
PREPARED BY:	Gloria Wallace, District Manager, TPCHHSD
CONSULTATION WITH:	Dr Michael Cleary EDMS TPCHHSD
CLEARED BY:	D. Bergin, Zonal Manager, Central Zone
DEADLINE:	24th February 2005
SUBMITTED THROUGH:	**D Bergin, Zonal Manager, Central Zone**
SUBJECT:	**Management of the Mahar Johnson Report**

COMMENTS SED HEALTH SERVICES:

Mr Terry Mehan
A/Senior Executive Director
Health Services Directorate

/ /

PURPOSE:

To inform the SEDHS of issues in the development of the Mahar Johnson Report and of a proposed way forward.

BACKGROUND:

On 29th August 2004, Dr Russell Denman sent an email relating to the death of a young patient awaiting implantation of an Automatic Implantable Cardiac Defibrillator (AICD) which was distributed to a range of medical staff, including the Chair of the Queensland Branch of the Cardiac Society of ANZ and the Director of Cardiology at Royal Brisbane and Women's Hospital. This email was critical of Queensland Health ie. *"the public health sector and Queensland Health is still not taking this problem seriously despite having access to almost the cheapest ICD's (sic) in the world.*

On 30th August an email from Dr Darren Walters was forwarded to a similar group of staff, relating to the death of another patient, who had been awaiting urgent elective cardiac surgery.

There had been two prior deaths on the waiting list and those were investigated, a final report was provided and this was submitted to the Acting General Manager Health Services, who on-forwarded to the A/Director General Dr Steve Buckland on 20th January 2004.

Given the tenor of the new emails and the nature of the issues, it was locally agreed that a further investigation would be undertaken in relation to the two new deaths. This occurred during and was discussed with, the Zonal Manager, Mr Dan Bergin at the State Strategic Forum 31 August – 2 September, 2004.

On 6th September 2004 a detailed briefing was provided to the A/Senior Executive Director Health Services. This briefing advised of the intent to investigate the allegations and issues surrounding the deaths and of arrangements regarding the appointment of investigators. The brief also advised that the specific cases had been referred to the TPCH Morbidity and Mortality Committee to monitor the process of review.

The investigation was established under the delegated powers of the Director General to the District Manager, Appointments (10) Investigating Officers (Delegations Manual 16/7/04).

Terms of Reference were developed and on 20th September Drs Andrew Johnson (TGH) and Leo Mahar (Royal Adelaide Hospital) were appointed as investigating officers. On 21st September, the District Manager wrote to the two staff who had raised the concerns and indicated that a formal investigation into their concerns was being organised.

The Terms of Reference were revised and finalised 29th September 2004 and the investigators formally met in Brisbane to commence their investigation on 12 October 2004.

An initial draft report was received on 2nd November This report contained all of the summary transcripts of the people interviewed. At the request of the Director General, a copy of the draft report was provided to him on 3rd November when he attended TPCH to speak with medical staff.

Comment provided back to the investigators from the District administration saw the transcripts removed and the report modified. The final draft report was received on 18th November. The

Director General had requested the report as a matter of urgency and this was forwarded to Deborah Miller on 19th November.

The District Manager has not, at this time, accepted and concluded the report, nor validated it through the Morbidity and Mortality Committee in discussion with clinicians, due to instructions from the Director General that the report could not be released to clinicians until such time as it was corporately endorsed for this to occur.

KEY ISSUES:

The Mahar Johnson Report is now the subject of FOI applications being managed corporately.

Feedback from Clinicians:

On 23rd February 2005 it was agreed with the Acting Director General, Dr John Scott, that the District Manager could show the report to Drs Darren Walters and Russell Denman and could obtain their feedback. Drs Walters and Denman have identified a range of inconsistencies between their interview summary transcripts and some of the issues within the report. Drs Walters and Denman have also pointed out issues within the report that they believe are not a true reflection of the evidence provided by clinicians ie. specifically:

- they believe that assumptions have been made by the investigators that are incorrect;
- they believe that information provided by some witnesses to the investigators is opinion and is not validated.

Dr Walters was accompanied to his interview by an AMA industrial representative. Dr Walters has advised that he raised a concern with the investigators that he might have been subject to retribution for the evidence he was about to give, and asked if he had protection under the Whistleblowers Legislation. Dr Walters says he was advised that this would be followed up by the investigators with Audit and Operational Review. The summary transcript of his interview supports Dr Walters advice as to this matter.

Feedback from the Investigator:

Dr Andrew Johnson contacted February 24th 2005 to discuss process issues raised by Dr Walters. Dr Johnson advised that he:

- followed the procedures outlined in the Investigator's Manual;
- advised people being interviewed that he would make notes and that if they wanted to see them he would provide them for review. Only Dr Walters requested the notes for review and Dr Johnson reports that Dr Walters was happy with them.
- Did not tape interviews and that transcripts were typed copies of his notes. He therefore did not undertake validation of the transcripts. This would have been undertaken had staff requested the notes for validation.
- Advised staff at the commencement of the interviews of the processes of the Whistleblowers legislation, but that no staff members advised of their preference to take up the process. Had staff wished to invoke this legislation they would have been referred to Audit and Operational Review.

- Did not specifically advise staff being interviewed that the notes taken by the investigators would be accessible under FOI. This was not considered necessary as the records were not taped transcripts.

Current Climate at TPCH

The current climate at TPCH in Cardiology is very productive and cooperative. Dr Walters has been the acting Director of the Department since October 2004 and has made a great effort to restore the department's functionality and cooperation.

Dr Walters has also made a substantial contribution towards the establishment of collaborative patient management processes with RBWH and is preparing the Business Case regarding this for the two Districts.

Impact of Release of Information on Services:

The public release of the transcripts would have an enormously detrimental impact on the service and this needs to be considered in managing the FOI response. In the view of the District Manager, the enormous gains made in recent months would be lost, as clinicians would once again be pitted against each other and may lose face publically, and professionally. This could lead to resignations and the downturn in a service which is fragile and only just being restored to proper functioning.

RELATED ISSUES:

A range of improvements are currently occurring through the funding of additional activity, the opening of an additional catheter laboratory at RBWH, and plans towards a Statewide Cardiac Services Plan.

BENEFITS AND COSTS:

Not relevant.

ACTIONS TAKEN/ REQUIRED:

In the view of the District Executive and the Director of Cardiology the following actions need to be taken:

- The FOI application needs to be addressed to ensure that the process is risk managed to release the minimum of information publically, that is legally required.
- The Report needs to be concluded satisfactorily through the process of validation with clinicians and revision and finalisation with the Investigators.
- Given that the report was commissioned by the District Manager, the District Manager needs to be able to manage the completion of the process.
- Any information released needs to be acknowledged as in draft, and for completion.

- The completed report needs to be formally accepted by the District Manager and the TPCH Morbidity and Mortality Committee, which was asked to assist in the process oversight.
- The District Manager and the Director of Cardiology need to meet with Mrs Stanley (this meeting has been offered to Mrs Stanley who will telephone to confirm her availability).

ATTACHMENTS:

Nil