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QUEENSLAND

COMMISSIONS OF INQUIRY ACT 1950

BUNDABERG HOSPITAL COMMISSION OF INQUIRY

STATEMENT OF DIANNE JOAN JENKIN

1. I, **DIANNE JOAN JENKIN,** Nurse Unit Manager, Surgical Ward, of c/- Bundaberg Hospital, Bourbong Street, Bundaberg, in the State of Queensland, acknowledge that this written statement by me dated 7 July 2005 is true to the best of my knowledge and belief.

2. This statement is made without prior knowledge of any evidence or information held by the Inquiry which is potentially adverse to me and in the expectation that I will be afforded procedural fairness should any adverse allegation be raised against me

Qualifications and Experience

3. I was awarded a Certificate of Nursing (General) from the Maryborough Base Hospital in 1969. I subsequently attained a Statement of Achievement in the Care of the Aged Program from the University of Central Queensland in 1993 and obtained a Bachelor of Health Science (Nursing) from Monash University in 1995.

4. I completed my initial training in 1965 at the Maryborough Base Hospital. I then worked at the Mater Hospital in Maryborough for around 1 year. I then left nursing until 1983.

5. In 1983, I completed an informal re-entry program at the Mater Hospital in Bundaberg and I then gained a position, firstly, as a Level 1 Nurse, then as a Level 2 nurse, and finally as a Nurse Unit Manager, Level 3.

6. I commenced at the Bundaberg Base Hospital in 1995 as a Clinical Nurse Consultant in charge of a surgical ward, which combined managerial and clinical work.

7. In July 2003, my role changed and it became known as Nurse Unit Manager (NUM) and became mostly a managerial role. However, I am involved in clinical matters where the need arises. I have resigned from the role of NUM at the surgical ward, effective from 11 July 2005, due to my decision to retire.

8. Attached and marked **DJJ-1** is a copy of my resume.

9. As NUM of the surgical ward, I am responsible for maintaining ethical, legal and clinical standards in the surgical ward in addition to dealing with rostering and payroll duties. I am responsible for managing the performance of staff of the surgical unit, and that includes conducting staff appraisals and performance improvements programs where necessary.

10. One of my other responsibilities is preparation, monitoring and managing of the budget for the unit.

11. My role also involves attending numerous meetings and committees within the Bundaberg Base Hospital (Hospital) as follows:
    - Anesthetic, Surgical, Pre-Admission and Intensive Care Forum (ASPIC)
    - Nursing Level 3, 4, 5, 6 meetings
    - Continuum of Care Forum
    - Department Heads
    - Product review
    - Nursing Heads of Departments
    - Consumer Participation Sub-Committee

12. My role includes liaising with all members of surgical teams and other paramedic and operational staff involved with the surgical unit, and I am also responsible for mediating disputes between staff, managing grievances and investigating and reporting of complaints in relation to the surgical unit.

13. Within the surgical unit, I am responsible for managing the incident reporting process. That includes taking action with respect to any adverse events which occur in the ward. Whenever an adverse event occurred in the ward, I would complete an Adverse Event form. I would also encourage my staff to do the same thing. I would then do my best to bring the adverse event to the attention of the relevant staff for action and risk management strategies are often implemented by myself and others as a result.

14. I started to keep a copy of all Adverse Event forms that were generated in the surgical ward from February 2004 as a committee was being set up to monitor and implement strategies to manage adverse events in the surgical ward. Incidents such as medication incidents, pressure area data, staff injury, protocol failure, patient injury falls and miscellaneous incidents are recorded on the adverse event forms.

15. The surgical unit has about 25.3 full time equivalence, which equates to a staff of around 30.

16. As the NUM, my direct line of reporting is to the Director of Nursing for the Bundaberg Health Services District. Attached and marked **DJJ-2** is a copy of my position description for the role of NUM as it is currently described.

Treatment of Shannon Mobbs (Patient P26)

17. I first saw Shannon when I came in after the long weekend of Christmas 2004, after a period of leave. Shannon was a patient in the surgical ward and I

understand from the night duty handover report that Shannon had been transferred to the surgical ward from the Intensive Care Unit (ICU).

18. I recall the first time I saw Shannon I inspected his wounds and dressings as he was a serious case and my practice was to involve myself in the more serious cases that presented to the surgical ward.

19. When I saw Shannon's leg, I was horrified at the state of his injuries. I recall his lower leg and foot were very dark and dusty in appearance and were mottled. The whole leg was swollen and the wound in his groin was leaking ooze. Shannon also had massive fasciotomies in the thigh and calf.

20. I recall I was very concerned about the state of Shannon's leg, and I expressed my concern to one of my registered nurses, Michelle Mullins. I recall saying to Ms Mullins words to the effect of 'This boy's leg looks dreadful'.

21. I understand, from my reading of the Trendcare computer system, Ms Mullins had been deployed to the ICU two days before and had been involved in Shannon's care in the ICU. I recall Ms Mullins told me that she had looked after him in the ICU and, to her, his leg looked better than it did then.

22. From the Trendcare diagnosis list, I was aware that Shannon had been in hospital for a while; that he had been returned to theatre after his original surgery and that he had undergone vascular surgery. At this time I was aware that Dr Patel was going on holidays and I subsequently became aware that Dr Gaffield had taken on Shannon's care. From my subsequent review of the progress notes, Dr Gaffield was formally referred the care of this patient on 26 December 2004.

23. In my experience, any patient who had injuries similar to those Shannon displayed upon my first review of him would usually be transferred to Brisbane.

24. After I inspected Shannon's foot, I asked Shannon's mother if I might be able to speak with her privately about her son.

25. I recall I took Shannon's mother into a tutorial room and closed the door.

26. I asked Shannon's mother whether or not she was aware that she was entitled to a second opinion, and that she could ask for her son to be transferred.

27. I again suggested to Shannon's mother that she could ask for a second medical opinion because I considered her son's condition quite serious.

I remember responding to her with words to the effect 'As long as you're happy?', and had my hands outstretched to her, emphasising my question to her.

28. I have been told at an interview with the CMC investigator and a lawyer from the Commission of Inquiry that it has been suggested that I asked this boy's mother to stop questioning the doctors. I deny that this occurred at any time. I say that at all times it my only intention to make sure that this boy's mother was aware of her rights and the rights of her son.

29. I recall from my review of the patient notes that Shannon stayed in the Hospital for several more days after my first review of his injuries.

30. During that week, I also asked the Senior House Officer of Dr Patel's surgical team (whose name I cannot now recall) if Dr Gaffield was reviewing Shannon. I recall the Senior House Officer assured me that Dr Gaffield was doing so.

31. Over the course of the week, I recall Shannon's foot continued to be very swollen and was a dusty navy colour. I recall his whole foot and leg were extremely swollen from the groin down.

32. I recall that around that time Dr David Risson, orthopaedic doctor and house officer, would perform rounds on weekends and was responsible for all surgical patients during these times. From my subsequent review of the progress notes, I understand that Dr Risson liaised with Dr Gaffield and arranged for Shannon's transfer to Brisbane on Saturday, 1 January 2005.

33. I do not recall having a meeting with staff about Shannon, apart from the normal interactions when there is a complex patient in the surgical ward.

Treatment of Gerard Kemps (Patient 21)

34. I do not recall having any personal involvement in the care of Mr Kemps. Mr Kemps was placed in the care of the surgical ward on 19 December 2004, prior to his admission to theatre on 20 December 2004. However, I do not recall being present on the day of his admission as it was a Sunday and I am not rostered to work on Sundays.

35. I was aware that it was planned that Mr Kemps would go to the ICU after his surgery. I became aware that Mr Kemps had deceased within hours of his surgery. I do not recall the source of this information. However, I recall Nurse Tilsed coming to me on or around 21 December 2004 with words to the effect, 'It's terrible; he was wheeled out of here laughing; why did they have to operate so close to Christmas?'

Conversation with Linda Mulligan (Director of Nursing at the Hospital)

36. Sometime during the Christmas and New Year period 2004/2005, I spoke with Linda Mulligan about the concerns of the surgical nursing staff regarding Dr Patel.

37. I recall that Ms Mulligan was in my office in the surgical ward for another reason when I spoke to her about Shannon Mobbs and Gerard Kemps. I recall closing the

door to my office and saying to Ms Mulligan words to the effect of 'Does the Executive know what's going on with Dr Patel?'. I recall Ms Mulligan asking what I meant. I recall telling Ms Mulligan words to the effect that there had been a lot of complications and disasters with his surgeries. I recall specifically mentioning Mr Kemps and Shannon Mobbs, and I recall mentioning that there had been all sorts of other complications, although I cannot now recall the specifics of what I said at the time.

38. I wanted to ensure that the Executive were aware of the problems involving Dr Patel's patients and that the staff felt strongly about the issue. I recall Ms Mulligan telling me that both myself and my staff should put any concerns in writing.

39. At the meeting with Ms Mulligan, I also recall mentioning that some staff (whose names I do not now specifically recall) had mentioned taking their issues to the Health Rights Commission. I recall Ms Mulligan looked horrified and said words to the effect of 'Complaining to the HRC was not the right way to go about it and that the best way was for staff to put their concerns in writing to the Executive'.

ASPIC meetings and wounds dehiscence

40. As NUM I represent the surgical unit at the ASPIC committee meetings. The ASPIC meetings are usually held once a month and discuss various clinical issues that arise, including topics such as returns to theatre, wound infections, complication rates and re-admissions to the Hospital following discharge. However, given the amount of material that had to be covered in the time allowed at each meeting, often it was not possible to cover every topic in detail.

41. I recall in or around April 2004 that I was concerned about the number of incidents of wound dehiscence that had been occurring. It seemed that there was an unusual number of incidents with wound dehiscence, and I was concerned that some incidents of wound dehiscence may not have been picked up by the coders when they were inputting data from the patient charts.

42. My feeling was that there seemed to be a large amount of full wound dehiscence, so I raised the subject at the ASPIC meeting in April 2004.

43. A summary of the discussion in relation to wound dehiscence was made in the meetings of the ASPIC meeting on 14 April 2004. I recall I was nominated as the central person for that all clinical areas to report any incidence of wound dehiscence. Attached and marked **DJJ-3** is a copy of the minutes of the ASPIC meeting held on 14 April 2004.

44. At the meeting, I was directed to gather sufficient data to support the anecdotal evidence.

45. After the ASPIC meeting in April 2004, I examined all of my patient charts from January 2003 until June 2004 to investigate the incidents of wound dehiscence. I recall that, after the ASPIC meeting of 14 April 2004, I also spoke with a staff member, Kaye Ferrar from the District Quality Division Support Unit (DQDSU).

Myself and Ms Ferrar then generated a report that listed all of the incidents of wound dehiscence between January 2003 and June 2004.

46. There was an ASPIC meeting on 19 May 2004. Attached and marked **DJJ-4** is a copy of the minutes of the meeting held on 19 May 2004. The minutes indicate that I was still collecting data on wound dehiscence. However, I was not present at this meeting. Upon reviewing the record of minutes of the meeting, it appears it was stated that I was still collecting data in relation to wound dehiscence. I agree that I was still collecting data at this time.

47. The report was tabled at the ASPIC meeting held on 9 June 2004. The table presented at this meeting was not completed to the extent that now appears on the attachment. I recall it was an outcome of the ASPIC meeting of June 2004 that I was to add certain information to the wound dehiscence report. I subsequently did this, and the completed report appears as the attachment to this statement. Attached and marked **DJJ-5** is a copy of the completed wound dehiscence report.

48. At the ASPIC meeting of June 2004, I recall I supplied a textbook definition of 'wound dehiscence'. Attached and marked **DJJ-6** is a copy of the minutes of that meeting. Attached and marked **DJJ-7** is a copy of the definition that I supplied to the ASPIC meeting.

49. The report I presented at the ASPIC meeting of June 2004 is similar to attachment **DJJ-5** to this statement. The incidents of wound dehiscence included in that report were not exclusive to Dr Patel, and I included incidents of dehiscence that had occurred under the care of all surgeons during that period. Under the column SURG I included a numerical code for the surgeons undertaking each operation that resulted in a wound dehiscence. The key is as follows:
    - 1 – Dr Patel;
    - 2 – Dr Laksman Jakaysarya;
    - 3 – Dr Gaffield;
    - 4 – Dr Kingston;
    - 5 – Dr Thiele;
    - 6 – Dr Wijeraja

50. The wound dehiscence report in its completed form was tabled at the July ASPIC meeting held on 14 July 2004. From my perusal of the records of meeting, I recall that a discussion was held as to the diagnostic relationship groupings which exist to give a common coding to patients with similar conditions. I recall that a discussion was held regarding dehiscence and the co-morbidity of the patients. I recall there was a discussion in regards to the number of abdominal surgeries and dehiscence. I do not recall the specifics of these discussions. It appears from the records of meeting that Dr Patel and Kaye Farrer were to look into the diagnostic relation groupings and to report back to the ASPIC committee at a later date. A copy of the minutes of meeting for the ASPIC meeting on 14 July 2004 is attached and marked **DJJ-8**.

51. At the ASPIC meeting held on 18 August 2004, Dr Patel presented his own report on wound dehiscence. Attached and marked **DJJ-9** is a copy of the minutes of the

ASPIC meeting held on 18 August 2004. Further attached and marked **DJJ-10** is a copy of the report that Dr Patel presented to the meeting on 18 August 2004.

52. The report presented by Dr Patel had omitted the other patients attended to by other surgeons as were shown in my original report. Dr Patel's report showed there were 9 dehiscence of his patients, plus 1 patient with a major complication of a fistula near a colostomy that had to be refashioned and whose length of stay was 70 days as a result.

53. I recall at this meeting that Dr Patel argued that over the two year period the incidents of wound dehiscence were within the expected range. I recall have some concerns about Dr Patel's methodology, as he had compared the data over a two year period and not the 18 month period that I had examined. The period Dr Patel had worked at the Hospital during this period was only 12 to 13 months, due to him starting in April 2003 and going on extended leave in April 2004, until the time of the report. Dr Patel did not produce any scientific data to back up his statements about the wound dehiscences being within the expected range.

54. I recall it was agreed that any wound dehiscence in the future would be documented through the adverse reporting system.

55. I do not recall whether an ASPIC committee meeting was held in September 2004. However, I recall a ASPIC meeting was held on 13 October 2004. A review of the minutes of this meeting shows there was no discussion in relation to the topic of topic of dehiscence and that the item was now closed. Attached and marked **DJJ-11** is a copy of the minutes of meeting of 13 October 2004.

56. At the ASPIC Committee in October 2004, I recall that there was a discussion about forming a morbidity and mortality committee. I recall there had been a lot of complications with patients and the idea of a multi disciplinary morbidity and mortality committee was raised. It was suggested might be able to find out what went wrong and how to improve patient care.

57. I recall that Dr Patel said that he had his own morbidity and mortality program and conducted his own audit. I recall Dr Carter asking Dr Patel what his terms of reference were and who he reported the results of his audits to. I recall Dr Patel avoided these questions. I recall Dr Patel never produced any documentation relating to those audits to the ASPIC Committee.

58. Due to Christmas and the New Year period, I do not recall ASPIC meetings being held in November and December 2004 and January 2005. It appears from the minutes of the meeting that the morbidity and mortality committee was not proceeding, and I cannot recall the reasons for this. Attached and marked **DJJ-12** is a copy of the minutes of meeting for the ASPIC Committee of 9 February 2005.

59. Between August 2004 and upon departure of Dr Patel in April 2005, there were two other incidents of full wound dehiscence of Dr Patel's patients, and I collated a list of these and I included them in a report of serious adverse events from August 2004 to August 2005 to the investigative team headed by Dr Gerry FitzGerald, which I understand was convened this year. Attached and marked

DJJ-13 is a list of these patients and their complications and data related to a patient Judith Taylor. A shorter version of this report and the report submitted by Dr Patel at the August 2004 ASPIC meeting was given to the team of Dr FitzGerald. The full report and Dr Patel's report were given to Dr Woodruff and Dr Wakefield in the course of their investigations this year.

Treatment of Judith Taylor (Patient 163)

60. On 19 January 2004, I recall one of my nurses (CN Jeroen Meerman) asking me to examine this particular patient. CN Meerman said he had found something foreign in one of the patients' wounds. From a review of this patient's charts, it appears that Dr Patel had performed a procedure to drain a collection from this woman some time earlier.

61. I recall that either myself or CN Meerman called Dr Patel to review this patient. I recall some time after, on the same day, Dr Patel returned to this patient. Using a pair of forceps, Dr Patel dug inside a wound separate to the drain wound and moved the forceps around until he appeared to find something in the wound. I recall he then pulled out a cannula, a plastic straw-like object used for inserting drips, from this woman's wound. Dr Patel pulled the cannula out and put it on a dressing tray and proceeded to walk out of the room without any explanation to the patient. The patient was in severe pain during this procedure and it was obvious that she was very uncomfortable when Dr Patel was probing inside the wound with the forceps and removing the cannula. I do not recall whether the patient was given any pain relief during this procedure. I recall after the procedure the patient was given analgesia.

62. I recall the following day I called Dr Patel and said words to the effect that I was really surprised he did not apologise or explain to the patient how such a foreign object could be left inside a wound. I asked Dr Patel to go and explain to the patient what had gone on. I recall Dr Patel saying that he would, however, I am not aware whether he in fact did this.

63. After this event, I completed an accident/incident report form, which is attached and marked **DJJ-14**. I sent the form to the Assistant DON in compliance with the process of notification of adverse events at the time.

64. After this time, in February 2003, a new system specifically providing a form to report sentinel events was implemented. If this incident with the patient had occurred after the implementation of the new system, this incident would have come within the sentinel event risk category.

65. The form appears to show that the Assistant DON referred the matter to the Assistant Director of Nursing, Dr Kees Nydam. It also appears that Dr Nydam states that he saw me in relation to this matter. I do not specifically recall any conversation about this matter with Dr Nydam.

Treatment of Marilyn Daisy (Patient P52)

66. I am aware that Ms Daisy has been a patient in the surgical ward over the course of some years. I recall Ms Daisy underwent a below knee amputation by Dr Patel late last year. The patient charts show Ms Daisy was a renal patient, although I do not recall whether she was reviewed by Dr Peter Miach in the peri-operative period.

67. Ms Daisy had several episodes of care in the renal unit as an outpatient following her discharge as an inpatient. I understand Ms Daisy's wound was reviewed in the weeks following her surgery, by two teams, the surgical team and the renal team. I recall Dr Miach contacted me to say that a consultant in Brisbane had reported to him that sutures had been found in her amputation wound approximately 6 weeks after her surgery. I completed the incident report to record the incident. However, to investigate the matter, and to assist me to complete the form with fuller details, I contacted Robyn Pollock, Nurse Unit Manager from the renal unit, as I felt the system had let us down. Nurse Pollock investigated the matter and responded with an email. Attached and marked **DJJ-15** is a copy of an email from Robyn Pollock to me regarding Ms Daisy. She also sent copies of documents from their renal unit records to show there had been five surgical reviews in the renal unit, at the request of renal nursing staff, up until the day before Ms Daisy's appointment in Brisbane on 1 November 2004. Nurse Pollock stated that staff had been instructed by the surgical team not to remove the sutures. Attached and marked **DJJ-16** is a copy of the adverse event form which I completed in relation to Ms Daisy.

Transcript of Evidence Issues: 20 June 2005

68. I have read the transcript of evidence of Gayle Aylmer to the Commission of Inquiry dated 20 June 2005. At page 1051 there are various suggestions that I was somehow 'controlling' and 'given to sort of semi taking over meeting with her (my) own views about whether doctors got all the lurks and perks and nurses didn't'.

69. I say those allegations and comments are false and baseless and I completely deny the allegations that I was 'controlling', 'given to taking over meetings' or that I ever spoke of 'lurks and perks' or said words to this effect to other staff at any time.

Signed at **Bundaberg** on 7 July **2005**.

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DIANNE JOAN JENKIN
Nurse Unit Manager
Bundaberg Base Hospital