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STATEMENT OF PETER LECK

DATED 11th **DAY OF** May **2005**

Qualifications and Employment History

1. I hold a Bachelor of Health Administration degree, awarded by the University of New South Wales in 1987.

2. I am an Associate Fellow of the Australian College of Health Service Executives.

3. From November 1986 until early 1991 I was engaged as a management trainee by the Hornsby and Ku-ringi-gai Health Service. This position involved acting in various management and administration capacities at a number of public health facilities.

4. From 1991 to October 1992 I relieved Chief Executive Officers and Deputy Chief Executive Officers at Grafton Hospital, Wauchope Hospital and Rylstone Hospital.

5. From November 1992 until June 1998 I was engaged as District Manager (originally called Sector Executive Officer) at the Mt Isa Health Service District.

6. From June 1998 to the present I have been employed as District Manager at Bundaberg Health Service District.

Role of District Manager

7. In the Queensland Health system the District Manager is the person who oversees and monitors all the public health services provided in the district. This involves:

   - Implementation of corporate policy and strategy;
   - Development of policies and strategies specific to the health service needs of the local community, within the framework of the corporate objectives;
   - Management of resources and patient activity within corporate targets;
   - Development and maintenance of appropriate systems and structures to manage service delivery;
   - Ensuring that local systems and policies are consistent with corporate guidelines and priorities;
   - Supervision of the management aspects of the executive team including the Directors of Medical Services, the District Directors of Nursing, the

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Directors of Community and Allied Health, Directors of Corporate Services, and Quality Co-ordinators.

8. Bundaberg Health Service District encompasses the following public health services:

   - Bundaberg Base Hospital;
   - Gin Gin Hospital;
   - Childers Hospital;
   - Mt Perry Health Centre, which is an outpatient health clinic staffed by registered nurses and visited by other clinical services; and
   - Community Health facilities located at the Bundaberg Base Hospital campus.

9. In addition to the general aspects of operating the health service district, during my time as District Manager, but particularly during the 2003 to 2005 period, I was involved with the following additional projects or issues:

   - A major review of the efficiencies and costs of the Operational Services;
   - A review of the Mental Health Services;
   - Redevelopment of the Gin Gin Hospital; and
   - Implementation of the Queensland Health Integrating Strategy and Performance Program.

Management Structures

10. The following mechanisms existed in order to establish governance & management. Some of these I introduced to Bundaberg Health Service District:

    - *Mortality & Morbidity Committees or "Erromed".* These were clinical audit committees, which reviewed individual cases to ascertain whether appropriate clinical standards have been applied and to develop improved service standards.

    - *Clinical Service Forums.* These committees met on a monthly basis and involve participants in various clinical interest groups.

    - *Executive Council.* These meetings created a forum for discussing the overall administration and management of the district health service.

    - *Improving Performance Committee.* The function of this committee was to review a variety of performance and management indicators.

- *Medical Staff Advisory Committee.* This committee provided an avenue for medical staff to contribute to policy and planning, to raise issues of concerns, and share information in relation to both management and clinical issues.

- *"Level 3, 4, 5, & 6" Committee.* The purpose of the meetings was to provide nurses with a forum similar to that which the Medical Staff Advisory Committee provides for doctors.

- *Incident Reporting System.* There was an incident reporting system in place that is consistent with Queensland Health policies.

- *Sentinel Event Reporting.* Queensland Health recently introduced a policy for reporting and managing sentinel events.

11. I attend many of the management meetings mentioned above regularly. At no time other than the occasions discussed below did any person indicate to me that Dr Jayant Patel's clinical skills were questionable. I am not a clinician and am not qualified to assess clinical competence nor am I qualified to analyse clinical data. However, I am able to identify trends in clinical data that may suggest the need to investigate further. None of the clinical indicators that I have seen indicate anything significantly out of the usual with Dr Patel's clinical performance.

12. As I have said, I am not a clinician so throughout my career I have relied very heavily on my directors of medical services to take care of matters dealing with clinical competence.

September 2003

13. I recently located an email that Ms Hoffman, Nurse Unit Manager for Intensive Care, sent to Glennis Goodman, the former District Director of Nursing in September 2003. This email dealt with concerns in relation to a particular patient. Ms Goodman sent the email to me. I do not recall receiving the email or what happened at the time. I can say, however, that this is the sort of isolated clinical issue that I would expect my Director of Nursing and Director of Medical Services to address.

March 2004

14. In March 2004 Ms Goodman retired and the Position of District Director of Nursing (DDON) was vacant. Ms Toni Hoffman was acting as the DDON for a

period of one or two weeks in March. I am uncertain of the exact dates but it was early or mid March.

15. Towards the end of her time as Acting DDON Ms Hoffman came to see me. She handed me a letter in which she raised some issues regarding Dr Patel. Ms Hoffman said "I want to talk to you about Dr Patel. It's about his behaviour". She then gave me the letter.

16. I no longer have a copy of the letter and I do not have a very clear recollection of its contents. However, so far as I can recall it principally dealt with Dr Patel's behaviour.

17. Either before I read the letter or immediately afterwards she said "I wanted to see you about this but I don't want you to take it further". I asked Ms Hoffman several times whether she wanted me to take action in relation to the issues raised. She was adamant that she did not.

18. I had a practice of meeting on a weekly basis with each of the various directors. I put a copy of Ms Hoffman's letter in "bring-up" files I kept for both Dr Keating and the new incoming DDON, Linda Mulligan.

19. Ms Mulligan started work on 17 March 2004. I spoke to her about Ms Hoffman's letter at our first meeting.

20. Ms Mulligan told me that she had spoken to Ms Hoffman during their "handover" meeting and that Ms Hoffman had told her that she had met with me to discuss the behavioural issues associated with Dr Patel. Ms Mulligan also said that Ms Hoffman had told her that the matters she had raised "were not important" and she would discuss them at a later time. Ms Mulligan said she would meet with Ms Hoffman again to discuss strategies to manage Dr Patel's behaviour.

21. I retained the copy of the letter on the "bring-up" file for my meetings with Ms Mulligan for two reasons. Firstly, I wanted to be aware if Ms Hoffman raised her concerns again with the DDON. Secondly, I wanted to monitor any ongoing issues concerning Dr Patel's behaviour.

22. Some time later, Ms Mulligan made reference to the fact that she had spoken to Ms Hoffman about managing Dr Patel's behaviour. I cannot now recall whether she gave me any detail about their discussions. I would not usually expect a DDON to provide me with the fine details of these sorts of discussions. I do recall that Ms Mulligan indicated to me that there were no clinical issues about Dr Patel and Ms Hoffman's concerns were purely in relation to his behaviour.

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23. I had also put a copy of Ms Hoffman's letter in Dr Keating's "bring up" file but did not speak to Dr Keating until after I had spoken to Ms Mulligan. I remember that ultimately I did not discuss the matter with Dr Keating during a routine weekly meeting. I cannot now recall the reason for doing so but I took the letter to his office and indicated that Ms Hoffman had spoken with me about Dr Patel.

24. I gave Dr Keating a verbal summary of the letter and showed it to him, pointing out the matters about which I was concerned. I indicated to Dr Keating that Ms Hoffman had said she did not want the matters she had raised pursued.

25. Dr Keating said that in his opinion the problem was entirely related to a personality conflict.

26. Ms Hoffman did not raise the issue again with me and I heard nothing further in relation to the matter from either Dr Keating or Ms Mulligan.

Dialysis Patients

27. A document entitled "Peritoneal Dialysis Catheter Placements – 2003", listing six patients who had undergone catheter placement and had developed associated complications appeared on my desk at some time between January and June 2004. I have no idea who put the document there. Dr Patel was listed as the surgeon in relation to each of the cases mentioned.

28. I did not know how many catheter placements were done at Bundaberg Hospital during the year and what proportion of those patients this document represented. I was concerned by the contents of the document as some of the patients had died, presumably from their complications.

29. The matters in the document were, however, clinical so I took the document to Dr Keating to ask him whether he was aware of it and whether there was cause for concern. I do not remember the details of the conversation but he said he did not think there was cause for concern. He said that renal patients often have significant co-morbidities and that some complications are inevitable. At the end of the conversation I was reassured that Dr Keating was aware of the circumstances associated with these patients and that he was not concerned.

30. Shortly after this incident we entered into an agreement, which resulted in all the catheter placements for renal dialysis patients being performed off site by a specialist vascular surgeon.

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Desmond Bramich Case-2 August 2004

31. Desmond Bramich was admitted to Bundaberg Hospital after a caravan fell on him causing significant crush injuries to his chest. He initially seemed to do well but ultimately died.

32. Ms Hoffman prepared an Adverse Event Report and Sentinel Event Report in respect of his death. Ms Hoffman raised a number of concerns but principally she was concerned by the fact that Dr Patel was performing operative procedures and was insisting on keeping patients in ICU beyond the capacity of the hospital.

33. I received copies of these documents through the internal mail system within days of them being completed. I do not know who sent them to me. In the usual course of events I would not normally receive copies of Adverse Event Reports but Sentinel Events Forms would usually be sent to me because I am required to send to send them to corporate office within a certain timeframe.

34. The issues raised in the Adverse Event Report and the Sentinel Event Report caused me concern so I contacted the Quality Co-ordinator. I was told that this case did not constitute a sentinel event within the terms of the specific criteria set out in the Queensland Health Incident Management Policy.

35. Given the advice I received from the quality Co-ordinator, I did not send the Sentinel Event Form to corporate office.

36. I had a discussion with Dr Keating who told me that he had also been speaking with the Quality Co-ordinator. I asked him to conduct an investigation into the Desmond Bramich case.

37. Dr Keating told me that the primary surgeon involved in the Desmond Bramich case was Dr Jim Gaffield. It was Dr Gaffield's decision to wait for a CT scan before considering whether to transfer the patient to Brisbane.

38. I raised the investigation into the Desmond Bramich case with Dr Keating during some of our weekly meetings. He indicated that he had asked Dr Kees Nydham to assist him with some aspects of the investigations.

39. At some time during the investigation process Dr Keating told me that the outcome of the Desmond Bramich case would not have been any different irrespective of the care he received. Dr Keating said that it appeared that there was no major problem with the management of the patient.

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40. Eventually, when I was arranging for the investigation of the other matters raised in Ms Hoffman's letter of the 22 October 2004 and, after discussions with Ms Mulligan, I decided that it would be best if the Desmond Bramich investigation be continued and concluded by the investigators of those other matters. I advised Dr Keating of my decision and he seemed satisfied with it. He indicated to me that there was a Coronial investigation into the case in any event. He said he would not do anything more in relation to the case.

41. As far as I am aware, the Coronial investigation is not complete.

Meeting with Ms Hoffman - 20 October 2004

42. During a meeting with Ms Mulligan on 20 October 2004, Ms Hoffman made a number of comments about Dr Patel's clinical competence.

43. I was not at that meeting. Ms Mulligan came to see me very shortly after her meeting with Ms Hoffman and told me that Ms Hoffman had raised some patient safety issues regarding Dr Patel. Ms Mulligan thought that Ms Hoffman needed to raise the patient safety issues with me. We decided the circumstances were such that we should have an immediate meeting with Ms Hoffman to discuss her patient safety concerns

44. I met with Ms Mulligan and Ms Hoffman at 3.30pm on 20 October 2004.

45. The first thing I made clear was that if Ms Hoffman intended to raise complaints with me I would fully investigate those complaints. She outlined concerns and I made notes of them.

46. During most of the meeting I simply listened and took notes and Ms Mulligan did most of the talking. I was concerned by what Ms Hoffman was saying. Accordingly, I asked her to put her concerns in writing because I needed more detail. I assured her the matter would be externally investigated.

47. One of the issues raised by Ms Hoffman was that some of the nursing staff had been to see Dr Keating with a number of issues regarding Dr Patel and were not happy about the way he had investigated or managed the complaints. For this reason, after discussion with Ms Mulligan, I asked Dr Keating to stop investigating the Bramich case. This was the first time I had any indication that nurses were making complaints about Dr Patel to Dr Keating and were dissatisfied with his response.

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Ms Hoffman's Letter of 22 October 2004

48. On 22 October 2004, I received Ms Hoffman's letter by email. A hard copy followed on 25 October 2004. I sent copies of the letter to both Dr Keating and Ms Mulligan.

49. In her letter Ms Hoffman states that Dr Patel would use my name as "a type of intimidation and threat to the staff". I had no particular relationship with Dr Patel and his opinion would have carried the same weight with me as any other senior member of staff.

50. In her email Ms Hoffman indicated that in the next few days she would also be sending copies of correspondence from other nurses. This additional correspondence arrived 25 October 2004 with Ms Hoffman's letter.

Response to Ms Hoffman's Letter

51. In order to obtain corroboration for Ms Hoffman's allegations Dr Keating and I met with some of the doctors named by Ms Hoffman. The results of these conversations confirmed my conclusion that there were some clinical issues in relation to Dr Patel that needed investigation.

52. On about the 5 November 2004 I met with Dr Keating to discuss what action should be taken in relation to Dr Patel. I told Dr Keating that I intended to arrange for an external investigation. Dr Keating was reluctant to agree to a review because he still considered that the allegations related to a personality conflict and lacked substance. He felt Dr Patel's scope of practice should be addressed in the review but otherwise did not think any immediate action was required.

53. Dr Keating said that if an external review was to be conducted, he thought it was important that it should be conducted by someone with regional experience. From early November to mid December Dr Keating and I made enquiries at various hospitals to ascertain a suitable person to conduct the enquiry. Dr Keating made enquiries at Townsville Hospital while I also made enquiries at Townsville Hospital and at Logan Hospital, and Redcliffe/Caboolture Hospital. I also asked other delegates about a suitable person to conduct the inquiry when I attended a Zonal Forum on 15 November 2004.

54. However, our endeavours were significantly interrupted when, on 16 November 2004, the tilt Train disaster occurred. For the next few weeks my time was almost entirely consumed in dealing with the aftermath of that event and progress in relation to the investigation was consequently delayed. Dr Patel co-ordinated the hospital's surgical response to the disaster.

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55. On 16 December 2004, I spoke with Audit and Operational Review Branch asking for advice in relation to the review. I faxed a copy of the letter from Ms Hoffman.

56. The next day I received an email from Rebecca McMahon at Audit and Operational Review Branch advising that, as the review involved issues of clinical practice, rather than official misconduct, it should be conducted under the auspices of Dr Gerry Fitzgerald, the Chief Health Officer.

57. Accordingly, on 17 December 2004, I telephoned Dr Fitzgerald's office. I was told that Dr Fitzgerald was about to depart on annual leave but that he was aware of the situation and should be able to assist with the review.

58. From 4 to 12 January 2005 I made numerous attempts to contact Dr John Scott, General Manager for Clinical Services. He returned my calls but, unfortunately, at times when I was not available to speak to him.

59. Also during the first week of January 2005 Dr Keating told me that, prior to Christmas, he had spoken with Dr Patel to place limits on the type of surgery he was performing.

60. By 13 January 2005 I was becoming concerned by the fact that we still had no fixed arrangements for the review into the issues raised by Ms Hoffman in October 2004. I sent an email to Dr Scott advising him of my concern with the delay and questioning whether the review should wait until Dr Fitzgerald returned from leave.

61. By this time we had received further complaints in relation to Dr Patel's clinical practices.

62. On 17 January 2005, I had a telephone conversation with Dr Fitzgerald during which he agreed to conduct the review. On 19 January 2005, I sent a memorandum, to Dr Fitzgerald together with a brief of relevant material.

63. On 14 February 2005, Dr Fitzgerald and Ms Susan Jenkins came to Bundaberg Hospital to interview the relevant staff. Dr Fitzgerald expected to complete the review by the end of March.

64. During the entire period when I was arranging for the review of Dr Patel's clinical standards, I had regular meetings with Ms Mulligan so that she could inform Ms Hoffman and others of developments.

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65. Dr Fitzgerald had not completed his review when the issue of Dr Patel's clinical competence was mentioned in parliament. Dr Patel initially resigned but then said that he would take sick leave until his contract expired on 31 March 2005.

66. I was shocked and deeply concerned by revelations in the media that Dr Patel has had restrictions placed on his registration in the United States. I was not involved in his recruitment and was completely unaware of any findings of negligence against him until I read of them in the media.

67. At no time did anyone with the clinical competence to do so tell me that Dr Patel's clinical skills were so poor that he should immediately cease operating.

68. Following the media interest in the mention of Dr Patel in parliament, I had a meeting with the ICU nurses and another with the Level 3 Nurses. I expressed my disappointment that the document in question had been "leaked" prior to the conclusion of Dr Fitzgerald's investigation. I reminded the staff of Queensland Health's values and stated that an investigation was being conducted into Dr Patel's clinical practices and he should be afforded natural justice with respect to that investigation.

69. I did not threaten any nurse with disciplinary action.

70. On about 14 April 2005, I decided to stand aside from my position pending the conclusion of various investigations. I did not have the opportunity to conduct any investigation into how the document had been "leaked".

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Signature of person making statement

PETER NICKLIN LEECK
Name of person making statement
(Please print)

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Signature of witness

Patricia Kirsty Feeney
Name of witness
(Please print)