18.

Submissions

Ms Linda MULLIGAN

QUEENSLAND PUBLIC HOSPITALS - COMMISSION OF INQUIRY

OUTLINE OF SUBMISSIONS ON BEHALF OF LINDA MULLIGAN

OVERVIEW

1. The evidence demonstrates that Linda Mulligan performed her duties as the District Director of Nursing ("DDON") of the Bundaberg Health Service District appropriately at all times.

2. There is clear evidence that any issues which were brought to Mrs Mulligan's attention were acted upon by her within her delegation and in a timely manner.

3. Mrs Mulligan gave evidence at the Bundaberg Hospital Commission of Inquiry ("the previous Commission") and tendered a detailed statement with attachments (exhibit 180). Following this, Mrs Mulligan was provided with a letter of comfort signed by David Andrews SC, Senior Counsel assisting the previous Commission, dated 26 August 2005 (attached). The letter is not binding on the current Commission, but it should be noted that the sentiments expressed in the letter were made after the previous Commission had seen and heard the witnesses, including Mrs Mulligan, give evidence and be cross-examined. In those circumstances, the opinions expressed in the letter should, it is submitted, be given appropriate weight.

BACKGROUND

4. Any assessment of the performance of Mrs Mulligan has to be made in the context of the background of issues pre-dating her appointment, the timing of her appointment and the workload attaching to her position consequent upon the management structure inherited by her at the Bundaberg Base Hospital ("the Hospital").

5. When Mrs Mulligan commenced in her position as the DDON on 17 March 2004, it was almost 12 months after Dr Patel had commenced as the Director of Surgery at the Hospital and approximately 6 months after the retirement of the previous DDON, Glennis Goodman in September 2003.

6. Ms Goodman's retirement seemed to coincide with the raising of a proposal that the nursing service be reformed as part of a general ongoing reform process taking place at the Hospital[1].

7. There was a very flat management structure within the Hospital where 25 staff reported directly to Mrs Mulligan on both operational and professional matters. This management structure was not of Mrs Mulligan's choosing but was in place prior to her appointment. In particular, the Assistant Director of Nursing ("ADON"), had been removed from the line management reporting structure prior to Mrs Mulligan's appointment. [2] This had been put into operation by the District Manager ("DM"), Peter Leck, as a result of a suggestion from the then Acting DDON, Beryl Callanan.[3] This meant that all Nurse Unit Managers ("NUMs") reported directly to Mrs Mulligan rather than through the ADON as had occurred previously. This necessarily dramatically increased Mrs Mulligan's workload and level of responsibility[4].

8. In her role as DDON, Mrs Mulligan reported directly to the DM, Mr Leck.[5] In particular, in a situation where there was a question as to the clinical competence of a member of the medical staff, Mrs Mulligan was required to report that issue to the DM, Mr Leck.[6] Mrs Mulligan had no authority to independently investigate such issues nor would it have been appropriate for her to undertake any such independent investigation. Although Mrs Mulligan could and did[7] refer medical matters to Dr Darren Keating, Director of Medical Services ("DMS") for his opinion, she had no authority to overrule or challenge the clinical decisions or judgments made by any member of the medical staff.[8]

---

[1] T.7267: 12-25 (Leck).
[2] Paragraphs 31, 32, 124 and 125, attachment LMM10, statement Mulligan (Exh 180); T:2450: 19 – 21 (Mulligan); T.7267: 47 – 54; T.7268: 23 – 24 (Leck).
[3] T.7267:51 – T.7267:14 (Leck).
[4] Paragraphs 45 and 47, statement Mulligan; T:2450: 33 – 40 (Mulligan); T.7268: 16 - 34.
[5] T.7265: 40 – 43 (Leck).
[6] T.7265: 45 – T:7266: 18 (Leck); para 110, statement Mulligan.
[7] Paragraph 156, statement Mulligan.
[8] T.7266: 20 – 42 (Leck).

9. As DDON and a member of the Executive at the Hospital, Mrs Mulligan was dependent to a large extent on others reporting to her to keep her abreast of developments occurring within the Hospital. There were a number of committees, forums and meetings where such information could be disseminated[9]. At no point after taking up her position in March 2004 and prior to the reporting of the sentinel event involving Mr Bramich in August 2004, were there any issues raised directly with Mrs Mulligan by any person or at any of the committees, forums or meetings she attended alerting Mrs Mulligan to issues of the clinical competence of Dr Patel. As such, it is submitted that there is no evidence suggesting Mrs Mulligan failed to act appropriately.

10. The context in which operational decisions were made by Mrs Mulligan and the remainder of the Executive included budgetary constraints imposed by Queensland Health.[10]

11. It is in the context of the matters raised above that the evidence concerning Mrs Mulligan's response to issues raised and the adequacy of that response must be viewed.

INFORMATION CONCERNING DR JAYANT PATEL, DIRECTOR OF SURGERY

12. Soon after Dr Patel commenced as Director of Surgery, Toni Hoffman, the NUM of the Intensive Care Unit ("ICU"), became concerned about the number of patients suffering postoperative complications following surgery conducted by Dr Patel[11].

13. As at June 2003, Ms Hoffman had concerns about Dr Patel's clinical soundness, but had not yet formed a view that he was clinically unsound[12].

14. In around February 2004, Ms Hoffman became aware that Dr Miach had given instructions that his patients were not to be operated on by Dr Patel. It was Ms

---

[9] See attachment LMM5 to statement Mulligan and generally T.7270 – 7278 (Leck) and Exh 478.
[10] T.7129: 20 – 35; T.7137: 12 – 25 (Leck).
[11] Paragraph 8 statement Hoffman: T.1354: 22 – 30 (Hoffman).
[12] T.1361: 12 – 17 (Hoffman).

Hoffman's evidence that she became aware of this directive first hand at a medical services meeting[13].

15. Ms Hoffman did not recall any specific meeting at which she discussed this directive with Mrs Mulligan[14]. Mrs Mulligan says the matter was not raised by Ms Hoffman as part of the handover from Ms Hoffman as Acting DDON in March 2004 or at all[15].

16. By the time Ms Hoffman prepared the document which is attachment TH10 to her statement (exhibit 4), which she provided to Mr Leck at a meeting in late February 2004, she had formed the view that Dr Patel was clinically unsound[16]. Despite this, Ms Hoffman did not include a comment to that effect in attachment TH10[17], nor did she mention this to Mr Leck in their meeting[18]. Indeed, Ms Hoffman specifically informed Mr Leck (and was adamant) that she did not want him to take any formal action[19].

17. Ms Hoffman, in her capacity as Acting DDON, was careful not to make any adverse comments about Dr Patel during her handover to Mrs Mulligan in March 2004[20]. Ms Hoffman did not raise any issues with Mrs Mulligan concerning Dr Patel at the time of the handover[21].

18. Further support for this view is contained in the evidence of Mr Leck where he acknowledged that Mrs Mulligan had informed him that she had been told by Ms Hoffman at the handover that she had been to see Mr Leck and that there were no clinical issues[22].

19. It is also clear that despite the fact that Ms Hoffman had raised serious events concerning Dr Patel with Dr Keating, Dr Carter, Mr Leck, Ms Goodman, and Mr

---

[13] Para 48, statement Hoffman: T.1370: 38 – 54 (Hoffman).
[14] T.1370: 56 – 58; T.1371: 1 – 14 (Hoffman).
[15] Para 27 statement Mulligan.
[16] T.1378: 17 – 20; T.1379: 1 – 7 (Hoffman).
[17] T.1378: 25 – 27 (Hoffman).
[18] T.1380: 54 – 58 (Hoffman).
[19] Para 53, statement Hoffman; T.1377: 15 – 21 (Hoffman); para 17, statement Leck (Exh 462); T.7215: 55 – T.7217: 50 (Leck).
[20] Para 54, statement Hoffman; T.1381: 10 – 17 (Hoffman).
[21] Para 24, statement Mulligan; T.1381: 44 – 53 (Hoffman).
[22] T.7219: 30 – T.7220: 21; T.7281: 1 – 13 (Leck).

Martin, those events were not revealed to Mrs Mulligan by Ms Hoffman, nor by anyone else.[23]

20. On 11 May 2004, during a meeting between Mrs Mulligan and Ms Hoffman, Mrs Mulligan says that Ms Hoffman did not raise any concerns regarding Dr Patel[24]. When this was put to Ms Hoffman, she said she could not see what was written down for the meeting and could not recall. She said she would probably be prepared to stand by what Mrs Mulligan's notes say (see attachment LMM2, statement Mulligan)[25]. Those notes make no reference to Dr Patel.

21. Similarly, in a series of meetings between 5 May 2004 to and including 8 July 2004, with other NUMs within the Hospital, no issues concerning Dr Patel were raised with Mrs Mulligan[26].

22. On 8 July 2004, Mrs Mulligan met with Ms Hoffman for a routine performance and development assessment.[27]

23. Mrs Mulligan's evidence is that it was during the course of this meeting that Ms Hoffman first expressed concerns about Dr Patel's style of communication and behaviour[28] and although Ms Hoffman was given the option of lodging a formal complaint or grievance against Dr Patel or alternatively meeting with Dr Patel together with Dr Keating and Mrs Mulligan to discuss the issues, Ms Hoffman declined both options[29].

24. Mrs Mulligan's evidence is and Ms Hoffman agreed that, at that meeting, Mrs Mulligan suggested to Ms Hoffman that it might help her skill development to consult a psychologist from the Employee Assistance Service ("EAS") and that Mrs Mulligan gave her a book on dealing with difficult people.[30]

25. It was at this meeting that Ms Hoffman raised the issue of the admission/transfer to ICU and the unit's capacity for ventilated beds. Ms Hoffman told Mrs Mulligan that

---

[23] T 1381: 47-52 (Hoffman).
[24] Para 28, statement Mulligan; T.1381: 55 – T.1382: 24 (Hoffman).
[25] T.1396: 20 – 33 (Hoffman).
[26] Para 105, statement Mulligan.
[27] Para 137, statement Mulligan; T.1411: 1 – 5 (Hoffman).
[28] Para 137, statement Mulligan.
[29] Para 139 and 140, statement Mulligan.
[30] Para 141, statement Mulligan; T.1411: 44 – 54 (Hoffman).

this was an issue that she had discussed with Dr Carter, that there were problems between doctors in internal medicine and those in surgical and that the situation could be improved by updating the existing admission/transfer guidelines. Ms Hoffman also told Mrs Mulligan that there was an existing policy which had been in place for some time to the effect that if there were more than two ventilated patients in the ICU arrangements would be made for transfer and that was because caring for more than two ventilated patients was difficult with the available nursing staff.[31]

26. Mrs Mulligan recalls that Ms Hoffman expressed the view that having a clear and concise updated policy would assist in resolving the communication issues between Dr Patel and herself, although Ms Hoffman said she did not remember the specifics of that.[32] Ms Hoffman agreed with Mrs Mulligan that she would work with Dr Carter (the Director of the ICU) to progress the updating of the admission/transfer policy.[33]

27. This evidence of Mrs Mulligan is supported in every material particular in evidence given by Ms Hoffman during her cross-examination.[34] Ms Hoffman agreed that the meeting of 8 July 2004 may have been the first occasion on which she told Mrs Mulligan of any issues that she had with Dr Patel[35]. Ms Hoffman also indicated that she had agreed with Mrs Mulligan at that meeting that she proposed to work with Dr Carter to progress the updating of the admission/transfer policy of the ICU[36].

28. That this was Ms Hoffman's stated intention as at 8 July 2004 is further supported by the monthly cost centre summary reports submitted by Ms Hoffman as NUM of the ICU. Each such cost centre report is in the same pro forma style with a number of categories required to be completed by the Cost Centre Manager, which in the case of the ICU is Ms Hoffman. On the fourth page into the August 2004 document the following is noted:

---

[31] Para 143 statement Mulligan; T.1412: 1 – 20 (Hoffman).
[32] Para 146, statement Mulligan; T1413: 10 – 20 (Hoffman).
[33] Para 146 statement Mulligan; T.1413: 22 – 27 (Hoffman).
[34] Paras 136 – 148, statement Mulligan; T.1411: 1 – 1413: 48 (Hoffman).
[35] T.1413: 32 – 48 (Hoffman).
[36] T.1413: 22 – 25 (Hoffman).

"5. Quality activities/improvements actioned
Review of ICU/CCU policies ongoing.
Little time for any other activities this month."[37]

29. There are similar entries in the monthly cost centre summary reports for October, and November 2004 and February 2005.[38]

30. On 3 August 2004, Mrs Mulligan received a copy of an adverse event report form and a sentinel event report form from DQDSU relating to the treatment of Mr Bramich. Copies were also sent to Dr Keating and Mr Leck[39].

31. Mrs Mulligan took action as detailed in paragraphs 150 to 161 of her statement. This action, it is submitted, was adequate and entirely appropriate. Mrs Mulligan was not involved and nor could she be in investigating the complaint concerning Mr Bramich. The complaint involved medical issues and hence Mrs Mulligan was not responsible for such an investigation nor was it within her area of expertise or delegational capacity to investigate such a complaint.[40]

32. Although Ms Hoffman gave evidence that Mrs Mulligan did not contact her regarding the complaint concerning the treatment of Mr Bramich prior to Ms Hoffman sending Mrs Mulligan an e-mail of 26 August 2004 (exhibit 21)[41], Ms Hoffman conceded in cross-examination that her recollection was incorrect as she had received an e-mail from Mrs Mulligan on 13 August 2004,[42] informing her of the progress of the investigation of the complaint relating to Mr Bramich.

33. Although it was Ms Hoffman's evidence that she forwarded statements regarding the complaint to Mrs Mulligan over a number of weeks from 3 September 2004[43], in fact only one statement, that of Karen Fox of 2 September 2004, was forwarded to Mrs Mulligan with the balance of the statements being sent by Ms Hoffman directly to Mr Leck[44].

---

[37] Exh 186.
[38] Exh. 186.
[39] Para 149, statement Mulligan.
[40] T.7266: 4 – 22 (Leck).
[41] T.150: 29 – 40 (Hoffman).
[42] Exh. 86.
[43] Para 112 – 114, statement Hoffman.
[44] Para 158 and 161, statement Mulligan; T.1427: 50 – T.1428: 7 (Hoffman).

34. Ms Hoffman conceded that Mrs Mulligan visited the ICU on 18 October 2004 and that they discussed Mrs Mulligan's meeting with the Queensland Nurses Union and that Mrs Mulligan told Ms Hoffman that she was the only person who had raised any issues regarding Dr Patel[45]. Ms Hoffman also conceded that they talked about issues regarding the number of ventilated patients and transfer issues[46] and Mrs Mulligan met with three ICU staff regarding Mr Bramich[47].

35. Mrs Mulligan met with Ms Hoffman on 20 October 2004 but it was Mrs Mulligan not Ms Hoffman who called the meeting[48]. This meeting was to discuss the unresolved behaviour/communication issues concerning Dr Patel together with the option of mediation between the parties[49].

36. It was during this meeting that Ms Hoffman raised serious concerns that she had regarding Dr Patel's clinical competence[50]. Mrs Mulligan's evidence is that this was the first time Ms Hoffman raised issues regarding Dr Patel's clinical competence with her, apart from the incident regarding Mr Bramich[51]. Although initially Ms Hoffman conceded only that that may be the case, she subsequently admitted that this was the first time Mrs Mulligan had heard about these issues from Ms Hoffman[52]. It is submitted that Mrs Mulligan's evidence should be accepted.

37. Shortly thereafter Mrs Mulligan arranged for Ms Hoffman to meet with her and Mr Leck regarding the issues Ms Hoffman had raised at the meeting that day[53]. Mr Leck asked Ms Hoffman to put her concerns in writing[54].

38. Both Mrs Mulligan and Mr Leck seemed horrified at the revelations made by Ms Hoffman at that time[55] and appeared not to be aware of the full details.[56]

---

[45] T.1428: 55 – T.1430: 10 (Hoffman); para 167 statement Mulligan.
[46] T.1430: 12 – 14 (Hoffman); para 169 statement Mulligan.
[47] T.1430: 36 – 38 (Hoffman); para 170 statement Mulligan.
[48] Para 174, statement Mulligan; cf para 120, statement Hoffman; T.1430: 43 – 46 (Hoffman).
[49] Para 175 – 176 statement Mulligan; T.1430: 53 – T.1431: 57 (Hoffman).
[50] Para 176, statement Mulligan, T.1431: 16 – 58 (Hoffman).
[51] Para 178, statement Mulligan.
[52] T.1432: 46 – 49; T.1435: 21 – 33; and T.1437: 32 – 36 (Hoffman).
[53] Para 170, statement Mulligan; T.1432: 51 – 53 (Hoffman); P.7283: 28 – 33 (Leck).
[54] Para 179, statement Mulligan; para 125, statement Hoffman; T.1432: 57 – T.1433: 2 (Hoffman); T.7283: 38 – 39 (Leck).

39. Mrs Mulligan was supportive of Ms Hoffman during both of these meetings[57].

40. Mr Leck, as DM and Mrs Mulligan's line manager, assured Mrs Mulligan that the matter would be dealt with and indicated to Mrs Mulligan that he would progress the complaint[58]. This was entirely appropriate since the complaint being made by Ms Hoffman concerned medical issues and specifically the clinical competence of the Director of Surgery.

41. Mrs Mulligan was on leave from 22 to 31 October 2004 and when she returned from leave, she became aware that Ms Hoffman had sent an e-mail to Mr Leck on 22 October 2004 setting out fully her concerns regarding Dr Patel[59].

42. The action taken by Mrs Mulligan between the time when she returned from leave In October 2004 and until she commenced her leave over the Christmas/New Year period on 21 December 2004, is set out in paragraphs 184 to 187 of her statement.

43. On the day Mrs Mulligan returned from leave over the Christmas/New Year (4 January 2005), she went on walkabout around the clinical areas of the Hospital. When she was in the ICU, she asked Ms Hoffman whether any issues had arisen while she was on leave and Ms Hoffman stated that no issues had arisen in ICU but that she had heard further rumors about Dr Patel from nursing staff in theatre and the surgical ward[60]. In response to this information, Mrs Mulligan took the steps set out in paragraphs 191 - 202 of her statement to obtain details of these issues and refer them to Mr Leck. Again, this activity by Mrs Mulligan, it is submitted was entirely appropriate and timely.

44. Mrs Mulligan met with Ms Hoffman, Ms Jenkin and Ms Doherty on 13 January 2005 and told them that an investigation would be proceeding concerning Dr Patel and reassured them about the process. She also asked them to talk to their staff to see if they had any issues and to tell them that there would be no retribution to staff

---

[55] Para 177, statement Mulligan; T.1434: 31 – 53 (Hoffman); and Exh. 88 (email Hoffman to Callanan 25/10/2004).
[56] T 1437: 20-37 (Hoffman).
[57] T.1435: 16 – 19 (Hoffman).
[58] Para 181, statement Mulligan; para 46, statement Leck..
[59] Para 183, statement Mulligan.
[60] Para 190, statement Mulligan.

who brought issues forward. She requested that they confirm to her that they had done so.[61]. Mrs Mulligan later received confirmation that this had been followed through[62].

45. Mrs Mulligan subsequently received other complaints from various nursing staff regarding Dr Patel. On each such occasion, Mrs Mulligan actioned the complaints appropriately, in accordance with her delegation in a timely manner[63].

CONCLUSION

46. In light of the above demonstrated sequence of events, it is submitted that it can not be fairly suggested that Mrs Mulligan failed to act appropriately on information provided to her concerning Dr Patel.

47. It seems clear that the first occasion on which any comment concerning Dr Patel specifically was made to Mrs Mulligan was 8 July 2004. It is also clear that the information concerned behavioural/communication issues which Ms Hoffman declined to take any further despite being given the clear choice to do so by Mrs Mulligan.

48. When Mr Bramich's complaint was made, Mrs Mulligan became aware that it had been referred to Mr Leck and understood that it was being appropriately investigated.

49. The issue of Dr Patel's clinical competence was not raised with Mrs Mulligan on any occasion before 20 October 2004 (apart from the incident regarding Mr Bramich) and, when it was, it was immediately and appropriately reported to Mr Leck for investigation. Mrs Mulligan was thereafter led to believe, reasonably it is submitted, that the complaint was taken seriously and properly investigated by Mr Leck.

---

[61] Para 204 – 206, statement Mulligan; para 143, statement Hoffman; T.1438: 13 – T.1439: 44 (Hoffman).
[62] Para 207, statement Mulligan; T.1439: 46 (Hoffman); T.2151: 34 – 50 (Gaddes).
[63] Para 217, statement Mulligan.

OTHER ISSUES

Information Contained in Monthly Cost Centre Summary Reports From the ICU Between April and November 2004, ICU Policy on Admission, Discharge and Transfer and Mrs Mulligan's response

50. It is clear that during this period issues concerning the operation of the ICU were raised. These included:

(i) Patients were being ventilated for more than 48 hours;
(ii) The number of hours that patients underwent ventilation in the ICU was increasing during 2004;
(iii) There were occasions when 3 ventilated patients were treated in the ICU at the same time;
(iv) As a consequence of the matters raised in (i) - (iii) above, it could well be inferred that the ICU was operating outside its service capability frame work as a level 1 ICU;
(v) There had been a number of unplanned admissions to the ICU from the operating theatre;
(vi) Patients had been returned to the operating theatre from the ICU on several occasions;
(vii) Patients had been unexpectedly returned to the ICU from other wards on several occasions; and
(viii) Concerns had been raised about the scheduling of large operations and the capacity of the ICU to provide adequate postoperative care for those patients.

51. In addition to the above which relates to the period Aril to November 2004, it should be noted that the Monthly Cost Centre Summary Reports for ICU for 2003 contain the following data:[64]

(i) Ventinated hours (per month) were as high as 587 hours;
(ii) There were many occasions when patients were ventilated for longer than 24 to 48 hours and more than one patient was ventilated at any time;
(iii) 11 patients were readmitted within 72 hours during that year;
(iv) Patients were being ventilated for up to 10 days.

52. This information must have been brought to the then Executive's attention at a time prior to Mrs Mulligan's appointment. It should be inferred that Mrs Mulligan was entitled to believe that these issues were ongoing and being dealt with by the Executive.

53. In relation to paragraph 50(viii) above, during the period April to November 2004, the only issue (apart from the incident involving Mr Bramich) which was brought to

[64] Exh 186

Mrs Mulligan's attention regarding the capacity of the ICU to provide adequate postoperative care in cases of complex surgery was when Ms Hoffman emailed her on 26 August 2004 regarding concerns she had about an impending surgical procedure which was to be performed by Dr Patel. The evidence is clear that Mrs Mulligan dealt with that issue immediately and appropriately by forwarding the email to Dr Keating and seeking his advice on the issue and then responding to Ms Hoffman once she had received Dr Keating's response.[65]

54. As the DDON, Mrs Mulligan had no power to direct Dr Carter (the Director of the ICU) to take any action in respect of any of the issues referred to above[66].

55. In particular, Mrs Mulligan had no ability or capacity to overrule any judgments made by medical staff as to the number of ventilated patients in the ICU at any one time or as to whether such patients should be transferred out of the ICU[67].

56. Furthermore, and generally, issues as to the way in which the ICU operated are essentially issues required to be addressed by the medical staff and it is clear from the evidence that there was a degree of flexibility about what constituted the proper approach[68]. In any event, the Service Capability Framework which was brought into operation in July 2004 was intended to be fully operational within a period of 12 months.[69]

57. The Executive Council, Leadership and Management Committee and Finance Committee addressed generally issues referred from the Clinical Service Forums.[70] All members of the Executive sat on these committees.[71] The individual Clinical Service Forums were established to address in detail, at the clinical level, issues relevant to those clinical areas.[72] The Clinical Service Forum relevant to the ICU

---

[65] Paras 155 and 156, attachments LMM15 and LMM16, statement Mulligan; attachments TH21 and TH22, statement Hoffman.
[66] T.7266: 40 – 52 (Leck).
[67] T.7266: 25 – 35 (Leck).
[68] T.4087: 41 – T.4088: 20; and T.4072: 45 – T.4074: 15 (Carter) and T.6946: 34 – 43 (Keating); paras 29 – 35, statement Carter.
[69] T.3147: 50 – 3149: 3; 3149: 11 - 15 (Fitzgerald).
[70] T.7268: 36 – 7260: 21; T.7275 (Leck).
[71] Exh 478
[72] T.7131: 42 – 7132:11; T.7275 (Leck).

was the ASPIC Committee[73]. Dr Martin Carter, the Director of the ICU, is the Chair of the ASPIC Committee[74]. Executive members of that Committee were Mr Leck and Dr Keating.[75] Ms Hoffman is also a member of that Committee.[76] However, Mrs Mulligan is not a member of the ASPIC Committee.[77]

58. Dr Carter was also a member of the Medical Staff Advisory Committee. The Executive members of that Committee were Mr Leck and Dr Keating.[78]

59. From Mrs Mulligan's point of view, it was clear that issues concerning the operation of the ICU were being raised at the appropriate forums, taken seriously and addressed within the confines of the procedures mandated by Queensland Health[79].

60. At the meeting of the ASPIC clinical forum on 14 April 2004, the issue of the high cost of long term ventilation for patients in the ICU was raised. The comments in the minutes record:

> "Director of Anesthesia/Surgery and Num of ICU + DMS or DNS need to have a proactive meeting about transferring ventilated patients"[80].

61. It is to be noted that nowhere in those minutes is there any suggestion that issues of the clinical competence of Dr Patel were in any way related to the long term ventilation of patients in the ICU. Furthermore, for the period following that meeting and up to the reporting of the sentinel event concerning Mr Bramich in August 2004, there was no mention to Mrs Mulligan in documentary or other form of issues concerning the clinical competence of Dr Patel.

62. Dr Carter, as the Director of the ICU and presumably the person who had the clearest understanding of any difficulties faced by the operation of the ICU and Dr Patel's role in creating those difficulties apparently did not ever, in this period, take action to bring to notice of the Executive issues of clinical competence of Dr Patel.

---

[73] Para 92, statement Carter(Exh 265).
[74] Para 92, statement Carter.
[75] T.7275: 20 – 21 (Leck); Para 94, statement Carter.
[76] Minutes of ASPIC meetings (TH11 which is Exh 81 and Exh 478(H)).
[77] T.7275: 16 – 18 (Leck); Para 95, statement Carter.
[78] T.4034: 30 – 46 (Carter).
[79] See generally minutes of various meetings collected at Exh 478.
[80] The minutes are TH11 to statement Hoffman and Exh 81.

63. In such circumstances, it is difficult to see how Mrs Mulligan could be at all criticised for her role in these events as they unfolded.

64. When the Executive Council met on 3 September 2004, the ventilation hours in the ICU were tabled for discussion and a reference was made to the ASPIC minutes of 18 August 2004[81]. Those ASPIC minutes[82] referred to the staff working long hours and made reference to one sentinel event (presumably that concerning Mr Bramich), from July 2004. Those minutes also record a discussion concerning the ICU category and the fact that the investment by Queensland Health was mainly being made in Brisbane, the Gold Coast and Nambour.

65. Once again, from Mrs Mulligan's view point, one would be entitled to infer that she gained some comfort from the understanding that the issues concerning ICU as they were articulated in various minutes as discussed, indicated an awareness of difficulties and a preparedness to address those difficulties. This is in the context where at no stage was there a connection being made between issues of the clinical competence of Dr Patel and the problems with the ventilation hours in the ICU either from the minutes of the various forums and committees or from staff members reporting issues of concern.

66. At the leadership and management committee meeting of 1 November 2004, the issue of the medical staff advisory committee of 14 October 2004 was raised. It was noted that the DQDSU and NUM ICU had been requested to provide data and that the DM had requested the DDON and DMS to review ICU activity[83]. Dr Keating gave evidence that Ms Hoffman provided data pursuant to that request which data was being analysed by Dr Keating and that he had some assistance in that process from Mrs Mulligan. Dr Keating went on to indicate that the exercise was done separately to the issues concerning Dr Patel even after the complaint of Ms

[81] Exh.478.
[82] Also Exh. 478
[83] Exh 478.

Hoffman of 22 October 2004 since those issues were being separately, and in his view, appropriately investigated by Mr Leck as DM[84].

67. There can be no doubt that as at November 2004, Mrs Mulligan was entitled to believe as mentioned earlier that Mr Leck was undertaking an appropriate investigation of the very serious matters raised by Ms Hoffman in her correspondence of 22 October 2004.

68. Dr Carter gave evidence that the statistics from the ICU which indicated an increase in ventilated hours and the like were taken by him to two forums being the Medical Staff Advisory Committee and the Executive Council. He indicated that the statistics were provided to the meetings as part of his normal report but that he could not remember when he first took the figures to those forums. Dr Carter agreed that the volume of complex surgery performed by Dr Patel contributed to the overtaxing of the resources in ICU but it was not the sole cause[85].

69. Significantly, Dr Carter gave the following evidence:

> "So, are you saying that you did not regard Dr Patel's undertaking complex surgery as a significant factor in the rise of ventilated hours? - Correct.
> So therefore, you wouldn't have voiced any concern to Executive as to the complexity of any surgery he was undertaking? - That is correct.[86]"

70. It is submitted that when the issue concerning the admission, transfer and discharge policy for the ICU was raised by Ms Hoffman with Mrs Mulligan on 8 July 2004, together with concerns about Dr Patel's behaviour and issues concerning communication between the doctors, it was agreed informally between Mrs Mulligan and Ms Hoffman that Ms Hoffman would speak with Dr Carter and they would together seek to update the policies as a way of resolving the then known difficulties involving Dr Patel. That was a not unreasonable approach by Mrs Mulligan to the difficulty in light of what she had been told about the nature of the problem at that time. Had Ms Hoffman revealed what her true thoughts in respect of Dr Patel were as at 8 July 2004, undoubtedly, Mrs Mulligan would have taken further action of the kind she ultimately took when fully informed in October 2004.

---

[84] T.6987: 7 – 6988: 12 (Keating).
[85] See generally T.4034: 30 – 4036: 1 (Carter).
[86] T.4036: 15 – 21 (Carter).

However, she should not be criticised for failing to act in circumstances where she was not given the information to trigger a different response.

71. That is where the matter rested with Mrs Mulligan believing that Ms Hoffman had in fact spoken to Dr Carter (something that apparently did not occur until both Dr Keating and Mrs Mulligan directed Dr Carter and Ms Hoffman respectively to update the policies early in 2005)[87].

72. On the basis of the evidence referred to above, it can not be suggested, it is submitted, that at any stage during the period April to November 2004, Mrs Mulligan failed to take action appropriate to the information she had been given.

Mrs Mulligan's Management Of Nursing Staff

73. It is clear that Mrs Mulligan had a different management style from her last full-time predecessor, Glennis Goodman. Ms Goodman was in the habit of doing second-daily ward rounds which some of the nursing staff seemed to think was more appropriate than Mrs Mulligan's more infrequent unannounced rounds at the Hospital.

74. What is clear however, is that the fact that Ms Goodman was purportedly more accessible did not seem to translate into an ability to inform her as DDON of any concerns in respect of Dr Patel's clinical competence such that action could be taken at an earlier time.[88]

75. There seems to be no basis for an assertion that any perceived difficulty in accessing Mrs Mulligan was a cause for the failure of the difficulties concerning Dr Patel being brought to notice at an earlier time.

76. Mrs Mulligan has dealt in some considerable detail with issues concerning her accessibility at the Hospital[89].

77. Again, this topic must be viewed in the context of the system Mrs Mulligan inherited when she took over as DDON. She had an enormous workload which

---

[87] T.4028: 22 – 48 (Carter).
[88] T.1362: 19 – 1364:3 (Hoffman); para 64 statement Mulligan.
[89] Paras 49 – 72, statement Mulligan.

included the significant task of reforming the nursing stream at the Hospital, a task that it may be inferred did not always endear her to those members of the staff.[90]

78. The sample of nurses whose evidence is before the Inquiry and who were generally critical of Mrs Mulligan's management style could not be said to be representative of the nursing workforce.

79. References tendered on behalf of Mrs Mulligan from those who had contact with her at previous workplaces were supportive of her management style.[91]

80. Ms Hoffman gave an example of an occasion when she claimed that Mrs Mulligan was not accessible but upon closer analysis in cross examination, it was revealed that there were many opportunities at which Ms Hoffman could have availed herself of an audience with Mrs Mulligan if she had so desired[92].

81. To summarise the issues concerning Mrs Mulligan's accessibility:

(i) Mrs Mulligan attended a number of committees and meetings at which the nurses could have raised issues with her;

(ii) Mrs Mulligan was available to meet generally with staff. (At the very first meeting with level 3-5 nurses, Mrs Mulligan made the point that she would be available to see any level 3's on the same day with respect to urgent matters and by appointment otherwise)[93];

(iii) Mrs Mulligan's contact numbers were listed in the Hospital's internal telephone directory and she carried a free set with her which had the same number as used by the previous DDON, Ms Goodman;

(iv) Mrs Mulligan toured the Hospital areas according to the needs of a particular area rather than on a defined roster basis but received reports from the ADON who conducted regular rounds of the Hospital areas;

(v) Mrs Mulligan was available to be contacted by e-mail at any time;

(vi) Mrs Mulligan kept her mobile on at all times so she was always contactable by NO level 3/4/5s, other Executive members and switch.

---

[90] T.7267: 9 – 41 (Leck).
[91] LMM1 statement Mulligan.
[92] Para 189, statement Mulligan; T1408: 41 – 1410:22 (Hoffman).
[93] Minutes (Exh 84)

82. Mrs Mulligan also took steps to ensure that staff were able to raise any complaints or concerns with her. An example illustrating this occurred in Mrs Mulligan's early days in her position on 23 April 2004 when prior to a meeting with nursing staff, she sent out an e-mail inviting them to raise any issues with her[94].

83. Mrs Mulligan also took appropriate steps to impress upon staff the need to properly document incidents within the Hospital to foster a learning and quality improvement environment.

84. To this end, Mrs Mulligan sent an e-mail to all level 3 and 5 nurses that they were expected to attend training on the updated process for documenting adverse events[95].

85. It is submitted that Mrs Mulligan was entitled to believe that the nursing staff generally were a professional body of persons who took their work seriously and performed it with pride and dedication. She was entitled to expect that if they had concerns, they would see it as their professional responsibility to bring those concerns to her notice either directly or via their line manager and she encouraged them to do so.[96]

86. She should not be held accountable for the activities of a small minority who chose for reasons best known to themselves, not to voice their concerns to her so that she could address those concerns in an appropriate and professional manner.

A J MACSPORRAN

Counsel for Mrs Mulligan

26 October 2004

[94] TH 12, statement Hoffman (Exh 4) and T 1395: 19-38
[95] Exh 181 (email of 20/4/04)
[96] Paras 73 and 75, statement Mulligan.

brian bartley & associates
LITIGATION LAWYERS

28 October 2005

BY EMAIL: david.groth@qphci.qld.gov.au

AND BY FACSIMLE NO: 3109 9151

Mr David Groth
Secretary
Queensland Public Hospitals Commission of Inquiry

Contact: Selina Hunt
Email: shunt@bartleylaw.com
Our ref: BDB.SH.8000776

Dear Mr Groth

OUR CLIENT: LINDA MULLIGAN

We enclose supplementary outline of submissions on behalf of our client (which relates to the evidence of Ms Jenner and Ms Doherty from yesterday).

As you will see in the body of the submission at paragraph 4, reference is made to a Ward Work Allocation Report for the ICU for 18 October 2004. As explained in the submission itself, this document was uncovered by our client during the course of her preparation for the making of this submission. The document should, in our submission, be tendered into evidence as it is clearly a relevant piece of evidence supporting the version given by our client when she completed her witness statement dated 8 July 2005. We apologise for the late production of the document but, as mentioned above, our client only discovered the document this morning. The document really speaks for itself but, of course, its authenticity could be confirmed by Queensland Health if necessary.

Please inform us if you do not propose to tender the document into evidence so that we may make further submissions.

Yours faithfully

Brian Bartley & Associates

Level 7 200 Creek Street Brisbane Qld 4000 | GPO Box 428 Brisbane Qld 4001
T +61 7 3831 9400 | F +61 7 3831 9500 | **ABN** 81 343 751 439

QUEENSLAND PUBLIC HOSPITALS - COMMISSION OF INQUIRY

SUPPLEMENTARY OUTLINE OF SUBMISSIONS ON BEHALF OF LINDA MULLIGAN

EVIDENCE OF KAREN LOUISE JENNER

1. Ms Jenner gave evidence that after the meeting on 23 March 2005 with Mr Leck and Ms Walls, Acting DDON, she was frustrated because she had never met Mr Leck previously and he had not offered any support to her regarding her complaint about Dr Patel.[1]

2. In oral evidence Ms Jenner stated that no one in the Executive contacted her regarding her complaint about Dr Patel until she was asked to attend an interview with Queensland Health staff (in connection with the Investigation by Dr Fitzgerald and Mrs Jenkins)[2].

3. Mrs Mulligan did not, at any time, receive a copy of the statement prepared by Ms Jenner concerning the incident involving Dr Patel as the statement was sent by Ms Hoffman directly to Mr Leck.[3]

4. Mrs Mulligan visited the ICU on 18 October 2004 and, while she was in the ICU, she met with three staff, two female RNs and one male RN, who talked about the incident involving Mr Bramich and gave examples of concerns they had about Dr Patel (which, other than the incident involving Mr Bramich which was being investigated, related to Dr Patel's behaviour, not his clinical competence).[4] In preparation for the making of this submission Mrs Mulligan found an official Hospital record which details the staffing of the ICU at the Hospital for the day shift for 18 October 2004 (attached).[5] The report clearly reveals that the two female RNs and one male RN who met with Mrs Mulligan in the ICU on that day were Karen Fox, Daniel Aitken and Karen Jenner. We respectfully submit that the report should be tendered into evidence as being clearly relevant to the resolution of the apparent conflict in the evidence between Mrs Mulligan and Ms Jenner.

---

[1] Para 15, statement Jenner (Exh 508).
[2] T.7391: 25 – 35; T.7393: 5 – 8 (Jenner).
[3] Para 33, submissions Mulligan; Paras 158 and 161, statement Mulligan; T.1427: 50 – T.1428: 7 (Hoffman).
[4] Para 34, submissions Mulligan; T.1430: 36 – 38 (Hoffman); para 170 statement Mulligan.
[5] Ward Work Allocation Report for the ICU for 18/10/04.

5. When it was put to Ms Jenner that she would have been in contact with Ms Hoffman regarding her complaint, she responded that she had asked Ms Hoffman many times if she had heard anything and she had not.[6]

6. It is not correct that Ms Hoffman had heard nothing regarding the complaint about the incident involving Mr Bramich. The evidence is clear that Ms Hoffman did receive feedback regarding that incident and her subsequent complaint concerning Dr Patel which was made in October 2004. The action taken by Mrs Mulligan is detailed in paragraphs 30 to 45 of the outline of submissions of Mrs Mulligan dated 26 October 2005. If the true position is that Ms Hoffman, as Ms Jenner's line manager, did not pass on any feedback received from Mrs Mulligan to Ms Jenner, Mrs Mulligan should not be held accountable for Ms Hoffman's failure.

EVIDENCE OF GAIL YVONNE DOHERTY

7. Ms Doherty gave evidence about elective surgery targets and staffing issues within theatre.[7] She said that she after she raised those matters with Karen Smith, the elective surgery coordinator, she did not receive any other response from the Executive other than the email from Dr Keating (attachment GD1, statement Doherty).[8]

8. It is evident from the face of attachment GD1 that Mrs Mulligan did not receive a copy of that email.

9. Ms Doherty did not raise her concerns regarding the email with Mrs Mulligan.

10. Ms Doherty gave evidence that the Executive would have been given indications of the extent of overtime being undertaken in theatre through reports prepared by the After Hours Nurse Manager and sent to the DDON every morning and in cost centre reports because it would have impacted on fatigue leave, sick leave and the like.[9]

11. Mrs Mulligan spent a lot of time attempting to resolve theatre staffing issues.

---

[6] T.7391: 37 – 39 (Jenner).
[7] Paras 24 – 26, statement Doherty (Exh 509).
[8] T.7403: 12 – 16 (Doherty).
[9] T.7403:26 – 36 (Doherty).

12. Prior to Jennifer White resigning as NUM theatre (which was effective in August 2004), Mrs Mulligan worked with Ms White in relation to theatre staffing.[10]

13. The issue of theatre staffing was dealt with at a number of Committee meetings.[11] In particular, during the course of the Leadership and Management meeting of 24 January 2005, Mrs Mulligan as DDON and Peter Heath as Director of Corporate Services gave an overview of issues concerning the operating theatre. It was reported that discussions had been held with staff regarding workloads and rosters and it was agreed that a review should be undertaken with Dr Keating, the Director of Medical Services, and Mrs Mulligan to advise the Mr Leck, the District Manager, of preferred people to undertake the review.

14. The minutes do not reveal at any stage there being a connection between the theatre staffing issues and Dr Patel.

15. Despite claims that Executive management failed to take appropriate action in respect of theatre staffing issues, there is no evidence that Mrs Mulligan failed to take appropriate action in a timely manner in response to concerns brought to her notice.

A J MACSPORRAN

Counsel for Mrs Mulligan

28 October 2004

[10] Paras 243 – 247 statement Mulligan; T.1299: 13 – T.1304:14 (White).
[11] Exh 478 (Executive Council meetings of 7/5/04, 4/6/04 and 2/7/04; ASPIC meeting of 18/08/04; Leadership and Management meetings of 27/09/04, 18/10/04 and 24/01/05).

Ward Work Allocation Report

Printed: 26/04/2005 11:08:13

Ward: INTENSIVE CARE UNIT
Cycle Date: Day - 18/10/2004

WL	Position	Staff Member	Start Avail Hours	Meal Break	Bed	Patient Name	Pat Req Hours	WL Var Hours	Other Allocated Activity
wl01	RN L1 GS	FOX, Karen	7:30		5	CULLERTON, DOUGLA	10:00	-2:30	
wl02	RN L1 GS	AITKEN, Daniel	7:30		4	DREDGE, CLIVE	4:50	2:40	
wl03	RN L1 CZ	JENNER, Karen	7:30		7	STROHFELDT, CLIFFO	10:00	-2:30	
NA					1				
					2				
					3				
					6				
					8				

Shift Total

Available Hours:	22:30
Required Hours:	24:50
Variance:	-2:20 UNDER

NOTES: This report identifies patients / workload allocated to individual or team nurses for the selected shift.

brian bartley & associates
LITIGATION LAWYERS

31 October 2005

BY EMAIL: david.groth@qphci.qld.gov.au

AND BY FACSIMLE NO: 3109 9151

Mr David Groth
Secretary
Queensland Public Hospitals Commission of Inquiry

Contact: Selina Hunt
Email: shunt@bartleylaw.com
Our ref: BDB.SH.8000776

Dear Mr Groth

OUR CLIENT: LINDA MULLIGAN

We enclose submissions on behalf of our client in response to submissions on behalf of the Queensland Nurses Union and others.

Yours faithfully

Brian Bartley & Associates

SUBMISSIONS ON BEHALF OF LINDA MULLIGAN IN RESPONSE TO SUBMISSIONS ON BEHALF OF THE QUEENSLAND NURSES UNION ("QNU") AND OTHERS[1]

1. At various points in submissions made on behalf of the QNU and others, there is criticism of the "Executive Management" of the BBH for failing to take action in respect of concerns raised about Dr Patel and criticism generally of "management"[2].

2. Although it is not entirely clear, some at least of the references referred to above are impliedly critical of Mrs Mulligan. To the extent that that is the intention of those submissions, such criticism, where it is broadly stated and not referenced to the transcript or exhibits or is otherwise not supported by the evidence, is rejected as unfounded.

3. The submission made that the "failure of the Director of Nursing, Ms Linda Mulligan, to provide effective nursing leadership contributed to the dysfunctional gulf between Executive Management and clinical nursing staff"[3] is meaningless with respect. If what is sought to be conveyed is that Mrs Mulligan failed to act appropriately once in possession of the true facts, then the submission is factually incorrect for the reasons advanced in the primary submission on behalf of Mrs Mulligan dated 26 October 2005.

4. After all, for example, the previous full time DDON, Glennis Goodman, on being told of concerns in relation to Dr Patel's clinical competence in May and June 2003, apparently passed those concerns onto Mr Leck. Ms Goodman is not criticised for failing to do more, nor could she be.

5. Presumably for the same reason, Ms Goodman was never called to give evidence before this or the previous Commission to explain any perceived "failure on the

---

[1] See footnote nos 2 and 6.

[2] See QNU submission 28/10/05, paras 7, 21, 27, 28, 49, 50, 51, 54, 70, 78, 80, 81 and 90; See also Dr Buckland submission 26/10/05, paras 20 and 25(f); Patient Support Group submission, Executive Summary (b)(iv) para 1, (d) paras 2 and 3, para 146, 155, 179, 184 and 185.

[3] QNU submission, para 13.

part of executive management" to take action in response to concerns about the clinical competence of Dr Patel.

6. Indeed, even Ms Hoffman, while she was Acting DDON, did not report her concerns to Mrs Mulligan in February or March 2004 concerning Dr Patel.

7. It is difficult then to understand why Mrs Mulligan should be singled out for criticism when firstly she was not told initially of the true position and secondly when she was informed, she acted immediately and appropriately.

8. That Mrs Mulligan was proactive in following up even a hint of a complaint and supporting the staff involved is revealed in the evidence generally and, in particular, is well illustrated by the events of January 2005 when Mrs Mulligan returned from annual leave to learn of a difficulty that had arisen in her absence with staff from theatre and the surgical ward[4].

9. It is unfortunate that in a submission the QNU no doubt wished to be taken seriously, reference is made in paragraph 22 to the Executive Management exemplifying the "three monkeys" management ethos and, in particular, to Mrs Mulligan as "one of the three monkeys" who would "hear no evil". The only reference given for such an outlandish claim in respect of Mrs Mulligan is to the evidence of Mr Leck[5].

10. There are several points that should be noted[6]:

    (a) Mrs Mulligan gave evidence before Mr Leck and this issue was never raised;

---

[4] Paras 190 - 209, attachments LMM 21, 22, 23 and 24, statement Mulligan; exhibits 147, 148, 149, 151, 152 and 153; attachment TH43, statement Hoffman; T.2151: 34 - 50 (Gaddes).

[5] See also QNU submission, para 43.

[6] These would relate to both paras 22 and 43 of the QNU submission and page 12 of the Queensland Health submission dated 27/10/05.

(b) Mrs Mulligan's instructions on this point (put to Mr Leck in cross-examination)[7] are that there was no mention at the meeting of Ms Hoffman giving Mr Leck a note;

(c) Mrs Mulligan's instructions are consistent with the natural reading and meaning of the email from Mr Leck to Dr Scott of 11 April 2005[8];

(d) The evidence of Dr Keating is consistent with the note being destroyed and not shown to anyone by Mr Leck[9];

(e) Mrs Mulligan had been told by Ms Hoffman, during the handover shortly after Mrs Mulligan commenced as DDON in March 2004, that there were no clinical issues of concern with respect to the operation of the ICU and that she had met with and given Mr Leck the same information;

(f) As at March 2004, Mrs Mulligan had no awareness of any issues concerning Dr Patel. (Ms Hoffman, as Acting DDON, had been careful not to make any adverse comments about Dr Patel during the handover);[10]

(g) Mrs Mulligan's purported response to Mr Leck (that she did not wish to see the note which in her view should have been handed back to Ms Hoffman), is inconsistent with Mrs Mulligan's reaction to information provided to her by Ms Aylmer (which evidence was not even challenged)[11];

(h) It would not have been unreasonable to take a view that such a document should be handed back to the author for signing and dating to make it official and able to be formally acted upon[12].

---

[7] T.7278: 47 - 7281: 16 (Leck).

[8] Exh 317 JG512.

[9] T.7005: 20; Keating submission, paragraph 52, 28/10/05.

[10] Mulligan submission, para 17.

[11] Para 217, Statement Mulligan; T2596: 46 - 48; T.2599:4 - 16 (Mulligan).

[12] Woodruff review, Exh 102, p7, para 15; Exh 497, attachment MS-1 Recommendation 15.

11. In summary, the claim made at paragraph 22 of the QNU submission so far as it relates to Mrs Mulligan is completely without substance and, in those circumstances, is grossly unfair to her and constitutes an unjustified attack on her character and reputation.

12. The general criticisms made in paragraphs 45 - 48 inclusive of the QNU submission have already been appropriately addressed in Mrs Mulligan's earlier submission[13].

13. However, the following should be borne in mind:

(a) In relation to paragraph 46, Mrs Mulligan was on annual leave from 21 December 2004 until 4 January 2005 and was not aware of the death of Mr Kemps until her return from leave. On the day she returned, she went on walkabout of the Hospital and the action she took was entirely appropriate and supportive of staff.[14]

(b) In relation to paragraph 47, whilst it accepted that Mrs Mulligan received information in such reports it is not accepted that the information provides a basis to conclude that Mrs Mulligan should have been more proactive. Reference has already been made to the failure by the reporters of the information to connect that information with issues concerning the clinical competence of Dr Patel and as this being a significant impediment to the ability or need for Mrs Mulligan to act in a way other than as the evidence demonstrates.[15]

(c) In relation to paragraph 48, the QNU submission seeks to advance the proposition that Mrs Mulligan's lack of leadership of nurses left them in a position where they had to seek leadership from their union officials.

---

[13] Mulligan submission, paras 73 - 96; para 159, statement Mulligan; T.1408:41 - 1410:45 (Hoffman).

[14] See footnote no 4.

[15] Mulligan submission, paras 50 - 72.

(i) It is of concern that there appears to have been an attitude within the QNU to discourage the proper reporting of concerns by nurses through the DDON[16].

(ii) Again, Mrs Mulligan can hardly be legitimately criticised for failing to act on information that was not given to her.

14. It is noted that the submission from the QNU attaches as Appendices 1 and 2 the submissions made to the previous Commission seeking leave to appear and submissions made to the Foster Review respectively.

15. Appendix 1 contains a summary of the way in which the QNU then expected the evidence to unfold before the previous Commission.

16. No doubt so far as Mrs Mulligan's interests are concerned, this Commission will ignore any statements contained in that submission which are detrimental to Mrs Mulligan's interests where those submissions are not supported by evidence.

17. Similar consideration should be applied to the terms of Appendix 2.

A J MacSporran
Counsel for Mrs Mulligan
31 October 2005

[16] Paras 111 and 132, Statement Hoffman; T.171: 10-40; and T.1435: 55 - T.1436: 40 (Hoffman).