Submissions

Ms Dale ERWIN-JONES

Crown Law
Queensland Government

Department of
Justice and Attorney-General

Your ref:
Our ref: CS5/HEA027/5744/DZP
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Mr David Groth
Secretary
Queensland Public Hospitals Commission of Inquiry
Level 9
Brisbane Magistrates Courts Building
363 George Street
BRISBANE Q 4000

Dear Mr Groth

Submissions in response to Notices of Potential Adverse Findings

I **enclose** submissions on behalf of Drs Fitzgerald, Nydam, Krishna and Huxley, Ms Erwin-Jones, Mr Allsopp and Ms Miller in response to Notices of Potential Adverse Findings (or, as the case may be, Notices of Potential Adverse Findings and Recommendations) given to each of those individuals.

The submissions were drawn by Mr Farr of counsel and settled by Mr Boddice SC.

Yours faithfully

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QUEENSLAND PUBLIC HOSPITALS *COMMISSION OF INQUIRY*

SUBMISSIONS ON BEHALF OF DALE ERWIN-JONES

1. The evidence of Ms Erwin-Jones appears at:

   (a) Exhibit 329 – Statement of Dale Erwin-Jones – paragraph 49;

   (b) Transcript - T5416/16 – 5418/23; 5426/30 – 5429/20; 5432/20 – 5433/20.

2. The evidence of Dr Sean Mullen appears at:

   (a) Exhibit 330 – Statement of Dr Sean Mullen – paragraphs 37 – 39;

   (b) Transcript - T5469/1 – 5471/25; 5805/10 – 5819/55.

3. The evidence of Mr Michael Allsopp appears at:

   (a) Exhibit 456 – Statement of Michael Allsopp – paragraph 4.66;

   (b) Transcript - T7081/1-52; 7082/11-25.

Surgery cancellation

4. Whilst it is correct to say that Ms Erwin-Jones did not **"consult with Dr Mullen or any of the other doctors involved in that surgery"** the evidence clearly shows that the opinion of a relevant doctor was in fact taken into account by her. She was advised by the senior nurse on duty that:

   > **"The anaesthetist had already advised that we shouldn't perform the case because the patient had a chest infection and he believed that the patient should be treated for that chest infection and booked scheduled for Monday."**[1]

5. Ms Erwin-Jones was therefore provided with unambiguous information to the effect that the anaesthetist on duty was of the opinion that it was contrary to the patient's safety for the procedure to be performed that day.

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[1] T5416/44 – 5417/45.

6. No evidence has been placed before the Inquiry that Dr Mullen provided any reasons to the nurse on duty to support the scheduling of the operation on the Saturday.

7. Against that background, Ms Erwin-Jones had information that supported entirely the scheduling of the operation on Monday as opposed to Saturday.

8. Further, Mr Allsopp, the District Manager, was contacted by Ms Erwin-Jones prior to her confirming the duty nurse's decision to not book the procedure for that day. According to Mr Allsopp she provided all relevant information to him and requested his assistance. Mr Allsopp stated that he in fact was the person who confirmed the duty nurse's decision[2]. Ms Erwin-Jones made no mention in her evidence of having such a conversation with Mr Allsopp - apparently having forgotten that it occurred.

9. Given that Dr Mullen had not presented clinical reasons for the timing of the surgery (or at least there is no evidence of that having occurred), this cannot be said to be a situation where Ms Erwin-Jones substituted her own judgment for the clinical judgment of Dr Mullen. She did no more than act upon reliable information provided to her by a senior nurse which originated from the anaesthetist on duty.

10. Evidence has been placed before the Inquiry which proves that the issue of Dr Mullen wishing to perform elective surgery during weekend emergency hours has been the subject of consideration on prior occasions. In the Minutes of two meetings of the Surgical Services Management Advisory Committee (9 December 2002 and 12 March 2004)[3], the following passages appear:-

(a) Minutes of 9th October 2002, paragraph 4.2:

> **"Morgan spoke of the problems with Sean Mullen's doing elective surgery on the weekends. This includes physio cover ...."**

(b) Minutes of 12th March 2004, paragraph 5.4:

> **"Liz Willmott voiced concerns that theatre staff have been called in after hours for cases that could have waited until emergency theatre session. This is resulting in significant overtime for nursing staff as it creates**

[2] T7081/49.
[3] Exhibit 502.

problems with fatigue leave and paying staff double time."

The Minutes reveal that Ms Erwin-Jones was present at both of these meetings.

11. Given that Ms Erwin-Jones was not on duty at the time of this incident, it is unreasonable to expect her to chase after Dr Mullen who was on duty. She was quite entitled to reasonably expect Dr Mullen to contact her if he disagreed with the decision to book the surgery for Monday. She would also be entitled to expect Dr Mullen to contact the anaesthetist on duty to further discuss any clinical disagreement that may have existed between them.

12. Dr Mullen did contact the person who had confirmed the decision to not book the procedure for that Saturday - Mr Allsopp. He discussed with Mr Allsopp his clinical reasons for wishing to perform the surgery that day and provided Mr Allsopp with the name of another anaesthetist who had seen or could see and review the patient. Mr Allsopp took advantage of that information and subsequently spoke to the other anaesthetist before approving the surgery to take place on the Sunday morning. This enabled hospital staff to arrange a reserve emergency team in case another emergency patient arrived at the hospital during the procedure in question.

13. There is no evidential basis to find that Ms Erwin-Jones' conduct compromised the safety of a patient. Ms Erwin-Jones stated in evidence that **"we would never stop a doctor operating if he said it needs to be done"**[4]. Furthermore, insufficient evidence exists to support the contention that that decision had the potential to result in an adverse outcome and resulted in a real risk to the safety of the patient. The only evidence on this point comes from Dr Mullen[5]:

> **"Q: And is it best practice to treat such persons within 72 hours of the fracture?**
>
> **A: 48 - certainly - 48 hours in most of the recent evidence based medicine, 48 hours seems to be the ideal situation, provided there's not a really good contra indication. As I say, we looked at that issue and found there wasn't a contra indication."**

[4] T5427/33.
[5] P5470 L25.

Even Dr Mullen uses such terms as **"<u>most</u> of the recent evidence based medicine"** and **"<u>seems</u> to be the ideal situation"**. He was not asked during his evidence to offer an opinion as to the risk which delaying the surgery might pose.

Conclusions

14. Having regard to all of the evidence, there is no basis to find that Ms Erwin-Jones acted carelessly or incompetently or has been guilty of misconduct. Ms Erwin-Jones gave due consideration to the issue at hand, acted upon the information provided, and sought approval from the District Manager.

15. The making of adverse findings and recommendations against a person has serious consequences, particularly where the potential recipient of the findings is to be the subject of criticism in the context of carrying out workplace duties below an acceptable standard. Here, the evidence establishes that Ms Erwin-Jones performed her duties conscientiously, and in good faith, with the issue of patient safety in the forefront of her mind. In those circumstances, no adverse findings or recommendations should be made against her.