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STATEMENT OF GAIL MARGARET AYLMER of address known to the Queensland Nurses' Union of Employees

Qualifications and experience

1. I am a registered nurse licensed to practise in Queensland and have been so registered since 1995. Prior to this I was an enrolled nurse for approximately 17 years.

2. I hold a Bachelor of Nursing from the University of Southern Queensland which was awarded in 1995. I also hold a Master of Nursing and a Master of Mental Health Nursing which were awarded in 1999 and 2002 respectively. I am currently undertaking a Graduate Certificate in Infection Control at Griffith University which I expect to complete by the end of 2005.

3. I am currently employed on a fulltime basis in the Bundaberg Health Service District at the Bundaberg Base Hospital as the Infection Control Clinical Nurse Consultant ("CNC"). I have held this position since 2 June 2003. Attached and marked **GA1** is a true copy of the position description for the position of Infection Control Clinical Nurse Consultant. Prior to this, I was employed fulltime as a Nurse Educator. I have been employed as a registered nurse in the Bundaberg Health Service District since 1996 with an absence of seventeen months when I was employed as an associate lecturer at the Central Queensland University from February 2000 to July 2001.

Patient names

4. In this statement, in the interests of protecting the privacy of patients and the feelings of patient's family and friends, I have referred to patients according to a key devised by my lawyers which I have sighted and which I understand

is to be supplied by my lawyers to the Bundaberg Hospital Commission of Inquiry on a confidential basis.

Dr Patel and Infection Control Issues

5. In April 2003 I was the acting Nurse Practice Coordinator of the Surgical Ward at the Bundaberg Base Hospital from 14 April 2003 to 11 May 2003. I recall that Dr Patel commenced employment as the Director of Surgery during that time. I cannot now recall the date when he commenced as Director of Surgery.
6. In my role as acting Nurse Practice Coordinator I accompanied Dr Patel on patient rounds conducted on a daily basis from Monday to Friday. From the outset of his term, I observed that Dr Patel did not wash his hands after attending to his patients, which often involved him touching patients, handling their dressings and in some situations their wounds. In order to minimise risk of cross infection, it is best practice to handwash after attending each patient. I can recall that during rounds I tried inconspicuously to prompt Dr Patel to wash his hands. After a couple of days of prompting him to wash his hands he failed to respond to my prompting. I then resorted to carrying a box of gloves during his rounds to try and encourage him to improve his practise to minimise the risk of cross infection to his patients. He did use gloves when they were placed in his hands. I can recall that on at least two occasions I spoke to Dr Patel regarding the importance of performing basic infection control techniques. However, he continued to not wash his hands.
7. Because of my experience with Dr Patel in the Surgical Ward I decided to conduct an inservice on handwashing for the medical staff which was to be

conducted during their lunchtime meetings from 30 June to 8 July 2003. I coordinated the inservice with the Medical Education Officer Judy O'Connor. On 3 July 2003 the surgical team attended the inservice. Dr Patel initially attended and when I commenced the inservice he walked out of the room and made a telephone call and did not return. I noted this in my diary.

Wound Dehiscence

8. The Infection Control CNC position was unofficially responsible for consulting in relation to wound management issues as there was not a specifically appointed person to undertake wound management at the Bundaberg Base Hospital. This aspect of the role was not included in the position description for the Infection Control CNC.
9. As Infection Control CNC I conducted ward rounds on a regular basis. I can recall that during rounds in the surgical ward towards the end of June 2003 various nursing staff commented to me about the unusual number of wound dehiscence which had occurred over the last couple of months. In response to the concerns raised about the wound dehiscence, on 3 July 2003 I emailed relevant nursing staff requesting them to gather data about wound dehiscence over the past 6-8 weeks and arranged to discuss the issue further at a meeting on 7 July 2003 at 0900 hours in the seminar room. Attached and marked **GA2** is a true copy of my email dated 3 July 2003.
10. On 3 July 2003 I also telephoned a nurse at the Royal Brisbane Hospital who was part of the Infection Control team for guidance about how to manage wound dehiscence which was not caused by an infection. I was

informed that where wound dehiscence was not caused by infection it fell outside the scope of their role as Infection Control and could not advise me further. I made an entry in my diary of the fact that I telephoned the Royal Brisbane Hospital.

11. I initiated my own data collection from the information provided to me by surgical nursing staff and the Nurse Unit Manager of the Operating Theatres Jenny White. I initially identified 13 patient charts which identified patients who suffered from wound dehiscence during the period from May 2003 to June 2003. I then prepared my monthly Report to Leadership and Management dated 7 July 2003 and noted my initial concerns about wound dehiscence. This report was provided to the hospital executive consisting of the District Manager Mr Leck, Director of Medical Services Dr Keating, Director of Nursing Ms Goodman, Director of Corporate Services Mr Heath, Director of Community Services Ms Wallace and Director of Integrated Mental Health Service Ms McDonnell. Attached and marked **GA3** is a true copy of my Report to Leadership and Management dated 7 July 2003.

12. On 7 July 2003 I attended the meeting with the relevant nursing staff and collected further data in relation to wound dehiscence. After the meeting I correlated the data and produced an initial Wound Dehiscence Report dated May 2003 to June 2003. I recall that I listed 13 episodes of abdominal wound dehiscence in respect of 12 patients. I hand delivered the initial report to the Director of Medical Services Dr Keating. Shortly after handing the initial report to Dr Keating, Dr Patel came to my office to discuss the report. The majority of the patients on the list were patients

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under his care. We discussed each case and according to his definition of wound dehiscence, which he did not convey to me at any time, I agreed to decrease the number of wound dehiscence on the report from 13 to 5 incidences involving 4 patients. I then amended my initial report by amending the number of wound dehiscence from 13 to 5. Attached and marked **GA4** is a true copy of the Wound Dehiscence Report for May 2003 to June 2003. I did not keep a copy of the initial report that I provided to Dr Keating.

13. I was disappointed with the outcome of the meeting with Dr Patel as I felt I had been placed in an unenviable position because I was not qualified enough to argue with him about his interpretation of what constitutes wound dehiscence. I am not a wound care expert and did not possess the expertise to challenge his conclusions about the wounds. In my opinion, Dr Patel should have been required to explain the incidences of wound dehiscence before an appropriately qualified surgeon or wound management expert.

Surgical Site Surveillance

14. In my role as Infection Control CNC I am required to maintain and update the Electronic Infection Control Assessment Technology (eICAT) data base used to report surgical site surveillance. It is a data collection and analysis package developed within the Centre for Healthcare Related Infection Surveillance and Prevention (CHRISP) which was set up by Queensland Health to standardise methods for collection of surgical site surveillance, amongst other things. I attached eICAT generated reports to my reports to Leadership and Management Committee and the Infection

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Control Committee on a monthly basis up until August 2004 and then every second month. I did not keep copies of the eICAT generated reports. The eICAT reports were and continue to be provided to the ASPIC Clinical Service Forum and the Obstetric and Gynaecology Clinical Service Forum on a monthly basis. The information contained in the eICAT reports details in-hospital and post-discharge surgical site infections from the identified clinical indicators.

15. CHRISP provides standardised definitions for in-hospital and post-discharge surveillance. However, it is accepted that there is currently no validated method of surveillance for collection of post-discharge data. CHRISP report that over 50% of surgical site infections are diagnosed following the patient's discharge from hospital. Bundaberg Base Hospital does utilise the CHRISP post-discharge surveillance method, and follows up patients with a letter and a telephone call to their general practitioner if required.

16. In summary the surgical site surveillance data for Bundaberg Base Hospital did not identify an unacceptable infection rate for those clinical indicators which we used. However, when I presented the eICAT reports to the various committees mentioned above in paragraph 14 I was careful to point out that that the post-discharge data could not be relied upon as an accurate indicator for post-discharge infection rates. Attached and marked **GA5** is a copy of my Report to Leadership and Management dated 2 November 2003 which highlights the issue about surgical site surveillance, amongst other things.

Renal Unit Infection Control Issues

17. On 25 November 2003 I received an email from the Nurse Unit Manager of the Renal Unit Robyn Pollock regarding her concerns about Dr Patel's lack of appropriate aseptic technique when attending to patients in the Renal Unit. Attached and marked **GA6** is a copy of the email from Robyn Pollock to me dated 25 November 2003.

18. I immediately telephoned Robyn Pollock and then met with her and other Renal Unit nursing staff (whose names I cannot now recall) to discuss their concerns. I was informed at this meeting that an incident had recently occurred in the unit which involved Dr Patel and two patients (whose names I cannot recall). Dr Patel had inserted central lines into each patient about one week prior to the incident. The central line catheters had become blocked and Dr Patel attended to the patients in the Renal Unit to attempt to unblock catheters. He did not wash his hands prior to commencing the procedure and moved from one patient to the other and attempted to place some equipment used on one patient onto the equipment tray of the second patient. The nursing staff intervened to prevent him from contaminating the equipment. Only after the nursing staff's persistence did Dr Patel put on sterile gloves without washing his hands. He refused to wash his hands stating that "doctor's hands don't have germs". The nursing staff reported that he made this statement in all seriousness.

19. After the meeting with the Renal Unit nursing staff I arranged a meeting with Dr Keating to discuss the incident. Robyn Pollock and I attended a meeting with Dr Keating on 27 November 2003 and advised him of the

incident. Dr Keating advised that he would speak to Dr Patel and asked Robyn Pollock to provide him with statistical data to support the assertion that there was a problem with Dr Patel's aseptic technique. It is common practice for renal units to collect and maintain their own statistical data about infection rates which is the case at Bundaberg Base Hospital.

20. Shortly after the meeting, Dr Keating told me that he had spoken to Dr Patel about the incident in the Renal Unit and that his version of the incident was different to that given by the nursing staff. It was my impression that Dr Keating preferred the version given by Dr Patel over that given by the nursing staff.

21. On 3 December 2003 I informed Robyn Pollock of the conversation between Dr Keating and me. Robyn Pollock told me that Dr Patel had been in the Renal Unit that day and informed her that he had "*had enough of renal and wasn't going to do it anymore*". I sent an email to Dr Keating dated 3 December 2003 detailing my conversation with Robyn Pollock and to the acting Director of Nursing Beryl Callanan updating her on this matter. Attached and marked **GA7** is a copy of the emails I sent to Dr Keating and Ms Callanan dated 3 December 2003.

22. Sometime later, Robyn Pollock and the acting Director of Nursing Patrick Martin advised me that a meeting had occurred in February 2004 with Robyn Pollock, Lindsay Druce and Patrick Martin to discuss ongoing concerns about the infection rate of patients in the Peritoneal Dialysis program. The statistical data which was requested by Dr Keating at the meeting held on 27 November 2003 was made available at the meeting. Patrick Martin told me that he discussed the issue with Dr Keating and that

Dr Keating made a comment of words to the effect "*well if they want to play with the big boys, bring it on*". This comment by Dr Keating clearly indicated to me that we did not have his support and that it was pointless to continue to raise issues when, in my opinion, there was no appropriate action taken. I felt like I was the trouble maker for bringing these issues to the attention of management.

Post-discharge Surveillance

23. By December 2003, I formed a view that hospital acquired infections were occurring and not being reported to me through the formal channels, that is, by way of staff completing an infection control notification form. I was aware of an increased number of complications following surgery, such as haematomas, nicks to internal viscera, leaking of anastomosis and readmissions following surgery which alerted me to the possibility of infection occurring. I became aware of these occurrences through discussions with nursing staff not through formal channels.

24. According to CHRISP, it is the role of a surgeon to determine whether a surgical site infection exists. In order to capture data on post-discharge wounds and to meet the requirements of CHRISP, I devised a Specialist Out-Patients Post-Operative Follow-up form. It required the cooperation of Dr Patel as Director of Surgery to facilitate this attempt to catch more data. Dr Patel agreed to trial the form and educate his staff regarding the use of the form. Attached and marked **GA8** is a copy of the Infection Control Committee Record of Meeting dated 22 September 2003 and 9 December 2003.

25. The form was introduced in May/June 2004. Attached and marked **GA9** is a copy of the Specialist Out-Patients Post-Operative Follow-up form.

26. In May 2004 I increased the number of clinical indicators from which data was to be collected to include inguinal, umbilical and incisional hernia repairs. This data was not previously collected. In June 2004 I added further clinical indicators of simple, radical and extended mastectomies and revision of total joint replacements. I provide data to CHRISP twice a year for the period from 1 May to 31 October and 1 November and 30 April each year. As I had increased the number of clinical indicators in May/June 2004 I did not provide this data to CHRISP for the six month period ending 31 October 2004 as the data was not collected for a full collection period. The data which has been collected since May/June 2004 is waiting the next collection period by CHRISP.

27. From June to August 2004, on various occasions medical staff in the Surgical Review Clinic commented to me that they were too busy to complete the form because it required too much writing. Furthermore, they saw no need to do post-operative surveillance at all and questioned why it was necessary to complete the Specialist Outpatients Post-Operative Follow-up form when it was not required to be done at the Royal Brisbane Hospital.

28. I reported these comments about the difficulties medical staff experienced in completing the form to the Infection Control Committee at its meeting on 24 August 2004. Annexed and marked **GA10** is a copy of the Infection Control Committee Record of Meeting dated 24 August 2004. I also reported the comments to the Leadership and Management Committee at

its meeting on 30 August 2004. I advised that I would simplify the form even further. Dr Keating said that he would speak to the medical staff about the importance of completing the form and collecting the data. Attached and marked **GA11** is a copy of my Report to Leadership and Management dated August 2004.

29. The form was revised and renamed and introduced into circulation in or about October 2004. Annexed and marked **GA12** is a copy of Post-Operative Follow-Up form.

30. I was approached by enrolled nurse Janice Williams from Specialist Outpatients who informed me that when she asked Dr Patel to complete the form he scoffed and laughed at her. I cannot now recall when I was approached by enrolled nurse Williams. This was a good example of how Dr Patel would, at formal meetings such as ASPIC Committee meeting, give the impression that he was genuinely supportive of an initiative but outside the meetings he demonstrated a complete lack of interest to the point of undermining my efforts.

Inappropriate wearing of Theatre Attire

31. Another issue which came to my attention was the inappropriate wearing of theatre attire outside the theatre complex. I reported my concerns to the Infection Control Committee. Annexed and marked **GA13** is a copy of the Infection Control Committee Record of Meeting dated 26 October 2004.

32. On 5 November 2004 I sent an email to the Director of Anaesthetics Dr Martin Carter and Dr Patel detailing my concerns about the wearing of theatre attire outside the theatre complex. The Director of Medical Services Dr Keating and the Director of Nursing Ms Mulligan also

received a copy of my email. I sought their comments about how best to address the problem. Annexed and marked **GA14** is a copy of my email to Drs Carter & Patel dated 5 November 2004.

33. On or about 15 November 2004, Dr Keating told me that Dr Patel had discussed the theatre attire issue with the acting Nurse Unit Manager of Theatres Gail Doherty and indicated to me that the issue had been dealt with. I asked Gail Doherty whether Dr Patel had discussed the issue with her and she denied that he had spoken to her about it. I then sent another email dated 15 November 2004 to Drs Carter & Patel which was copied to Ms Doherty, Dr Keating & Ms Mulligan. The purpose of the email was to firstly, confirm that I had received no feedback from them and that the issue was not discussed at the Theatre Management Meeting or at all which was contrary to Dr Keating's understanding. Secondly, to provide them with a memorandum that I wished to distribute to all staff members who enter the theatre complex. Attached and marked **GA15** is a copy of my email to Drs Carter & Patel dated 15 November 2004 together with the memorandum.

34. I received an email from Dr Patel, the only email communication I have ever received from him, responding to my email and memorandum dated 15 November 2004. Attached and marked **GA16** is copy of the email from Dr Patel to me dated 21 November 2004. I responded to him by expressing my interest in reading the studies about theatre attire to which he referred in his email. However, the studies were not made available to me.

35. I discussed the theatre attire issue further with the acting Nurse Unit Manager of Theatres Gail Doherty and agreed upon a compromise. I provided an update on the issue in my report to the Leadership and Management Committee. Attached and marked **GA17** is a copy of my Leadership and Management report which briefly sets out the compromise reached regarding the wearing of theatre attire outside the theatre complex.
36. There was a Theatre Management meeting held in December 2004, a meeting to which I was not invited. I recall briefly speaking to Dr Patel in the lift about the outcome of this meeting. He told me that there was agreement on the proposed compromised position. I sent an email to Dr Patel requesting that he confirm the details in writing so that I could erect signage and inform staff of changes. He did not respond to this request.
37. On 3 February 2005, I sent an email to Dr Patel alerting him to further incidences of inappropriate wearing of theatre attire outside the theatre complex and of the fact that staff had overheard him telling junior medical staff words to the effect that *"they go on about trying to stop us wearing theatre clothes in the corridor, but that's rubbish*". I believe that Dr Patel was undermining the Infection Control Program because on the one hand he was feigning support for change and improving practice and on the other hand he was making comments of this nature to nursing and medical staff which demonstrated a complete lack of support. I did not, in my earlier email correspondence, refer to the fact that on numerous occasions I observed him to be outside the hospital buildings inappropriately dressed in theatre attire. Nor did I mention that I had spoken to him on more than one occasion about this and that he assured me that he changed his attire

on re-entering the theatre complex because I did not wish to embarrass him before his peers. As the Director of Surgery I expected him to set a good example and it was evident that he had no intention of changing his practice of wearing theatre attire outside the theatre complex. Attached and marked **GA18** is a copy of my email to Dr Patel dated 3 February 2005.

Other issues

38. During 2003 when Jenny White was the Nurse Unit Manager of Theatres she expressed her concern to me that Dr Patel did not seem to know his instruments well, using the wrong clamp for frail tissue, and that his technique was rough. I asked her to document her concerns but she declined. I was concerned about what she had said so I asked the Director of Anaesthetics Dr Martin Carter his opinion of Dr Patel's expertise. I asked him whether Dr Patel was a good surgeon. He replied "*I wouldn't let him operate on me*". On another occasion, when I was in the ICU staff room I heard Dr Carter refer to Dr Patel as "*Doctor Death*".

39. I was told by someone whose name I cannot now recall that two doctors overheard Dr Patel giving specific instructions to his student staff about what to record and not record regarding infection on the discharge summary. I was concerned about this and tried to investigate the situation but information was not forthcoming. Dr Patel was the person who signed off on the doctors/students assessments which placed them in a precarious position if they spoke up.

40. On 14 October 2004, I attended an Ethical Awareness Information Session which was, I believe, conducted by a number of presenters from corporate

office. I cannot now recall all the content covered in the session but I do recall that the code of conduct was mentioned and reference to the appropriate channels to use when disclosing information to persons/organisations outside Queensland Health. I remembered this part of the session because it was of interest to me given my knowledge of the complaints made about Dr Patel to the executive management. It was clear to me that complaints of that nature could not be disclosed outside Queensland Health without serious repercussions. I also recall saying to the Nurse Unit Manager of ICU Toni Hoffman words to the effect that "*it was a good thing that you had not taken your complaint to the CMC because you could get yourself into trouble*".

Patient P54

41. On 19 January 2005, I received a telephone call from a patient P54 who had undergone a breast biopsy performed by Dr Patel on a Monday 17 January 2005. She telephoned me because she was concerned about her breast as the area around her biopsy site had become hard, hot, and black and felt sore. She was very concerned. I advised her that I would contact Dr Patel as soon as possible and inform him of the situation and that someone would contact her. I telephoned the Theatres and spoke to the acting Nurse Unit Manager Gail Doherty and explained the situation to her. I requested to speak to Dr Patel but as he was not available she offered to pass a message on to him to telephone me. Several hours later, I saw Dr Patel having his lunch. I asked him whether he had received my message. He said he was going to telephone her but I knew that he could not do this because he did not know the name of the patient. I gave him

her mobile telephone number because she was not staying at her home. He agreed with me that he should see this patient and that it was very important for him to see her. Over the next few days I continued to telephone the patient, and it was leading into the weekend, and she still had not been contacted by Dr Patel. I telephoned her again on the following Monday and she still had not heard from Dr Patel. She told me that her discomfort had settled a little as she had attended at the Eidsvold Hospital where she was commenced on antibiotics. I sent two emails to Dr Patel reminding him of this patient but he did not respond to my emails or at all. Attached and marked **GA19** is a copy of the two emails I sent to Dr Patel dated 20 January & 4 February 2005.

Executive Management

42. It is my belief that many nursing and medical staff had concerns about Dr Patel's clinical practice, but felt there was no point in pursuing or reporting matters to the executive because Dr Patel appeared to be well supported by them. Dr Patel often made statements about the support he received from the executive and how much money he was making for the hospital. This belief was reinforced every time issues were brought to the attention of the executive and were met by no response.

43. In March 2004, Linda Mulligan was appointed as District Director of Nursing. I personally welcomed her appointment and looked forward to the prospect of having a strong nursing leader to buffer nurses from the negative comments made by the executive management. I was disappointed when I realised that Ms Mulligan was not there as a nursing leader but only as a manager. Her management style could best be

described as a micro-manager. She was very reluctant about allowing the senior nurses (level 3 upwards) to make decisions that fell within their responsibilities. For example, I accumulated TOIL hours but did not continue to have them credited to me because of the inquisition I was subjected to by Ms Mulligan when attempting to have the hours credited to me. She adopted an attitude that maybe I should not have been accumulating TOIL and that the work could have been undertaken in my usual hours. She did not give me any credit for acting responsibly in my role as a level four nursing officer. She was also very controlling in meetings. When issues were debated at meetings she had a habit of targeting certain nursing staff and silencing them.

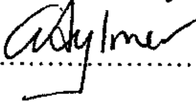
44. I later found out from the Quality Coordinator Leonie Raven that Ms Mulligan commented at a meeting in August 2004 that "*the Executive in this organisation were not able to delegate any decision making responsibilities to any middle managers because they did not have any middle managers who were reliable enough to delegate to*". Attached and marked **GA20.** The acting Director of Nursing Deanne Walls also told me that Ms Mulligan said that we (middle managers) did not like change. I did not find Ms Mulligan approachable nor did I find her very available to me as my line manager.

45. In my opinion, the executive demonstrated a disregard for nurses. For example, I attended the Improving Performance meeting held on 23 March 2004 shortly after Ms Mulligan had commenced in her new position. She entered an apology for the meeting. At the meeting the Press Ganey report was discussed and as the only nurse at the meeting I was asked to provide

an update on the progress nursing had made to address the recommendations of the report. I provided them with an update and in return I was confronted with a barrage of negative comments about nursing being obstructive and lying about the completion of a checklist. The District Manager definitely aired his disapproval to me that he was not happy with the progress nursing had made. I felt that nursing was being singled out for attack when, to the best of my knowledge, there were other health disciplines that similarly had not developed strategies to address the concerns. I was so disturbed by the manner in which I was treated at that meeting that I later requested to resign from the committee.

46. Following the Patel issue being leaked to the politician in March 2005, Nursing Officers 3, 4 & 5 were asked to meet in the Executive Conference Room with the acting Director of Nursing Deanne Walls. The District Manager Peter Leck attended the meeting and was obviously extremely angry and accusatory in his tone. I was offended by the ease in which he blamed nursing staff for this leak. He told us that he had heard from a number of reliable sources that nurses were responsible. I resented being accused of such behaviour and felt powerless to be able to defend myself and my peers. I was concerned that if nurses were made the scapegoat for this situation, then nurses in the future would be very reluctant to advocate for the patient. I was also very annoyed that the District Manager continued to report to the media that it would be difficult to recruit other doctors now, implying that Bundaberg nursing staff are in the habit of making malicious claims against medical staff, and that he expected that we would act this way again.

47. The Minister for Health Mr Nuttall and the Director General of Queensland Health Dr Buckland visited Bundaberg on 7 April 2005. They addressed the staff at Bundaberg Base Hospital and they too took a similar line to that previously taken by the District Manager. I was very offended and upset by their comments and aggressive tone. I believed their visit inflamed and upset many staff. It is my recollection that they said were words to the effect that *"we have just been to Springsure and what a great place that is, and now we have to come to Bundaberg"*. I believe that we, the nurses, were being punished for what had happened and were being characterised as troublemakers and responsible for the bad situation in Bundaberg. We were told due to the leak to the media the outcome of the Clinical Audit conducted by the Chief Health Officer Dr Fitzgerald in February 2005 could not be released.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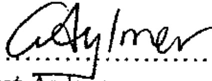
Signed: Gail Margaret Aylmer

Date: 24/5/2005

I, Gail Margaret Aylmer, do solemnly and sincerely declare that the content of this my statement for the Bundaberg Hospital Commission of Inquiry (this declaration being at the foot of the last page of the statement comprising 19 pages) is true and correct to my knowledge and belief and I make this solemn declaration conscientiously believing the same to be true and by virtue of the provisions of the *Oaths Act 1867*.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Gail Margaret Aylmer

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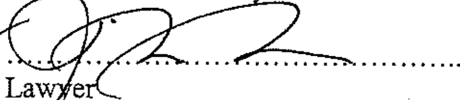
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Lawyer

Date: 24 May 2005