Bundaberg Hospital Commission of Inquiry

Statement of Michael Ian Cleary

Attachment MIC-6

MEMORANDUM

Queensland Government
Queensland Health

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

To:	Department Heads – Cardiology Program Department Heads - Cardiac Surgery Program		
Copies To:	Program Management Team – Cardiology Program Management Team – Cardiac Surgery District Executive Committee		
From:	Michael Cleary Acting District Manager	**Tel No:** **Fax No:**	3350 8223 3350 8825
Date:	31 March 2004	**File Ref:**	05.04.8

Subject: **Update TPCHHSD Cardiac Services**

Queensland Health is in the process of expanding the cardiac service infrastructure at the Princess Alexandra Hospital (PAH) so as to ensure that patients requiring cardiac care have optimal access to specialist services. The Prince Charles Hospital (TPCH) is actively participating in and supporting this initiative.

This service development will be supported through the allocation of new growth funds to PAH and through the transfer of a limited volume of non-quaternary cardiac surgical and cardiology activity to the PAH from TPCH.

In relation to the transfer of cardiac surgical and cardiology activity between the two hospitals, this will be based on the realignment of services for patients who reside in the south Brisbane metropolitan area or who live in the Southern Zone. The effective date for the completion of this transfer is the 1st July 2004.

To facilitate this process, a meeting was held 25th March 2004, between TPCH and PAH Cardiology and Cardiac Surgery Program Management Teams. The key outcomes of this meeting were:

- Agreement that the increase in cardiac surgical activity at PAH will commence on the 5st July 2004.
- Agreement that the increase in cardiology activity at PAH will commence on the 13th April 2004.

In line with the service transfer there will need to be a realignment of services at TPCH. This will allow clinical teams at TPCH to focus on the provision of state-wide quaternary services and on the provision of tertiary and secondary level care for patients who reside in the north Brisbane metropolitan area or who live in the Central Zone.

The realignment of services at TPCH is a complex process and is being lead by the Cardiac Surgery and Cardiology Program Management Teams with support from Executive Sponsors and myself.

I will keep staff informed in relation to this process as it progresses.

Kind regards

Michael Cleary
Acting District Manager

Queensland Government
Queensland Health

MEMORANDUM

To: Program Management Team – Cardiology
Program management Team – Cardio-Thoracic Surgery

Copies to: Cheryl Burns, Executive Director Nursing Services
Jeremy Hayllar, Executive Director Medical Services
Jon Roberts, Executive Director Finance & Information

From: Michael Cleary
A/District Manager, TPCHHSD

Contact No: 07 3350 8224
Fax No: 07 3350 8825

Subject: **Transfer of Cardiac Surgery to Princess Alexandra Hospital**

File Ref:

Central Zone and Southern Zone management have agreed on the funding and activity transfer from The Prince Charles Hospital (TPCH) to Princess Alexandra Hospital (PAH). The expectation is for the transfer of activity to occur as close as possible to 1 July 2004. Funding for the 2004/2005 year's activity will transfer on 1 July 2004. The activity and funding transfer is summarised below:

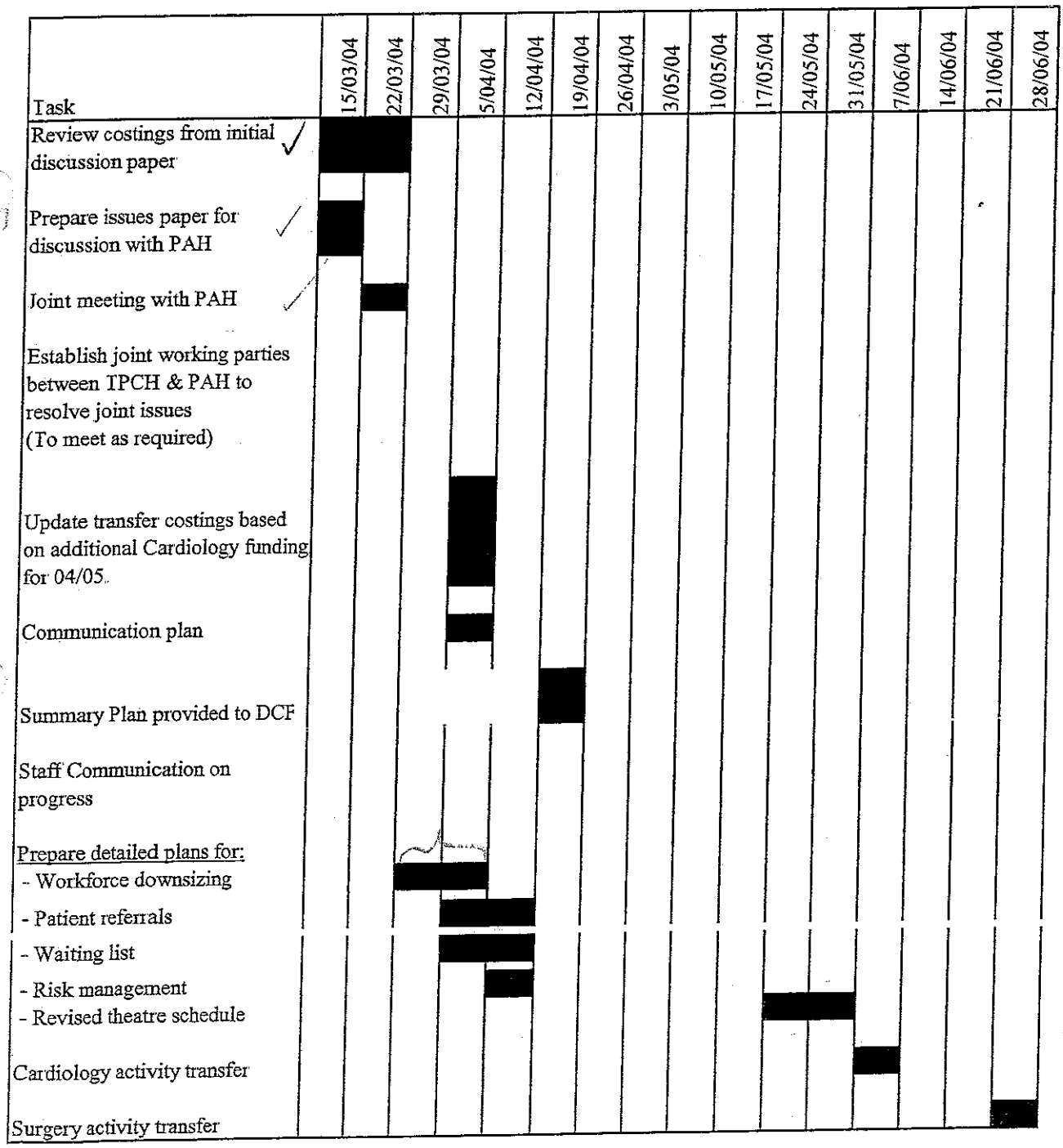
	Cases	Wt Seps (Phase 8)	% Public Mix
Cardiac Surgery			
Valve	112	924	86.92%
CABG	157	828	83.52%
Other	31	215	80.56%
	300	1,967	84.48%
Cardiology			
Angioplasty	90	219	90.60%
Other Procedures - See (1) for details	18	44	90.60%
Angiogram	500	532	90.60%
	608	795	90.60%

Funding	Original Costing $000's	(1) Adjustment $000's	(2) Transfer $000's
Cardiac Surgery	2,924	282	3,206
Cardiology	970	94	1,064
	3,894	376	4,270

(1) TPCH Working Party document "Implications of Transfer of Cardiac Activity from The Prince Charles Hospital to Princess Alexandra Hospital" (2003)
(2) Fifty percent of the difference between the PAH and TPCH costings after allowing for $1.0 M in supplementary funding.

In order to effectively plan for Cardiology activity levels for 2004/2005, TPCH has sort clarification on the funding allocation of the additional $2.0 M which has been allocated by the State Government for additional angiography and angiplasty activity in 2004/2005.

In order to facilitate the activity transfer to PAH the following tasks will need to be completed by the Program Management Teams:



A formal meeting of relevant Program Management Team members and Executive will be established to review the planing and monitor the progress of the transfer of activity. At this stage I would envisage that this meeting would weekly for 30 minutes following the Acute Program Management Meeting on Tuesdays.

I appreciate your support and ongoing leadership in relation to the transfer of this activity to PAH.

Michael Cleary
A/District Manager
The Prince Charles Hospital Health Service District
16/3/04.

Bundaberg Hospital Commission of Inquiry

Statement of Michael Ian Cleary

Attachment MIC-7

02-03.3.

EMAILED
MCZ
4/6/04

Queensland Government
Queensland Health

SUBMISSION TO THE A/GENERAL MANAGER HEALTH SERVICES

DATE: 24 May 2004

PREPARED BY:	Paul Winton – Program Business Manager, Cardio-Thoracic Surgery, Orthopaedic Surgery & Critical Care, TPCHHSD	**Contact No:**	(07) 3350 8802
	Dr Greg Stafford – Program Medical Director, Cardio-Thoracic Surgery, TPCHHSD	**Contact No:**	(07) 3350 8696
	Mary Wheeldon – Nursing Director, Cardio-Thoracic Surgery, Orthopaedic Surgery & Critical Care, TPCHHSD	**Contact No:**	(07) 3350 8215
	Jon Roberts – Executive Director of Finance & Information Services, TPCHHSD	**Contact No:**	(07) 3350 8418
	Dr Michael Cleary – Executive Director Medical Services, TPCHHSD	**Contact No:**	(07) 3350 8226
CLEARED BY:	Gloria Wallace - District Manager, TPCHHSD Wallace 3/6/04	**Contact No:**	(07) 3350 8224
SUBMITTED THROUGH:	Mr Dan Bergin – Zonal Manager, Central Zone Management Unit	**Contact No:**	(07) 3234 0825
DEADLINE:	District Initiated	**File Ref:**	02.03.3

SUBJECT: Funding Submission – Extra Activity Cardio-Thoracic Surgery

APPROVED/ NOT APPROVED

COMMENTS

Dr John Scott
A/General Manager Health Services

PURPOSE:

To seek additional funding to allow The Prince Charles Hospital to increase elective Cardiac Surgery throughput.

BACKGROUND:

The potential exists for The Prince Charles Hospital (TPCH) to increase elective Cardio-Thoracic surgery for the 2004/2005 financial year.

TPCH supports the largest Cardio-Thoracic Surgical Service in Australia.

TPCH redevelopment included 2 x 30 bed Cardio-Thoracic Surgical wards and an expanded operating theatre complex. The planned capacity in the redevelopment allowed for significant workload increases in cardiac and thoracic services.

Currently the Cardio-Thoracic service utilises 44 of the 60 beds allocated to Cardio-Thoracic Surgery. An average of 38 half day operating sessions per week are currently used to achieve funded activity levels.

As a result of the transfer of 300 cardiac surgery cases to the Princess Alexandra Hospital (PAH), there will be vacant theatre sessions available to facilitate additional Cardio-Thoracic Surgical activity.

ISSUES:

Queensland Health is in the process of expanding the cardiac service infrastructure at the PAH through the allocation of growth funds to PAH and the transfer of funding from TPCH to PAH. Planned activity transfer included transfer of both surgical and interventional cardiology.

To a large degree interventional cardiology activity from the Southern Zone has shifted to the PAH during the past 18 months.

- As at 1 April 2004, TPCH had 380 patients on the Cardio-Thoracic Surgical Waiting List, in the following categories:
  - Category 1 – 65
  - Category 2 – 243
  - Category 3 – 72

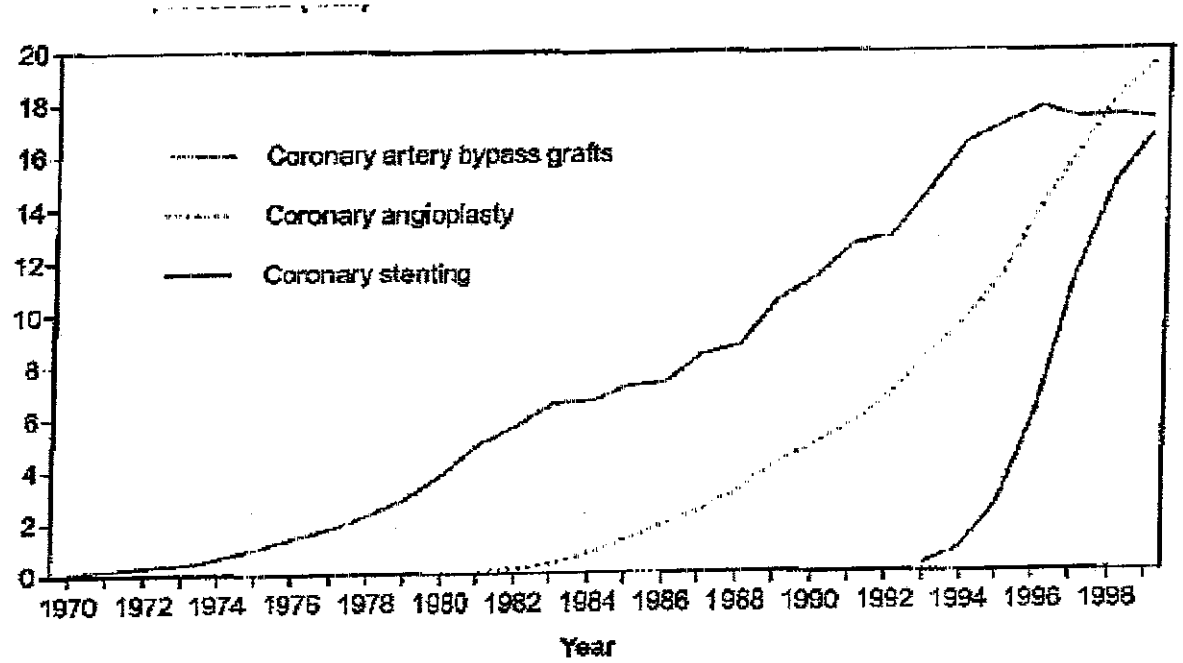
- As at 1 April 2004, TPCH had 79 new patients waiting to be seen in Cardio-Thoracic Surgical Outpatients.
- The average waiting time for a new patient appointment for a Cardio-Thoracic Surgical Outpatient Clinic is 5 weeks.
- New surgical referrals from the Cardiology Department to the Cardiac Surgical Department have increased over the previous 12 months from approximately 15 cases per week to over 20 cases per week.
- Ten to fifteen percent of cardiac surgical activity undertaken at TPCH relates to patients from the Southern Zone who require specialist services eg. Congenital Heart Surgery for children, transplantation, etc.
- Given the success of donor rates, transplantation procedures are likely to increase.

- Additional funding to support interventional cardiology totalling $2.0M has been approved for the 2004/05 financial year. This will result in an increase in the number of angiograms being performed within Queensland. Given that 30% of patients having angiograms are referred for surgery, this increase in cardiological activity will result in additional patients being referred for surgery.
- In Australia revascularisation (coronary angiogram and stenting procedures) rates vary across all states. Queensland rates are significantly lower than the national rates (see table 1 and figure 1).
- Clinical practice changes related to the treatment of acute coronary have resulted in, and will continue to result in, an increase in patients requiring acute cardiac surgery.
- As the population ages there will be an increasing need for cardiac valve surgery.
- Adults who as children had cardiac surgery to treat congenital heart conditions are increasingly requiring further corrective surgery. This is an emerging area of cardiac surgery demand.

TABLE 1:Percutaneous coronary intervention rates per million of population by region, 2000

	National Rate	Queensland Rate	Variance	Victorian Rate	West Australian Rate	SA & NT Rate	Tasmanian Rate
PCI	1125	944	-181	1370	1065	1155	1203

FIGURE 1:



Note: Coronary angioplasty includes procedures with or without stents.

Source: AIHW/NHF National Cardiac Surgery and Coronary Angioplasty Registers.

Figure 2.15: Trends in coronary revascularisation procedures, 1970 to 1999

BENEFITS AND COSTS:

Increasing the level of cardiac surgical activity at TPCH will provide the following benefits:

- Assist with the reduction of Category 2 long wait patients at TPCH.
- Improved community access to elective cardiac surgery.
- Increase the utilisation of the spare physical capacity at TPCH.
- Maintain service at TPCH in line with the Hospital Redevelopment Business Case.
- Reduce the average cost per weighted separation at TPCH.
- TPCH current activity target is 42,000 weighted separations under Phase 8 Cost Weights.
- The provision of an additional $2,432,500 in funding would allow an increase in net activity of 973 weighted separations under the Phase 8 Cost Weights.

CONSULTATION:

N/A

ATTACHMENTS:

N/A

RECOMMENDATION(S):

The Acting General Manager Health Services approve the allocation of an additional $2,432,500 in funding for elective cardiac surgery in the 2004/2005 financial year.

Bundaberg Hospital Commission of Inquiry

Statement of Michael Ian Cleary

Attachment MIC-8

EMAILED
6/1/04

01-01-4 Revised. 12-57pm

FOR USE BY EXECUTIVE SERVICES OFFICE STAFF ONLY
MIN / DG / A/GMHS / DDGP&O FILE
EMAIL :- MIN SDLO DLO EXDG EMMC MCM

Queensland Government
Queensland Health

AMMENDED BRIEFING TO THE MINISTER

BRIEFING NOTE NO:	N/A
REQUESTED BY:	Mr D Bergin – Zonal Manager, Central Zone, contact 3234 0825
DATE:	5 January 2004
PREPARED BY:	Dr S Phillips – A/Executive Director Medical Services The Prince Charles Hospital Health Service District (TPCHHSD) contact (07) 3350 8226 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
CLEARED BY:	Dr M Cleary – A/District Manager TPCHHSD, contact (07) 3350 8224
DEPARTMENTAL OFFICER ATTENDING:	N/A
DEADLINE:	6 January 2004
SUBMITTED THROUGH:	Mr D Bergin, Zonal Manager, Central Zone
SUBJECT:	**Cardiac Services**

MINISTER'S COMMENTS:

Wendy Edmond MP
Minister for Health and
Minister Assisting the Premier on Women's Policy
/ /

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 ddditional 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. The patient was planned to be transferred

in line with clinical protocols. The original referral to TPCH was made on the 14th November 2003 and the transfer was planned for 17th November 2003. During the intervening period the patient was receiving care in the hospital's Coronary Care Unit.

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 on the day that his procedure was booked. TPCH booking office contacted the patient's home and were advised the patient had died two weeks earlier. On review, this patient was placed on the waiting list as a Category 1 patient (recommended waiting time <30 days) and was scheduled to have his procedure within the 30 day waiting period. Upon review it was felt that this event did not represent a failure of the health care system.

- 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 between 15 patients 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.

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 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 and 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:

N/A

BENEFITS AND COSTS:

N/A

ACTIONS TAKEN/ REQUIRED:

That the Minister of Health note the contents of this Brief.

ATTACHMENTS:

1. Letter from Assoc Prof C Aroney and Dr K Hossack of the Queensland Branch of the Cardiac Society of Australia and New Zealand
2. Submission to the General Manager Health Services dated 24 November 2003

DRAFT MEDIA RELEASE:

[ ] ATTACHED

[X] NOT ATTACHED

Bundaberg Hospital Commission of Inquiry

Statement of Michael Ian Cleary

Attachment MIC-9

Michael Cleary - MEETING WITH DR ARONE

From: Kate O'Donnell
To: Michael.Dart@ministerial.qld.gov.au
Date: 7/01/2004 11:15 AM
Subject: MEETING WITH DR ARONE
CC: Bergin, Dan; Buckland, Steve; Cleary, Michael; Dall'Alba, Paul; Scott, John

Dear Michael,

RE: Premier's request for meeting to be held with Dr Arone

Yesterday morning Dr Arone met with:

- Dr Cleary (District Manager)
- Dr Sue Phillips (Exec Director Medical Services)
- Dr Andrew Gailbraith (Director Cardiology TPCH).

The reason for the meeting was to follow up with Dr Arone his concerns in relation to patient care that had been raised through the media and to clarify with Dr Arone that as a QH employee he was not approved to speak on behalf of QH.

In relation to the patient care issues Dr Arone indicated that he did not have direct knowledge of the patients referred to in the media but that the information had been provided to him by other cardiologists.

In relation to the patient from Lismore:

Dr Arone acknowledged that the circumstances surrounding the patient were as follows:

- the patient was referred to TPCH and was scheduled for an angiogram within the timeframe that is recommended for these procedures;
- on the day of the appointment the hospital followed up the non-attendance and was advised the patient had died approximately 2 weeks earlier;
- the patient's treatment was planned within the recommended timeframes.

Upon review it was felt by the District Manager that this event did not represent a failure of the health system.

In relation to the patient from Hervey Bay:

Dr Arone was not clear if this was the patient that the District had previously reviewed or if this was a different patient. This could not be followed up at the meeting but was followed up by Dr Phillips after the meeting who determined that the original referral related to this patient was made on 14/11/03 and that a transfer was planned for 17/11/03 and that during the intervening period the patient was receiving care in the Coronary Care Unit at Hervey Bay Hospital. During this time, the TPCH noted that there had been a significant increase in demands for inter-hospital transfers due to patients with higher risk and that these sicker patients were given priority.

In relation to the media:

The DM indicated that Dr Arone was not approved to speak on behalf of TPCH and that all media comments should be referenced to the Cardiac Society and not QH.

Dr Cleary also indicated that:

- he would not approve interviews being conducted on TPCH site;
- he would not approve footage of patients being obtained by the media unless it was organised via the media officer.

Other matters discussed:

There was a general discussion regarding cardiac issues including:

- the recruitment of an interventional cardiologist which is currently being undertaken;
- a potential support for Townsville Hospital for patients awaiting interventional cardiology procedures.

Please let me know if you need any further details regarding this meeting.

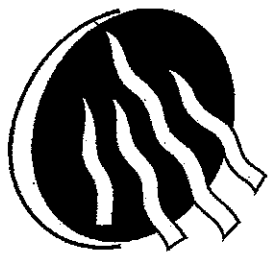
Kate O'Donnell
A/Senior Departmental Liaison Officer
Office of the Director-General

Telephone: 07 323 41570
Fax: 07 3229 0854
E-mail: Kate_O'Donnelll@health.qld.gov.au

Bundaberg Hospital Commission of Inquiry

Statement of Michael Ian Cleary

Attachment MIC-10



Queensland
Government
Queensland **Health**

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

TABLE OF CONTENTS

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, AT, 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, NI, 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, WS, 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.

P Thomas 21.01.04

Dr P Thomas **Date**

12/1/04

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