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STATEMENT OF LINDSAY ZIGRID DRUCE of address know to the Queensland Nurses' Union of Employees

Qualifications and experience

1. I am a Registered Nurse licensed to practise in the State of Queensland. I have been registered since 1986. I was a general nurse for 3 years from 1983 to 1985 before becoming qualified.

Patient names

2. In this statement, in the interests of protecting the privacy of patients and the feelings of patients' 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.

Background

3. I am employed by Queensland Health as Clinical Nurse (NO2) in the Renal Unit at the Bundaberg Base Hospital. I have been in the Renal Unit for 8 years. The Renal Unit cares for haemodialysis patients and peritoneal dialysis patients and we provide a follow up service for transplant recipients. I am the peritoneal dialysis nurse. On average we have 8 to 10 peritoneal dialysis patients at any one time. My Nurse Unit Manager is Mrs Robyn Pollock. The permanent Renal physician is Dr Peter Miach, however, in our nursing roles we liaise with other doctors within the hospital.

Review of Peritoneal Dialysis Patients

4. I was on maternity leave from November 2002 to November 2003. Mrs Mandy McDonald (Acting NO2) relieved in my position whilst I was on maternity leave. I returned from leave and it was during the handover with Mandy McDonald that I discovered there were problems with patients' peritoneal catheters. I reviewed all the patients' charts, including their surgical notes to see where patients were having problems. As the patients came in, I physically reviewed their catheter exit sites for infections and checked the external position of their peritoneal

catheters. In my opinion, every patient that had a peritoneal dialysis catheter placed by Dr Patel in 2003 had complications, with acute and chronic infections, migration of catheters requiring further surgery, and incorrect external positioning of the catheters. In December I raised my concerns with Dr Miach and began to pull together my findings in a report.

5. Sometime after speaking to Dr Miach, I approached Dr Patel while he was in the Renal Unit seeing another patient, to raise concerns about the positioning of the renal catheters and in particular the external tunnelling of the catheter. I was hoping to deal with the catheter placement problems informally. He was very dismissive when I raised these concerns and responded "I'm the surgeon" and walked out of the unit. He made me feel that I was stepping out of my place. I felt that this wasn't good enough so I continued to compile my findings so I could clearly show that there was a problem that needed addressing.

Death of Patient P30

6. P30 died on 17 December 2003. He was undergoing surgical intervention to address the migration of his peritoneal catheter. He died as a result of haemopericardium due to perforated thoracic veins during the insertion of a permacath by Dr Patel during the same operation to address the migration of the peritoneal catheter. I am of the opinion that P30 would not have needed a permacath inserted during the operation if the peritoneal catheter had been positioned correctly in the first place. The death of this patient concerned me greatly as to my knowledge no other patient has died at the BBH due to the insertion of a permacath.

7. I spoke to Dr Miach about the death of P30 sometime in January and as I had finished my report, I presented that to Dr Miach. Dr Miach responded that he would not allow Dr Patel to operate on any of his patients anymore. That became the case. My concerns at this stage were that the Peritoneal Dialysis Service could not continue to operate out of BBH as we had no surgeon to place the catheters if Dr Patel did not place the catheters, and the patients would need to go to the Royal Brisbane Hospital, which had a waiting list. Patients would have to

travel and I was concerned we would be asked why catheters could not be placed at the BBH. Due to the impact of Dr Miach's decision, as it had far reaching consequences, I felt the executive needed to know.

Peritoneal Dialysis Report

8. After returning to work in November 2003, I had compiled the bulk of my report by January 2004. The report (attached and marked LD1) is headed "Peritoneal Dialysis Catheter Placements – 2003". Each entry in this report names the patient, the surgeon who undertook the procedure, the date the catheter was placed, the date the patient presented to me with the problem, and in general the type of problem experienced by the patient, the patient's outcome, and then further detail as to the catheter's position and infection.

9. Dr Patel was the only surgeon placing catheters in 2003. The findings of this report show that with respect to every catheter that Dr Patel placed, the patient experienced complications.

10. The report is in alphabetical order according to patient surname. The column headed "Catheter Problem" indicates generally whether the catheter had migrated, become infected or appeared to have been incorrectly positioned. By "Migration" I am indicating that the catheter had moved internally in the patient and the tail end of the catheter was sitting in the wrong position in the peritoneal cavity. By "Position" I am indicating that the patient had problems in the way the catheter was exiting the skin.

11. With every patient that presented with complications, the external peritoneal catheter exit site was found to be positioned incorrectly. In the report under the column headed "Catheter Position" I have described catheter positioning as being either "upwards" or "side-upwards". It is normal practice and my experience that surgeons place the catheters we use ("swan neck" catheters) so as to face downward to ensure that any fluids and sweat or any infection inside will drain away from the exit site and the catheter. I added this column to describe the incorrect positioning of the catheters. "Downwards" positioning is the ideal, "side-upwards" is problematic and can cause infection, but "upwards" causes the

most problems with regards to catheter infections. If the catheter is facing in an upward facing position, the likelihood of infection is high as infections are able to pool inside the tunnel created for the catheter.

12. In the column headed "Outcome", "Surgical Intervention" means that the patient required surgery to fix the problem relating to the catheter. Other outcomes described in that column detail the type of infection the patient developed and the treatment of it. Where the patient did not die, they received antibiotic therapy to treat infections. I have written "Hernia repair performed privately" in patient P45's Outcome column. This patient was reviewed by Dr Patel, who was not prepared to operate on the hernia. The patient was privately insured, so he obtained a second opinion and had the hernia repaired privately. The catheter remained in place and since then the patient has developed exit-site chronic infection.

13. The column headed "Infection" details the degree of infection the patient experienced. As noted above I have recently become aware that the patient P45 has since had a chronic infection as well, this means four of the six patients have developed chronic infections, and the other two patients have since died.

14. The findings in this report confirmed my concerns.

Management response to the "Peritoneal Dialysis Catheter Placements 2003" Report

15. As noted above, I completed my report and Dr Miach received a copy of this report in January 2004.

16. On the 4 February 2004 I sent an email to my Nursing Unit Manager, Mrs Robyn Pollock, wanting to arrange an appointment with her regarding the Peritoneal Dialysis Service run by the BBH. I outlined my concerns in this email. As Dr Patel was the only general surgeon at the BBH able to place catheters, I wanted to talk to her about Dr Miach's decision not to allow any more catheter placements at BBH by Dr Patel, and what this would mean for the Peritoneal Dialysis Service at the BBH. I had some other concerns I wanted to discuss with her that were unrelated to the adverse catheter related events. We had this meeting not long

after I sent the email. Robyn Pollock was also concerned with these findings and she made an appointment for both of us to see the Acting Director of Nursing.

17. On the 10 February 2004, Robyn Pollock went with me to see the Acting Director of Nursing, Patrick Martin. I brought with me my report, discussed the decision Dr Miach had made that Dr Patel was not to do catheter placements, and spoke of my concerns regarding the long term prospects for the Peritoneal Dialysis Service. The purpose of the meeting in my mind was to ensure that the Acting Director of Nursing knew that Dr Miach had refused to let Dr Patel operate on his patients. I also wanted to know what we could do for patients that needed catheters placed as they would now be required to go to the Royal Brisbane Hospital. I wanted to know what support the hospital could provide for these patients.

18. Patrick Martin said he would take the findings from the report and our other concerns to Peter Leck and Dr Darren Keating. I do not recall receiving any feedback with regards to my concerns from Patrick Martin, Peter Leck or Dr Keating.

Peritoneal Dialysis Catheter Access Program

19. I was so concerned about the problematic catheter placements and the future of the Peritoneal Dialysis Service that, sometime in March 2004, I spoke to the representative for Baxter, Mr Brian Graham. Baxter is the medical supply company used by Queensland Health. Baxter currently holds the contract to supply almost all of the fluids which are used in peritoneal dialysis.

20. We spoke about how the problems could be resolved and Mr Brian Graham suggested that he could approach Dr Patel to offer training in Brisbane as to catheter placements. I was told that Robyn Pollock that Mr Graham had approached Dr Patel and Dr Patel appeared to be more interested in being wined and dined by the medical supply company. This response apparently disgusted Mr Graham and the offer of training Dr Patel was not followed up. Other solutions were sought.

21. On 18 March 2004, Brian Graham, Robyn Pollock and me had a meeting to discuss options for the Peritoneal Dialysis Service. Brian told us of a similar program that Baxter was running in WA. He suggested that he could talk to Baxter management to see if a similar program could be offered to us. I asked Brian to suggest a similar program for the BBH to Dr Miach, as I felt that it was the best approach rather than Robyn and myself speaking to Dr Miach about it.

22. On 29 April 2004, Brian spoke to Dr Miach about the program and my understanding is that Dr Miach thought it was a good idea and presented the program to the executive around the end of April or early May 2004. I was not involved in the presentation of this program to the executive team, or how Dr Miach got agreement from the executive to run this private program. I was surprised that the executive allowed the program to go ahead because they hadn't addressed the issue as to what had caused the problem in the first place, and the hospital was outsourcing a function that it had always provided. But in the circumstances, I was happy as a solution had been provided for our patients.

23. Attached and marked **LD2** is a copy of an email sent by Brian Graham from Baxter to my NUM, Robyn Pollock and me, which contains the text of an offer sent by him on behalf of Baxter to Dr Miach.

24. If a patient does not have a peritoneal catheter inserted, they must come into the hospital on a regular basis for a different type of dialysis, haemodialysis. Baxter had the state contract to supply almost all of the consumables required for peritoneal dialysis such as fluids. The consumables costs approximately between $2000 and $3000 per month per patient. I know this because I sign off on the invoices from Baxter each month. The consumables associated with haemodialysis come from many medical supply companies.

25. On the 15 June 2004, I attended a meeting at the Friendly Society Hospital, Bundaberg. All interested parties were in attendance. Attendees included Dr Darren Keating, Dr Miach, Robyn Pollock, and myself from the BBH. From Baxter three representatives attended, Brian Graham, Donna Williams, and Trevor Barnett. From the Friendly's, Alan Cooper, Dr Thiele and Dr Merefield attended.

Dr Hanelet, Director of Medical Services attended from the Hervey Bay Hospital as Dr Miach wanted to provide this service for his Hervey Bay patients.

26. The purpose of the meeting was to look at how the Peritoneal Dialysis Catheter Access Program would be run and to talk about any concerns. The agreement that came out of the meeting was that Baxter was to pick up all out of pocket expenses for the patient, that is the gap, the surgical fees and the bed fees. Friendly's would invoice Baxter directly. On referral from Dr Miach, it was then up to Dr Theile to identify it was a Peritoneal Dialysis Catheter Access Program patient to the Friendly Society Hospital when he first saw them. Through this program, BBH patients are effectively getting private health care funded by Baxter. The BBH provides the catheter and consumables, and pre and post operative follow up of the patient. The patient either returns the next day to the BBH or is discharged home.

27. Attached a marked **LD3** is a copy of a letter dated 9 September 2004 sent by Dr Keating to Baxter (which was copied to my Nurse Unit Manager, who gave me a copy) accepting Baxter's offer.

28. The results of the Peritoneal Dialysis Catheter Access Program have been positive. We have had good external positioning of the catheters, no catheter migrations and a reduction in infection rates.

Sexual assault on the patient P23

29. One other issue that I feel needs to be raised in my statement is the lack of management response to an alleged sexual assault on the patient P23.

30. P23 was admitted to hospital in October 2003 with deep vein thrombosis. At the time P23 was on peritoneal dialysis, and she would have continued dialysing in hospital. This is a daily continuous dialysis which she usually manages at home. On average I would see her every one to two weeks, which is how I came to know this patient.

31. On 17 March 2004, she came to see me regarding being sexually assaulted by a doctor. This was the first time she had mentioned this incident to me. She was distressed and crying when she told me about the incident.

32. P23 said that a doctor had pulled down the sheet of her bed to examine the condition of the calf affected by the deep vein thrombosis. She said he ran his fingers up the inside of her leg and touched her vagina and continued down the inside of her other leg. She said she immediately knew that this was not right and was very upset. She told she spoke to a nurse and reported the incident through the nurse manager. An incident report was hand written and then signed by P23. The incident report was then sent up to executive. P23 was not given a copy of it. She told me that she went with her partner to the police to report the incident, but she was unable to say which doctor it was that had assaulted her.

33. She asked me to find out which doctor it was so she could report that to the police. At that time the police wanted her to make a statement. I told her I couldn't access her chart and get that kind of information without going through the appropriate channels and that she needed to sign a Freedom of Information release to get a copy of her records. I took her to admin where she did the requisite paperwork and she later obtained a photocopy of a section of her chart. The doctor was Dr. Trek Karesh. I asked P23 what feedback she had received from the hospital. She said there was none.

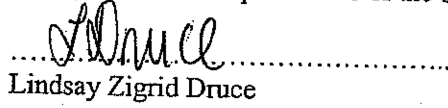
34. Sometime after 17 March 2004, P23 told me that she had made a statement to the police. The feedback from the police was that the doctor had since fled the country. I asked Dilys Carter, Nurse Unit Manager of the medical ward about the incident. She said that she had seen the incident report and that it had been sent to executive and that Dr Darren Keating had come to the medical ward to see the patient about this. Dilys did not accompany Dr Keating, and does not know if he actually spoke to her.

......[signature]......................

Signed: Lindsay Zigrid Druce

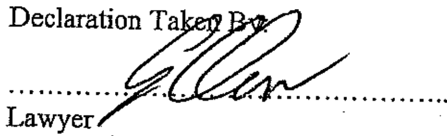
Date: 18/5/05

I **Lindsay Zigrid Druce** do solemnly and sincerely declare that the content of this my statement for the Bundaberg Hospital Commission of Inquiry (this declaration being at the end of the statement on page 9.) is true and correct to the best of 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*.



Lindsay Zigrid Druce

Declaration Taken By:



Lawyer

Date: 18/5/05

Peritoneal Dialysis Catheter Placements - 2003

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

LD2

From: <brian_graham@baxter.com>
To: <Robyn_Pollock@health.qld.gov.au>, <Lindsay_Druce@health.qld.gov.au>
Date: 29/04/2004 5:03pm
Subject: Baxter Healthcare Pty Ltd - Catheter Access Program

Robyn / Lindsay

Please find attached the original email that I sent to Dr Peter Miach.

I shall talk with you soon in relation to the program. Alternatively, please contact me if you require any further information.

Regards

Brian J Graham
Renal Product Specialist (QLD)
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25 Murdoch Circuit
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www.kidneydirections.com

"European APD Outcome Study: Anuric PD Patients - APD & EXTRANEAL"

----- Forwarded by Brian Graham/SHS/SP/Baxter on 29/04/2004 04:48 PM -----

Brian Graham
29/04/2004 04:47 PM

To: peter_miach@health.qld.gov.au
cc:
Subject: Baxter Healthcare Pty Ltd - Catheter Access Program

Dear Dr Miach

Thank you for speaking with me this morning in relation to Baxter Healthcare's Catheter Access Program for Bundaberg / Hervey Bay.

As per your request, below I have provided you with an informal overview of the program.

The aims of the program include:

To provide a value added service to Renal Units and Patients.
Enable timely commencement of treatment resulting in improved clinical outcomes. Gorriz J.L et al. (2002). "Spanish Multi-Centre Study - Prognostic Significance of Unplanned Start Dialysis".
Provide a dedicated resource eg: Surgeon - Theatre access
Viable Peritoneal Dialysis catheters

The Program at a Glance:

Public patient identified for Peritoneal Dialysis (PD) Catheter placement.
Public patient admitted to designated Private Hospital.
PD catheter placed in theatre by surgeon and anaesthetist.
Patient then discharged (Same day case or Overnight stay)
Patient then followed up by referring Renal Unit.

Baxter Healthcare will cover the cost of :
Private Hospital Bed Accommodation for 1 night
Theatre Costs for the procedure
Pharmacy related cost for the patient admission

Medicare will pay 75 per cent of the Medicare Schedule fee for services and procedures provided by the surgeon / anaesthetist. If the nominated practitioners (Surgeon / Anaesthetist) charges more than the Schedule fee, Baxter Healthcare will pay any charges in excess of the scheduled fee (The GAP).

There is NO cost to the patient.

I look forward to speaking with you next week to identify the stakeholders.

Baxter Healthcare will need to have an understanding of the total costs of the program (eg: GAP's, Private Hospital Accommodation fees etc) to ensure the program is a viable option for Baxter and for your Renal Service. I will attempt to ascertain the costs for the private hospital before we speak next week.

If the program is viable for both parties, Trevor Barnett (Regional Manager Baxter Healthcare - Queensland) and myself will visit Bundaberg on Tuesday, 11th May 2004 to meet with yourself and the stakeholders, and formally present the program for discussion.

If you require further information on the Catheter Access Program prior to our meeting, please do not hesitate to contact me on 0417 265 859.

I look forward to your reply.

Regards

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LD3

Executive Services
Bundaberg Health Service District

Enquiries: Queensland Health Dr Darren Keating
Telephone: 4150 2210
Facsimile: 4150 2029
Our Ref: DK:jaw

9 September 2004

Mr Trevor Barnett
Regional Manager – QLD
Baxter Halthcare Pty Ltd
PO Box 6122
ACACIA RIDGE DC QLD 4110

Dear Mr Barnett

RE: Baxter Tenchoff Access Programme

I write in reply to your letter dated 21st June 2004. Please accept my apologies for the delayed reply. I am please to accept the offer as outlined, on behalf of Bundaberg Health Service District.

As discussed at the meeting, Dr Miach understood that in the unlikely event of the Tenchoff Catheter requiring repositioning or revision the Baxter programme would also cover such instances. Would you please confirm this understanding?

Bundaberg Health Service District would be happy to commence the programme as soon as possible. Dr Miach and/or Ms Robyn Pollock Nurse Unit Manager Renal Unit are your initial points of contact.

Yours sincerely

Dr Darren Keating
Director of Medical Services

Copy: Dr Peter Miach
Ms Robyn Pollock