QUEENSLAND PUBLIC HOSPITALS COMMISSION OF INQUIRY

SUBMISSIONS ON BEHALF OF THE QUEENSLAND NURSES' UNION

Contribution of the QNU to Investigations in relation to the Bundaberg Base Hospital

1. The Queensland Nurses' Union ("the QNU") supported nursing staff in raising concerns with the Director of Nursing, Ms Linda Mulligan, in October 2004[1] and February 2005[2]. The QNU encouraged Ms Toni Hoffman to put her concerns in writing to the District Manager and discussed other possible avenues of complaint to the Medical Board and Health Rights Commission. QNU officials met with Mr David Kerslake, Health Rights Commissioner, on 4 February 2005[3], the Chief Medical Officer, Dr FitzGerald, on 11 February 2005[4] and Mr James O'Dempsey, Executive Officer of the Medical Board, on 15 February 2005[5] in relation to concerns held by nursing staff at the Bundaberg Base Hospital ("BBH").

2. Subsequent to the then Minister for Health, Mr Nuttal, and the then Director-General of Queensland Health, Dr Buckland, advising staff on 7 April 2005 that the results of Dr FitzGerald's investigation would not be released, the QNU complained to the Crime and Misconduct Commission ("CMC") in relation to the failure of members of the executive management at the BBH to act upon complaints regarding Dr Patel.

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[1] Statement of Linda Mulligan, exhibit 180 paras 164 - 166

[2] Statement of Linda Mulligan, exhibit 180 paras 210

[3] Statement of David Kerslake, exhibit 354, paragraphs 46 – 47, T5661 - 5663

[4] Statement of Dr FitzGerald, exhibit 225, para 62, T4205

[5] Statement of James O'Dempsey, exhibit 28, paras 30 – 31, T638-639, T641 - 642

3. Subsequent to the announcement of the Bundaberg Hospital Commission of Inquiry, the QNU and its legal representatives provided assistance to the Commission of Inquiry and the CMC by facilitating interviews by CMC investigators of its members, and the provision of statements of its members to the Commission of Inquiry.[6] The QNU, through its legal representatives, have provided 33 statements of its members to the Commissions of Inquiry. 19[7] of those statements have been admitted into evidence before the Commission of Inquiry and 11[8] of those members have been called to give evidence before the Commissions of Inquiry. The QNU also provided additional information to assist the Commission of Inquiry in its investigations,[9] and devised a patient key system which was adopted by the Commission.

4. The QNU filed a preliminary submission to the Bundaberg Hospital Commission of Inquiry, a copy of which is attached as Appendix 1. The QNU made a submission to the Forster Inquiry into Queensland Health, a copy of which is attached as Appendix 2.

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[6] By letter dated 3 May 2005, Commissioner Morris QC requested the QNU to "provide full cooperation with the Inquiry", and specifically, "to identify those persons ... who are likely to be able to provide useful evidence to the Inquiry, ... [and] to prepare, and provide to the Inquiry, statements of the evidence which such witnesses are able to provide."

[7] It is presently proposed by Counsel Assisting that a further 3 statements prepared by the QNU (Karen Jenner, Margaret Mears and Gail Doherty) will be tendered to the Inquiry on 27 October 2005.

[8] Counsel Assisting has advised that a further 3 QNU members will be called to give oral evidence on 27 October 2005: Karen Jenner, Margaret Mears, and Gail Doherty.

[9] The further information provided included suggesting lists of potential witnesses and documents to obtain on 16 May 2005. Many of the suggested witnesses were interviewed by Inquiry staff and ultimately gave evidence, and many documents the QNU suggested should be obtained were ultimately tendered in evidence.

Scope of these Submissions

5. These submissions are directed towards the terms of reference in paragraphs 2(b) to (e) of the Commissions of Inquiry Order (No 2) 2005 insofar as those terms of reference apply to evidence before the Commission concerning the Bundaberg Base Hospital ("the BBH").

6. The QNU is confident that the Commission, consistent with the thoroughness of its examination of issues during the public hearings, will conduct a thorough analysis of all the relevant evidence touching upon such matters. These submissions do not seek to duplicate such a process and are not intended to be an exhaustive or definitive analysis of all the evidence relevant to the BBH.

7. These submissions will attempt to highlight some of the most striking examples of failure on the part of the executive management at the BBH to address concerns raised by nursing staff during the course of Dr Patel's tenure as Director of Surgery and the findings and recommendations it is submitted should follow.

8. Consequent recommendations as to processes for clinical governance will be addressed mainly by reference to the QNU's submission to the Forster Inquiry and the Final Report of Mr Forster. Further submissions will be made as to some systemic issues which have been highlighted in evidence before the Commission.

9. It is not proposed in these submissions to address the questions of whether or not Dr Patel or any other practising doctors should face criminal or disciplinary action as a result of findings of failure in the care of patients. The QNU is confident that the Commission, assisted by submissions by the Bundaberg Hospital Patient Support Group and the Medical Board of Queensland, will address such matters without the assistance of submissions from the QNU. The

QNU does not see its role as including passing judgment on the clinical competence of medical practitioners mentioned in evidence before the Commission. The QNU's approach has been to ensure as far as possible that the legitimate concerns of its members as to patient safety were appropriately investigated by this Commission and other investigative bodies, and that the appropriate bodies pass such judgment. This is consistent with the approach taken by its members at the BBH during 2003 and 2004 when raising concerns regarding Dr Patel. Those members did not purport to be in a position to form conclusive judgments as to Dr Patel's clinical competence, but sought an appropriate assessment of such. As stated by Ms Toni Hoffman to Mr Leck on 20 October 2004[10], Ms Hoffman would have been quite happy to be proven wrong in her fears but wanted independent assurance from outside of the BBH that her fears were unfounded.

Summary of submissions re failure of clinical governance at BBH

10. The failure on the part of the Medical Board to properly investigate Dr Patel's United States registration history meant that an opportunity was lost to refuse registration of Dr Patel as a medical practitioner in Queensland or place appropriate restrictions upon his scope of practice.

11. The failure on the part of Dr Kees Nydam and, thereafter, Dr Keating and Mr Leck, to ensure that Dr Patel was appropriately credentialled and privileged prior to, or soon after, his appointment as Director of Surgery permitted the following consequences:

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[10] Exhibit 8

(i) Dr Patel was permitted to perform surgery outside the scope of practice of the BBH;

(ii) Dr Patel was permitted to perform surgery outside his own scope of practice; and

(iii) Patients underwent procedures, in particular oesophogectomies, performed by Dr Patel that should never have been undertaken and died or otherwise suffered harm as a result.

12. Mr Leck and Dr Keating failed to take appropriate steps to ensure that Dr Patel was credentialled and privileged or to restrict his scope of practice despite knowledge of adverse outcomes of the patients, concerns voiced by medical and nursing staff and their knowledge as to the lack of credentialling and privileging of Dr Patel.

13. 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.

14. Mr Leck and Dr Keating should have, at the very latest in October or November 2004, at least restricted the scope of practice of Dr Patel. They failed to do so. This was most likely because of the prioritisation of budgetary considerations. Meeting elective surgery targets outweighed concerns for patient safety.

15. Mr Leck and Dr Keating failed to diligently investigate concerns raised by nursing staff as to Dr Patel's practice, apparently motivated by a desire to maintain his services as a surgeon.

16. Dr Keating was prepared to express dishonest opinions as to Dr Patel's level of clinical competence to Dr FitzGerald and the Medical Board so as to retain his

services and Mr Leck was prepared to write a dishonest and unbalanced letter of support for Dr Patel to the local newspaper to the same end.

17. Mr Leck and Dr Keating betrayed the public trust incumbent in their positions as District Manager and Director of Medical Services in a way that requires consideration of charges of official misconduct.

18. The audit process of investigating concerns raised in relation to Dr Patel's practice, conducted by Dr FitzGerald, was not conducive to eliciting the full truth but rather fashioned to manage any adverse consequences to Queensland Health.

19. Such circumstances presented a compelling reason for Ms Toni Hoffman to ventilate her concerns outside Queensland Health to a local member of Parliament.

20. The response of Mr Leck, and subsequently the Director General and the Minister, to the public airing of legitimate concerns was to criticize and denigrate such disloyal behaviour.

21. The failure of the Queensland Health executive management at the BBH, and of Queensland Health generally, to appropriately address concerns raised regarding Dr Patel is indicative of a problematic management culture in Queensland Health that requires fundamental reform.

The Three Monkeys

22. The triumvirate of executive management at the Bundaberg Base Hospital exemplified the "three monkeys" management ethos of Queensland Health when addressing concerns as to clinical services and patient safety. Whilst each of the District Manager, Director of Medical Services and Director of Nursing

demonstrated characteristics of each of the three monkeys, emphasis can be placed upon the relevant characteristics of each:

- Mr Leck would "see no evil" in the detailed written documentation of concerns from patients and nursing staff regarding Dr Patel;
- Linda Mulligan would "hear no evil", stifling verbal communication of concerns by nursing staff and taking the view that anything that could not be seen in writing need not be heard[11];
- Dr Darren Keating was the true exemplar of all three monkeys in closing his eyes and his ears to the mounting body of evidence casting serious doubts upon Dr Patel's competence and finding himself unable to utter words critical of Dr Patel to his District Manager, Dr FitzGerald or the Medical Board.

Scope of Practice of the Bundaberg Base Hospital

23. Dr Patel was permitted to perform surgery beyond the scope of practice of the BBH. Complex surgical procedures such as oesophagectomies and Whipples procedures were beyond the proper scope of practice of the BBH, in particular because of the nature of the available intensive care facilities.

24. The Intensive Care Unit (the "ICU") at the BBH is a Level 1 Combined Intensive Care/Coronary Care Unit. It did not have the services of a Specialist Intensivist but was medically managed by Dr Carter, an Anaesthetist. The limited number of available appropriately qualified and experienced nursing staff placed practical

[11] Evidence of Mr Leck T7219 Lines 30 - 40

restrictions on the number of acutely ill patients who could have their needs met in the unit at any one time. It was well recognised at all relevant times that Level 1 Intensive Care Units of the nature of that at the BBH, should generally only keep patients who require ventilation for between 24 and 48 hours before transferring them to a hospital with a higher level of intensive care[12]. The BBH ICU could only realistically deal with a maximum of two patients on ventilators at any one time because of nursing staffing levels.

25. The level of post operative care required for patients undergoing complex procedures such as oesophagectomies exceeded the capabilities of the BBH ICU. Such was recognised not only by Toni Hoffman but also by doctors who had practised at BBH prior to and during the relevant period under investigation[13]. Dr FitzGerald's evidence was that one would reasonably expect a reasonably competent Director of Medical Services to realise that such procedures were outside the scope of practice of such a hospital[14].

Scope of Practice of Dr Jayant Patel

26. It is now of course abundantly clear that surgery of such complexity was also outside the individual scope of practice of the surgeon, Dr Patel. He had in fact been restricted from performing procedures including oesophagectomies and Whipples procedures in the United States. Two of the four patients upon whom

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[12] Statement of Toni Hoffman, Exhibit 4, paras 3 – 6 and statement of Dr Carter, Exhibit 265, paras 29 – 35

[13] Dr Jayasekera at T.5973; Dr Baker at T.6358; Dr Joiner at T.5012, l.45 to 5013, l.5; Dr Risson at T.2813, ll.40-45 and 2811, ll.10-30; Dr Kariyawasam at T.3074, l.30 to 3075, l.5. (cf. Dr Anderson T.2764-2765). Such opinion was shared by other witnesses including Dr FitzGerald at T.3146, ll.1-15 and Dr De Lacy at T.3603 – 3604, 3612, ll.20-30, 4422, l.5 to 4423, l.10

[14] T. 3152, ll.15-50

Dr Patel performed oesophagectomies died shortly thereafter. The other two suffered significant post operative complications. Dr de Lacy gave graphic evidence as to the poor outcome of the second of such survivors, Mr Philip Deakin, and the impact upon his quality of life[15]. The other survivor, Mr Grave, underwent three returns to theatre for post-operative complications, an extended stay in the ICU at Bundaberg and his post-transfer treatment is described in the evidence, including that of Dr Peter Cook.

27. There are real questions as to whether any of these four patients should have undergone oesophagectomies at all. Certainly, none of them should have undergone oesophagectomies at the BBH carried out by Dr Patel. The fact that Dr Patel was not restricted from undertaking surgical procedures of such complexity until after the death of the fourth oesophagectomy patient, Mr Kemps, is tragic and disgraceful. That Dr Patel could be permitted to continue to undertake surgery of this nature for a period over 18 months after specific concerns were raised with regards to it by Toni Hoffman and Dr Joiner in May and June 2003 exemplifies the failure of clinical governance on the part of the executive management of the BBH.

28. The failure on the part of the Medical Board of Queensland to make further enquiries into Dr Patel's United States registration history meant that an opportunity to not register or to restrict Dr Patel's scope of practice upon registration was lost. Such unfortunate failure would not have had the tragic consequences it did but for the failures of those who held management positions at the BBH.

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[15] T.3064, l.30 to 3065, l.10

Lack of Credentialing and Privileging of Dr Patel

29. The Commission has heard a great deal of evidence confirming the importance of an appropriate process of credentialing and privileging medical practitioners. The importance of such is spelt out in the terms of the relevant Queensland Health policy governing credentialing and privileging[16]. The then Acting Director of Medical Services, Dr Nydam, gave no consideration to any process of credentialing and privileging of Dr Patel before or upon employing him as a Senior Medical Officer, and soon after appointing him to the unsupervised position of Director of Surgery. Dr Keating became well aware of the lack of any process of credentialing and privileging of surgeons upon commencing in the position of Director of Medical Services soon after. The requirement for appropriate credentialing and privileging of a surgeon in such circumstances is manifest. The need that Dr Patel be appropriately credentialed and privileged with regard to the service capabilities of the BBH and its ICU, should have been seen as even more acute by any diligent Director of Medical Services upon concerns being raised by Toni Hoffman and Dr Joiner in May and June 2003 in relation to the two patients who underwent oesophagectomies during that period, followed by the voicing of concerns by Dr Peter Cook in relation to the second of those patients.

30. The inability on the part of Dr Keating to secure a nominated representative of the relevant college to sit on a credentialing and privileging committee does not excuse such failure in the circumstances. The need for such a process being

[16] Exhibit 279

manifest in relation to any surgeon, combined with the mounting chorus of alarm regarding Dr Patel's practice and in particular his willingness to practice outside the scope of practice of the BBH, required an appropriate response on the part of Dr Keating and Mr Leck, not a slavish adherence to the terms of a written policy. Evidence has been given by appropriately qualified persons that a practical and available option was to seek the participation of an appropriately qualified surgeon, either from the local or from a hospital in Brisbane. Such an approach would have been infinitely preferable to doing nothing.

Mr James Phillips (P34)

31. On 19 May 2003, Mr Phillips underwent an elective oesophagectomy performed Dr Patel. An anaesthetist reported to ICU staff that the patient had no obtainable blood pressure during the last 45 minutes of surgery. The patient was obviously critically ill when admitted to the ICU and ultimately died on 21 May 2003. During the course of the patient's time in the ICU, Dr Patel informed medical and nursing staff that the patient was stable.

32. In late May or early June 2003[17] Toni Hoffman, accompanied by the then Director of Nursing, Ms Goodman, met with Dr Keating to voice concerns arising from the above events. Toni Hoffman expressed her concerns about surgery such as oesophagectomies being undertaken at the BBH given the lack of appropriate ICU facilities for post operative care for such patients. She expressed her concern that Dr Patel would describe a patient as stable when they were

[17] Statement of Toni Hoffman, exhibit 4, para 10; Dr Keating states on or about 30 May 2003 at para 48 of his statement exhibit 448.

obviously critically ill. She voiced further concerns as to Dr Patel's behaviour and the apparent lack of modern clinical knowledge. The Commission would accept the evidence of Ms Hoffman that at this meeting she raised the issue of Dr Patel undertaking oesophagectomies outside the scope of practice of the BBH[18].

33. Dr Keating's response to such concerns raised by Ms Hoffman at that time was completely inappropriate and inadequate. Ms Hoffman states that she was told by Dr Keating that Dr Patel was a very experienced surgeon and that she was required to cooperate with him and work together, that there was an expectation that the BBH would continue to provide surgery to the people of Bundaberg and that Dr Patel was experienced and used to performing those types of surgery[19]. Dr Keating states that he suggested to Toni Hoffman that she make an appointment with Dr Patel to discuss the issues raised by her, explain unit capability and capacity and the need to work together as a team[20]. Given the nature of the issues raised and the confronting personality of Dr Patel, it is of no surprise that any attempt at rational discussion of such issues and cooperation with Ms Hoffman was flatly rebuffed by Dr Patel. It was inappropriate in the circumstances to expect Ms Hoffman to be able to successfully resolve such a situation with Dr Patel. It was an inexcusable abdication of responsibility on Dr Keating's part to proceed in such a fashion. The matters raised with him at that time should have led him to facilitate an appropriate process of credentialing and

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[18] Although Dr Keating claims a lack of recollection of this issue being raised (Para 48 of Exhibit 448), at no time prior to the commencement of the Commission hearings did he voice dissent with the contents of Ms Hoffman's correspondence to Mr Leck in October 2004 referring to such an issue having been raised (Exhibit TH10 andTH37)

[19] Exhibit 4, para 11.

[20] Para 48 of exhibit 448.

privileging of Dr Patel and to properly define the scope of practice of Dr Patel and the BBH with regards to complex procedures such as oesophagectomies.

34. Ms Hoffman recalls a further meeting soon after with Dr Keating in the company of Dr Joiner during which she once again raised concerns about oesophagectomies being carried out at the BBH in light of her understanding that Dr Patel was to undertake another oesophagectomy. Dr Joiner's recollection was unclear as to having accompanied Toni Hoffman to any meeting with Dr Keating and as to exactly when in relation to the dates of procedures regarding Mr Phillips and Mr Grave that he had two meetings with Dr Keating to discuss associated issues. The Commission would accept Ms Hoffman's recollection as to having met with Dr Keating and Dr Joiner, despite Dr Keating's denial of such, given Dr Keating's lack of dissent to Ms Hoffman having clearly stated that such a meeting occurred in her correspondence with Mr Leck[21].

Mr James Grave (P18)

35. Mr James Grave underwent an elective oesophagectomy performed by Dr Patel on 6 June 2003 and was admitted to the ICU later that day. He returned to the operating theatre on 12 June 2003 and 16 June 2003 for abdominal wound dehiscence and on 18 June 2003 for leakage from the jejunostomy site. Prior to the third return to theatre, steps had been taken to find a bed in a Brisbane

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[21] Exhibit 4, TH10 and TH37 which was available to Dr Keating at the very latest on or about 22 October 2004. Notwithstanding some variations in the accounts of Ms Hoffman, Dr Joiner and Dr Keating as to the exact chronology of conversations with Dr Keating on such topic, it is most certain that Ms Hoffman and Dr Joiner raised concerns with Dr Keating on at least 3 occasions as to the capability of the BBH to appropriately care for patients undergoing oesophagectomies.

Hospital for the patient. Dr Patel did not cooperate in the process required for transfer.

36. Toni Hoffman communicated her concerns as to Mr Grave, in the context of her continuing concerns of Dr Patel operating outside the BBH scope of practice, by e-mails to the then Director of Nursing[22] and to the Director of Medical Services, Dr Keating[23].

37. It was in the context of his concerns as to the circumstances of Mr Grave, that Dr Joiner again raised concerns with Dr Keating as regards to the capacity of the BBH to properly care for oesophagectomy patients[24]. His evidence[25] is enlightening when depicting the nature of Dr Keating's dealings with Dr Patel. Dr Joiner attended a meeting with Dr Keating and Dr Patel regarding Mr Grave. Dr Joiner states that he and the intensive care staff had formed the view that the patient required ongoing intensive care support and should be transferred to an intensive care unit at the Royal Brisbane Hospital. At the time that decision was made, it was ascertained that a bed was available in the RBH ICU so that the patient could be transferred. Dr Patel confronted Dr Joiner and threatened to resign if the patient was transferred to the RBH. At the meeting with Dr Keating and Dr Patel, Dr Keating was informed that an ICU bed in Brisbane had been arranged but that Dr Patel was not agreeable to the patient being transferred to

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22 Exhibit 4, TH2.

23 Exhibit 4, TH3.

24 T5013 - 5014.

25 T5015 - 5016.

Brisbane. Presented with the sound clinically-based arguments for transfer of the patient on the one hand and the unreasoned but adamant refusal on the part of Dr Patel to the patient being transferred, a compromise was reached at the meeting that the patient would remain for another couple of days and his clinical condition be reviewed. The fact that Dr Keating would permit a compromise of care of the patient to mollify the recalcitrant Dr Patel is an inexcusable abdication of responsibility on his part. It exemplifies the approach of Dr Keating throughout the controversy regarding Dr Patel in that he was prepared to make decisions compromising the clinical care of patients in light of a fear that to do otherwise would result in the loss of the services of Dr Patel to the Hospital.

38. Mr Grave was eventually transferred to the Royal Brisbane Hospital on 20 June 2003. In late June or early July 2003, Dr Peter Cook, Intensivist, and communicated his concerns regarding surgery of such complexity and being undertaken at the BBH, including verbally to Dr Keating. Dr Keating states that such conversation occurred on 1 July 2003, and that Dr Cook expressed concern about this type of operation being performed at Bundaberg in that it required robust intensive care backup[26]. Dr Keating says that he told Dr Cook he would discuss such concerns with the Directors of Surgery and Anaesthetics and with the Credentials and Privileging Committee at the Hospital. No such functioning committee in so far as surgery was concerned was then in existence. Dr Keating claims to have relied upon the opinions of Dr Patel and Dr Carter to conclude that oesophagectomies could be safely performed at Bundaberg Hospital[27]. The

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26 Exhibit 448, para 52.

27 Exhibit 448, para 55.

failure on the part of Dr Keating, in light of the manifestly unfavourable outcomes for Mr Phillips and Mr Grave and the concerns raised by a specialist intensivist, to take appropriate steps to credential and privilege Dr Patel and define an appropriate scope of practice for the BBH is inexcusable.

Other Warnings Ignored

39. During 2003, every one of six patients at the BBH who had a peritoneal dialysis catheter placed by Dr Patel suffered complications, including acute and chronic infections and migration of catheters requiring further surgery, mostly related to the incorrect external positioning of the catheters. On 17 December 2003, Mr Eric Nagle (P30) underwent surgical intervention to address the migration of his peritoneal catheter. This additional surgery was required because of the incompetence of Dr Patel in inserting the catheter, yet was performed by Dr Patel. The patient died as a result of haemopericardium due to perforated thoracic veins during the insertion of a permacath by Dr Patel. The patient would not have required this additional procedure had his peritoneal catheter been in position correctly in the first place. Renal Unit Nurses, Ms Robyn Pollock and Ms Lindsay Druce, reported their concerns on 10 February 2004 to the then acting Director of Nursing, Mr Patrick Martin[28]. Mr Martin spoke to Dr Keating on the same day to relay such concerns[29]. Mr Martin relayed to nurses Druce and Pollock that Dr Keating required further statistics regarding procedures

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28 Statement of Lindsay Druce, exhibit 67, para 17. Statement of Robyn Pollock exhibit 70, para 30.

29 Statement of Patrick Martin, exhibit 139, paras 26 - 27.

undertaken by Dr Patel highlighting all renal related cases uneventful compared with the number of adverse events which had recurred as a result of an intervention[30]. Dr Keating took no immediate steps to clarify the significance of the information that had been presented to him which would have informed him of the alarming fact of a 100% failure rate on the part of a surgeon undertaking such a procedure.

40. Dr Miach has given evidence that he supplied Dr Keating in about April 2003 with the results of the Renal Unit Nurses' investigations demonstrating 100% complication rate in relation to the insertion of peritoneal dialysis catheters. It is not completely clear on the evidence whether such document would have been that which now forms exhibit 18 or exhibit 69. Dr Miach's evidence is that when he again raised such issue with Dr Keating on 21 October 2004, Dr Keating denied having earlier spoken to Dr Miach regarding the matter or seeing any such document. The Commission would prefer the evidence of Dr Miach in this regard. In any event, even according to the account given by Dr Keating, at the time he was following up on the most recent concerns raised by Toni Hoffman on 20 October 2004 with Mr Leck, he failed to question Dr Miach as to the significance of such information and claims that even at that stage not to have realised that the information indicated 100% failure rate in such a procedure. Dr Keating claims to have failed to advert to the possibility that such information would be evidence indicative of a general lack of clinical competence on the part of Dr Patel.

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30 Exhibit 139, PM3.

41. Dr Keating showed a repeated inability or unwillingness to address concerns raised by nursing staff in relation to the clinical practice of Dr Patel. When concerns were raised by Gail Aylmer, the Infection Control Clinical Nurse Consultant, as to rates of wound dehiscence in mid 2003, she was placed in the invidious position as a nurse of having to question an apparently experienced surgeon as to the possible courses of wound dehiscence noted in relation to his patients. Ms Aylmer should never have been placed in such a position and Dr Keating should have taken the obvious and appropriate steps of having such an issue examined in an appropriate mortality and morbidity committee by appropriate clinicians or at least reviewed by an appropriately qualified surgeon[31]. This was yet another example of Dr Keating seemingly not wanting to become involved in examining concerns regarding Dr Patel's clinical confidence and not taking appropriate steps for proper review of such concerns.

42. Similarly, after receiving a report sourced from three nurses who witnessed serious breaches of aseptic technique on the part of Dr Patel, Dr Keating was prepared to dismiss the matter on the basis that Dr Patel denied such behaviour. Dr Keating demanded statistical data to support the assertion that there was a problem with Dr Patel's aseptic technique[32] despite the available eye witnesses who could verify a very serious breach of aseptic technique.[33]

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[31] Statement of Gail Aylmer, exhibit 62, para 3.

[32] Statement of Gail Aylmer, exhibit 59, para 19.

[33] See statements of Waters, Yeoman and Turner (Exhibits 195 – 197)

Toni Hoffman raises concerns with Mr Leck in March 2004

43. The Commission would accept the evidence of Mr Leck that he discussed the matters raised with him (and confirmed in writing) by Ms Hoffman in March 2004 with both Dr Keating and Ms Mulligan. Not only is it likely that such matters would be discussed by the District Manager with the Director of Medical Services and the Director of Nursing, but Mr Leck's account of such conversations was detailed and plausible. In particular, his detailed recollection of the nature of the response from Ms Mulligan had the ring of truth[34]. It exemplified the management style of Ms Mulligan that if a concern was not raised officially and adopted in writing, then it could be disregarded.

44. The nature of the concerns communicated directly to Mr Leck at such time, notwithstanding Toni Hoffman's communication that she did not wish the matter to be treated as an official complaint, would have caused any reasonable District Manager in Mr Leck's position to question the advice he was receiving from Dr Keating that the matter was a mere personality conflict and to consider some type of appropriate peer review of Dr Patel's surgical competence. At the very least, it would have caused a reasonably diligent District Manager to ensure that the long overdue process of credentialing and privileging of Dr Patel proceed as a matter of haste and that the scope of practice of the BBH be urgently reviewed in light of the matters raised.

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[34] "I went to talk to Linda about it and I said I had received this correspondence from Toni but that Toni didn't want me to do anything with it, and Linda said that her usual response in that situation would be to hand the letter back and ask the staff member to give it to them when they were prepared to lodge a complaint.", T7219 Lines 30 – 40.

Lack of Nursing Leadership

45. From the time of her commencement in the position of District Director of Nursing, Ms Linda Mulligan had the responsibility for providing leadership to the nursing staff of the BBH, being accessible to staff who wished to voice concerns or seek her assistance and to advocate for the nursing staff with executive management. As a nursing professional Ms Mulligan had professional responsibilities in addition to managerial responsibilities. It is clear that she failed to fulfil these responsibilities of her position. She adopted the role of a manager rather than a nursing leader[35]. She made herself inaccessible to nursing staff, placing restrictions on the ways in which she could be contacted and essentially remaining invisible to most of the nursing staff[36]. She did not do rounds of the wards and if staff wanted to see her they had to make appointments. Toni Hoffman in her statement says "We had to make appointments with her secretary and had to give a reason for why we wanted the appointment. The appointments were often cancelled after they were made."[37] She discouraged open discussion of concerns ventilated by nursing staff at meetings[38].

46. In a hospital the size of the BBH, there was no practical reason why the Director of Nursing could not play a visibly supportive role and provide leadership to the nursing staff. Her cessation of regular nursing rounds upon taking up her

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[35] Statement of Gail Aylmer, exhibit 59, para 43

[36] Statement of Toni Hoffman, Exhibit 4, paras 78-81; statement of Jennifer White, Exhibit 71, paras 31-32

[37] Exhibit 4 at [78] to [80]

[38] Statement of Gail Aylmer, Exhibit 59, para 43; statement of Toni Hoffman, Exhibit 4, para 77

position removed the opportunity for nursing staff to ventilate concerns with her in an informal way. She did not choose to take a proactive role in visiting nursing staff in e.g. the ICU after becoming aware of events that must have been traumatic for nursing staff e.g. following the death of Mr Kemps.

47. Ms Mulligan regularly received reports from the after hours nurse manager and monthly cost centre reports for the ICU which should have led her to take a more proactive approach in investigating those stresses being placed upon the ICU and nursing staff by Dr Patel operating outside of the scope of practice of the ICU.

48. The extent of Ms Mulligan's failures to provide nursing leadership left nurses feeling unsupported by management and Ms Hoffman in the position that she felt that she had to look to officials of the QNU for such nursing leadership.

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49. In a meeting with Mr Leck and Ms Mulligan on 20 October 2004 and in subsequent correspondence, Ms Hoffman raised detailed concerns in relation to Dr Patel's behaviour and clinical competence including reference to particular patients. The failure of the executive management to act swiftly and decisively at such time was inexcusable and had tragic consequences, eg for Mr Gerard Kemps. The concerns of executive management should have been heightened by the subsequent interviews of Drs Berens, Risson and Strahan[39]. The failure to discuss the matters raised with Dr Miach is inexplicable. Dr Keating's advice to Mr Leck that there were no substantial matters of concern requiring any immediate action was either dishonest or grossly incompetent.

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[39] Exhibit 448 DWK 62-64

50. It is clear that the approach of management in response to the matters raised by Ms Hoffman was to attempt to arrange a review by a hand picked doctor suitable to management who would report only to the executive management of the BBH. It was not until mid December that there was any official contact with the office of the Chief Medical Officer and not until January 2005 that there was official advice of the complaint to zonal management.

51. The executive management's inertia in response to the matters raised by Ms Hoffman contributed directly to the unfortunate result for Mr Gerard Kemps.

52. At the very latest following upon the interviews of medical practitioners in early November 2004, Mr Leck and Dr Keating should have taken action, if not to suspend Dr Patel from practice entirely, than to at least limit his scope of practice by way of prohibiting him from undertaking complex surgery such as oesophagectomies. Their failure to do so constituted a gross breach of the trust invested in them by way of their positions.

53. Mr Leck and Dr Keating as District Manager and Director of Medical Services respectively, both held an appointment in a unit of public administration within the meaning of s.21 of the *Crime and Misconduct Act* 2001. It is submitted that their failures as particularised above involved breaches of the trust placed in them as holders of the respective appointment within the meaning of s.14 of the Act. It is submitted that such conduct could amount to a disciplinary breach providing reasonable grounds for termination of the services of such a holder of an appointment and thus can amount to official misconduct within the meaning of s.15 of the Act. It is submitted that the evidence before the Commission is sufficient for referral of both Mr Leck and Dr Keating to the CMC for investigation of charges of official misconduct.

54. In a telephone conversation with an officer of the Queensland Health Audit and Operational Review Branch on 17 December 2004[40], Mr Leck stated that the district would need to handle Ms Hoffman's complaint carefully as Dr Patel was of great benefit to the district and they would hate to lose his services as a result of the complaint. It is an irresistible inference from all the evidence that the manner in which the executive management responded to Ms Hoffman's complaint was coloured by the executive management not wishing to lose the services of Dr Patel as a surgeon. Any surgeon was better than no surgeon at all in the context of budget imperatives driven by the need to meet elective surgery targets for the financial year. Dr Patel's value to the BBH in maximising the throughput of elective surgery procedures was well known to both Mr Leck and Dr Keating and such was expressed to Dr FitzGerald in his subsequent investigation. The e-mail from Dr Keating to the Nurse Unit Manager of the Operating Theatres[41] of 8 February 2005, lends support to the view that the executive management were desirous of retaining the services of Dr Patel at least until 30 June 2005, notwithstanding the seriousness of any concerns being raised as to his clinical competence. Such an attitude provided the context in which Ms Hoffman eventually saw no alternative but to raise her concerns outside the Queensland Health system with a Member of Parliament.

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[40] Exhibit 225 GF10

[41] Exhibit 72 AKA Exhibit 501

Mr Gerard Kemps (P21)

55. Mr Kemps underwent an oesophagectomy carried out by Dr Patel on 20 December 2004. The Commission received evidence from nursing staff, including Mr Damien Gaddes, Ms Jenelle Law and Mr Martin Brennan, and doctors, including Dr Berens, Dr Kariyawasam and Dr Carter, as to the circumstances of Mr Kemps' operative and post-operative treatment. For the reasons explored elsewhere in the submission, Mr Kemps should never have undergone such a procedure at the Bundaberg Base Hospital, and certainly not at the hands of Dr Patel.

56. Mr Kemps death was a "reportable death" within the terms of s.8(3)(d) of the *Coroners Act* 2003. Drs Berens and Carter sought the advice of Dr Keating as to whether such death should be reported to the Coroner. Dr Keating abdicated his responsibility as Director of Medical Services to advise Dr Berens and Dr Carter that such death should be reported and failed to take any steps to report the death himself.

57. In circumstances where Dr Berens and Dr Carter acted conscientiously in seeking the guidance of the Director of Medical Services as to whether the death should be reported and were motivated partly by concerns that reporting such death might cause further distress to Mr Kemps' family in light of his impending funeral, it is not submitted that the Commission should make recommendations adverse to those doctors.

58. Dr Keating's failure in such regard is more serious because of his position of responsibility in responding to Drs Berens' and Carter's request for advice. It is submitted that there is sufficient evidence to justify referral of this matter to the CMC for consideration as to whether or not a charge of official misconduct

should be laid against Dr Keating for failing to advise Dr Berens and Dr Carter that the death should be reported and failing to take any steps to report the death himself. Alternatively, it is submitted that there is sufficient evidence for consideration as to whether the matter should be referred to the Commissioner of the Police Service for prosecution of Dr Keating for an offence pursuant to s.7(2) of the *Coroners Act* 2003.

Executive Management's attempts to retain the services of Dr Patel

59. The conduct of Mr Leck and Dr Keating throughout the whole period of time that concerns were raised in relation to Dr Patel was indicative of a desire to retain his services as a general surgeon so as to meet budget imperatives, regardless of any legitimate concerns as to patient safety. The extent to which they were prepared to disregard patient safety and the length they were prepared to go to to retain Dr Patel's services are starkly demonstrated by their conduct in early 2005.

60. Dr Keating expressed dishonest opinions as to Dr Patel's clinical competence and judgment in conversations with Dr FitzGerald and in written communications to the Medical Board considering Dr Patel's re-registration. Mr Leck authored a dishonestly unbalanced letter of support for Dr Patel to the local newspaper for the express purpose of attempting to retain Dr Patel's services as a surgeon.

61. After Mr Messenger's statements in Parliament had been publicly reported, the Acting Director of Nursing, Deanne Walls, called a meeting of ICU staff on the 23 March 2005. This meeting was attended by the District Manager, Mr Leck. Mr Leck expressed anger about nurses breaching the confidentiality provisions of

Queensland Health's Code of Conduct.[42] Mr Leck referred to a departmental Industrial Relations document to the effect that staff breaching confidentiality could be imprisoned for two years and lose their jobs[43]. He stated that he was appalled that such a senior surgeon of the hospital could be treated in such a way that denied him natural justice[44]. Mr Leck left without giving any of the nurses an opportunity to respond to his comments or to discuss their concerns about Dr Patel[45].

62. Mr Leck later that day had a meeting with Level 3 Nursing staff. He reiterated that the leak was a breach of the Code of Conduct. "He was visibly angry and upset. He was saying that he knew that it was a nurse that was responsible for the leak"[46]. He went on to say that "a nurse had gone behind our backs and released this information before the report was released and they would be reprimanded"[47]. Nursing staff felt extremely "intimidated"[48] and "powerless"[49] as a result of the comments made by Mr Leck. Robyn Pollock wanted to respond to Mr Leck "...but I didn't because I felt intimidated ... I felt chastised after he left, and I hadn't done anything wrong. I was very concerned for whoever had sent

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[42] Exhibit 70 at [48]

[43] Exhibit 4 at [167]

[44] Exhibit 4 at [168]

[45] Exhibit 4 at [169]

[46] Exhibit 70 at [48]

[47] Exhibit 70 at [48]

[48] Exhibit 70 at [49]

[49] Exhibit 59 at [46]

the letter to Mr Messenger. I felt that if it was known who leaked the letter, that person would lose their job."[50]

63. Mr Leck's letter to the Bundaberg News Mail, 28 March 2005 while clearly supporting Dr Patel[51] expressed Mr Leck's view that the fact that allegations had been made public was "reprehensible"[52].

64. An email from Mr Peter Leck to Mr Dan Bergin, dated 7 April 2005, indicates that Mr Leck was prepared to threaten staff with reprisals for raising issues in a public forum. He refers to the staff member as "the culprit who leaked this information" and refers to them being "on very dangerous ground". He is prepared to use the Code of Conduct to "deliver some firm and scary messages"[53].

65. At the Staff Forum attended by Mr Leck, Dr Steve Buckland and the Honourable Gordon Nuttall MP on the 7 April 2005 Mr Nuttall and Dr Buckland told nursing staff that, because of the release of material in Parliament by Mr Messenger and the departure of Dr Patel from Australia, results of the Queensland Health investigation that had been underway would not be released[54]. Nursing staff felt that they were being criticised as being disloyal and believed that the Department would not be further investigating matters regarding Dr Patel. Dr Buckland

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[50] Exhibit 70 at [48] – [49]

[51] "Dr Patel is an industrious surgeon who has spent many years working to improve the lives of ordinary people in both the United States and Australia. He deserves a fair go."

[52] Exhibit 473

[53] Exhibit 477

[54] Statement of Gail Alymer (Exhibit 59) at paragraph 47

acknowledged in his evidence that, with the benefit of hindsight, he and the Minister had not handled the meeting well[55].

Dr FitzGerald's investigation

66. Dr FitzGerald's conduct in relation to the clinical review instigated as a response to Ms Hoffman's complaint was indicative of a preparedness on his part to "manage" the situation in a manner that would not reflect adversely upon the hospital management or Dr Patel and facilitate the desire of the executive management to retain Dr Patel's services. The report initially authored by Dr FitzGerald failed to include the serious findings as to Dr Patel operating outside the scope of practice of the BBH and the failure of the executive management to address concerns raised about Dr Patel over a lengthy period of time. The admitted approach of Dr FitzGerald to only include positive comments in relation to Dr Patel and deliberately not include negative ones necessarily presented a skewed report of the true situation.

67. It seems clear that subsequent steps on the part of Dr FitzGerald and Queensland Health were driven only as a result of the growing public exposure of the true situation and recognition on the part of Dr FitzGerald and his superiors that their response needed to be heightened in light of the growing public controversy. In the absence of public disclosure by Mr Messenger of matters in Parliament, it is a reasonable inference that the process of response to Ms Hoffman's complaint may well have finished with the preparation of the confidential audit report of Dr FitzGerald, with the real adverse findings by Dr FitzGerald never finding their way

[55] Statements of Dr Buckland Exhibit 335 para 34 and Exhibit 337 paras 10 -13

into print. The addition of the memo to the Director-General containing those adverse findings would appear to have been responsive to the matters being raised in Parliament and advice being sought by the Director-General as to the process of his review.

68. It is a reasonable inference that, but for the depth of negative feeling ascertained by the Director-General and the Minister for Health on their visit to Bundaberg on 7 April 2005 and the knowledge obtained by the Director-General through an internet search regarding Dr Patel's registration on the same date, the matter would have concluded as was flagged to staff on that date, ie Dr FitzGerald's report would never have been released, the investigation would have ceased and the whole matter been buried. The announcement of a further review on 9 April 2005 was clearly a response to the realisation on the part of the Director-General and the then Minister that adverse publicity would necessarily result when the information regarding Dr Patel's registration became public knowledge.

Additional Submissions on Systemic Issues

69. The QNU submissions to the Queensland Health Systems Review (the Forster Inquiry) is included as Appendix 2. We urge upon the Commission consideration of the whole of such submission and the recommendations submitted therein. We refer in particular to the following aspects of that submission which have been highlighted and exemplified by evidence given before the Commission.

Chronic Underfunding of Queensland Health Services

70. The Commission has received evidence which puts beyond doubt those propositions submitted in Appendix 1 and Appendix 2 by the QNU that the Queensland public health system has been chronically underfunded for many years, with consistently lower expenditure per capita than in other States and Territories[56]. Queensland Health has placed an undue emphasis upon achieving greater and greater efficiency outcomes with insufficient emphasis placed upon the quality of care provided and whether health outcomes are satisfactory. By producing a situation where Queensland has the lowest number of medical practitioners and nursing practitioners per head of population than any other State[57], emphasis on efficiency gains has had a negative impact on quality of care as doctors and nurses are placed in situations where they are unable to deliver an optimal standard of nursing care. Frustration at being unable to provide appropriate standards of care has led to medical practitioners and nurses leaving the Public Health system or decreasing their hours of work because they can no longer cope with unrealistic work demands and the consequences such have upon their ethical obligations as health professionals[58]. Doctors and nurses within the Queensland Health system are working harder and being paid less than their interstate counterparts, becoming increasingly frustrated by the level of care that they can provide their patients and leaving the Public Health system in many cases after being burnt out by the system. The inescapable conclusion is

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[56] See eg Exhibits 336 Statement of Dr Buckland, paras 64, 77 & 78; Exhibit 310 Extracts from the Productivity Commission's report on Government Services 2005

[57] Exhibit 209, Statement of Dr Young

[58] See eg the evidence of Dr McNeill at T.4748, 24749

that there can be no real solution to the crisis existing in the Queensland public health system without a greater allocation of public monies to that public health system.

Queensland Health's Culture of Secrecy

71. The Commission has a body of evidence before it which confirms and exemplifies submissions previously made by the QNU as to the culture of secrecy in Queensland Health and the need for improved openness, transparency and accountability in Queensland Health. The obsession with secrecy in Queensland Health has largely been derived from a combined imperative to "put a lid" on controversy and dissent and at the same time manage the budget imperatives of continuing to do more with less. Greater openness and transparency is necessary for there to be a genuine community debate in relation to priorities for our Queensland Health system. The evidence before the Commission in relation to the Queensland Health management of information concerning waiting lists and the measured quality program are only examples of the past approach which must be changed.

72. The evidence before the Commission has also provided examples of abuse of the cabinet exemption provisions of the *Freedom of Information Act* 1992. Attached as Appendix 3 to these submissions is a submission of the QNU on the review of the *Freedom of Information Act* 1992 to the Legal, Constitutional and Administrative Review Committee dated 14 May 1999. Submissions with regards to s.36 of the Act appear at page 7 of that document.

The Code of Conduct

73. The evidence shows instances of the Queensland Health Code of Conduct being used to intimidate nurses in an attempt to stifle discussion about concerns nurses had in Bundaberg.

74. As well as the specific events referred to above, there has been a general concern amongst Queensland Health staff as to reprisals from management in response to them raising issues. In his evidence to the Commission, Dr Nankivell stated: "The people in Queensland Health are terrified of the code of conduct, particularly the nurses, because the nurses are much more vulnerable. Doctors, if they get sacked, can always go to the private sector. Nurses are - because they're a more vulnerable group, are terrified"[59].

75. Toni Hoffman was concerned that on making the complaint in October 2004 her career was over[60]. Enrolled nurse Jenelle Law, in referring to the death of Mr Kemps, stated: "I was so distressed with what had happened that I wrote a statement early in January 2005 ... It took me quite a while to work up the courage to hand it in after I had written it as I feared for my job." She concludes "I have been concerned that I will lose my job. A few weeks ago, around the end of April start of May 2005, the tension over the Inquiry and the media attention

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[59] T2958

[60] T171: "I was very well aware that by making this complaint, even just to Peter Leck and Linda Mulligan at that particular time, that I would never get a chance to progress my career in Queensland Health...My belief was that I would never get an opportunity to act up into a higher position, I would never be given the opportunity to go to conferences or any of the things that enable you to progress in your profession. I knew that my making this complaint, that that would be the end of my career and it may even be the end of my career at that hospital.

just became too much. I broke down because I was so upset. Counsellors have since been brought in to speak to us"[61].

76. Nursing staff were concerned about reprisals which operated as a disincentive to make complaints and raise issues. Ms Robyn Pollock stated her feelings towards speaking out after an incident where Mr Peter Leck and others from the executive team accused staff of the Renal Unit of leaking information to the head of the renal patients support group: "I became so guarded in what I said to Richard and to others after this experience. That treatment was a huge disincentive to speaking out to management"[62]. As to the meeting where Mr Peter Leck accused nurses of leaking information to Mr Messenger in March 2005, Ms Gail Aylmer stated: "I was concerned that if nurses were made the scapegoat for this situation, then nurses in the future would be very reluctant to advocate for the patient."[63]

77. The lack of leadership support by Queensland Health management at BBH and management inaction in responding to concerns raised by nursing staff caused the nurses great anxiety and distress, especially as further incidents occurred. Registered Nurse Karen Fox pinpoints the cause of the major depressive disorder she is currently suffering as resulting from "the events I witnessed on 27 July 2004 [the death of Mr Bramich], and exacerbated by subsequent events at the BBH concerning Dr Patel. My condition deteriorated during the time Dr Patel

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[61] Exhibit 160 at [18] – [25]; Jenelle Law clarifies in cross examination that until she spoke to her solicitors she thought she would lose her job (transcript page 2214 at line 55)

[62] Exhibit 70 at [47]

[63] Statement of Gail Alymer at [46]

continued to work at the hospital and I ultimately needed to cease work for a period of time earlier this year"[64].

78. It is the right of all Queensland Health staff and citizens to raise concerns in the public domain about the conduct of public institutions including hospitals and other health facilities. It is the department's role to deal with these concerns in a timely and appropriate manner or to refute them. Misuse of the Code of Conduct and legislation must cease if we are to create a positive, problem solving and open culture in Queensland Health it must not be used to silence criticism and debate.

79. Recommendations:

(i) It is essential that the Code of Conduct be reviewed and amended to allow for discussion without fear of disciplinary action.

(ii) It is recommended that a penalty to be imposed for the inappropriate use of this document by Queensland Health management.

(iii) Amendments must be made to the *Health Services Act* 1991 and the *Whistleblowers Protection Act* 1994 to remove doubts held by QNU members as to whether they can approach the QNU, and other appropriate bodies, to raise and discuss matters of concern without the fear of disciplinary action or criminal prosecution.

Amendments to the *Whistleblowers Protection Act* 1994

80. The QNU agrees with the recommendations put forward by the Forster review as to changes to the *Whistleblowers Protection Act* 1994:

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[64] Exhibit 485 at para [9]

(i) Whistleblowers should be able to lodge Public Interest Disclosures with Members of Parliament and have protection under the Act;

(ii) The media should not be approved as one of the bodies to whom Whistleblowers can lodge Public Interest Disclosures and have protection under the Act; and

(iii) Any person not just a public officer should be afforded protection for disclosing danger to public health and safety.

(iv) In addition it is submitted that whistleblowers should be able to lodge Public Interest Disclosures with their relevant professional and / or industrial organisation, eg the AMAQ and QNU.

Amendments to the *Health Service Act* 1991

81. The QNU submits that in addition to changes recommended by Mr Forster to the *Whistleblowers Protection Act* 1994, it is necessary to amend the provisions relating to confidentiality contained in the *Health Services Act* 1991. Section 62A of the *Health Services Act* 1991 presently makes it a summary offence for employees to disclose to another person any information "if a person who is receiving or has received a public sector health service could be identified from the confidential information". The exceptions in which such information can be disclosed are numerous, but unlikely to be of assistance to a clinician who is confronted with having to "blow the whistle" in the interests of advocating patient safety.

82. In particular, it seems quite absurd that section 62I requires the written authorisation of the Director-General of Queensland Health before a disclosure to prevent "serious risk to life, health or safety" can legally be made. Similarly,

disclosures in the "public interest" pursuant to section 62F must first be authorised, in writing, by the Director-General.

83. Section 62A may even operate to prevent a clinician from obtaining professional, industrial or legal advice concerning occurrences in Queensland Health.[65]

84. It is submitted that the current provisions are plainly unbalanced and serve as a disincentive to clinicians who feel ethically bound to act in a particular way in the interests of their patients. While it is not disputed that there should be proper protections for the confidentiality of patient information, this should not operate in any way which may fetter patient safety. At the very least, there should be amendments that allow clinicians to disclosure confidential information to:

(i) prevent risks to life, health or safety; and

(ii) obtain professional, industrial and legal advice.

85. Furthermore, it is submitted that the threat of criminal sanction is inappropriate in respect of clinicians who hold appropriate professional registration. Section 62A should not apply to registered clinicians on the basis that they are subject to professional disciplinary proceedings if they make unethical disclosures of patient information.

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[65] A written authority pursuant to section 62F was finally given by the then Director General Dr Buckland on 16 May 2005 to enable Queensland Health employees to communicate freely with the QNU and its legal representatives in respect of any official inquiries into the Bundaberg Base Hospital after an exchange of correspondence in which it was implied by Queensland Health that the union's members could not communicate any information to the union or the lawyers engaged to represent them which could identify patients.

Complaints Management & Resolution Reform

86. Effective management and resolution of complaints is of great concern to members. The QNU's ultimate submission in this regard is that there is a need for complaint management and resolution reform. The experience of the nursing staff at the BBH is that complaints and concerns raised by nursing staff regarding clinical outcomes were not adequately addressed by Queensland Health Executives. The internal complaints process was not promoted and not well known by staff. As an illustration, Michelle Hunter, indicated that while she knew that the BBH had access to the Queensland Health intranet, she did not know of web pages that gave guidance as to how to go about making a complaint[66].

87. On the whole the QNU supports the risk management and clinical governance recommendations in Chapter 9 of the Forster Review, the Final Report of findings of the Queensland Health Systems Review, tabled in Parliament on Friday 30 September 2005.

88. As detailed in the Forster review, the QNU supports and advocates for the adoption of a complaints model that provides for local complaint resolution with an escalation process to an independent complaints body. However, the QNU submits there should be a reduction in time frames regarding the escalation of complaints in the recommended Complaints Management & Resolution Model. The nominated total period of 30 days for escalation of the complaint to an independent complaints body is too long in the current environment where patient and staff safety are compromised by staff shortages. Furthermore, the

[66] Transcript at page 2046 line 7

QNU recommends that such reform be implemented across both the public and private sectors.

89. The QNU recommends that an adequately funded patient advocacy group be established to support patients in making complaints through this process.

90. Any new legislative framework should explicitly provide that complaints may be made as of right by medical and nursing staff as well as patients (cf s 59 *Health Rights Commission Act* 1991).

J.J. Allen

L.D.Coman

Counsel for the QNU

26 October 2005

David Groth

From: Gavin Rebetzke
Sent: Friday, 28 October 2005 12:59 PM
To: David Groth
Cc:

Subject: Revised submissions of QNU

The Secretary
Queensland Public Hospitals Commission of Inquiry

I attach revised QNU submissions to replace the submissions previously filed.

Apart from some cosmetic changes to the formatting of footnotes, the only changes are, in accordance with the Commissioner's direction yesterday, to supplement the submission by reference to the additional evidence given yesterday. Those supplementary submissions are:

a. para 3 - updating details re number of witnesses and statements
b. para 54 - reference to evidence of Gail Doherty
c. paras 62-64 - reference to evidence of Jenner and Mears
d. paras 67-68 - reference to evidence of Jenner and Mears
e. para 70 - reference to evidence of Jenner.

Gavin Rebetzke
Roberts & Kane Solicitors

QUEENSLAND PUBLIC HOSPITALS COMMISSION OF INQUIRY

SUBMISSIONS ON BEHALF OF THE QUEENSLAND NURSES' UNION

Contribution of the QNU to Investigations in relation to the Bundaberg Base Hospital

1. The Queensland Nurses' Union ("the QNU") supported nursing staff in raising concerns with the Director of Nursing, Ms Linda Mulligan, in October 2004[1] and February 2005[2]. The QNU encouraged Ms Toni Hoffman to put her concerns in writing to the District Manager and discussed other possible avenues of complaint to the Medical Board and Health Rights Commission. QNU officials met with Mr David Kerslake, Health Rights Commissioner, on 4 February 2005[3], the Chief Medical Officer, Dr FitzGerald, on 11 February 2005[4] and Mr James O'Dempsey, Executive Officer of the Medical Board, on 15 February 2005[5] in relation to concerns held by nursing staff at the Bundaberg Base Hospital ("BBH").

2. Subsequent to the then Minister for Health, Mr Nuttal, and the then Director-General of Queensland Health, Dr Buckland, advising staff on 7 April 2005 that the results of Dr FitzGerald's investigation would not be released, the QNU complained to the Crime and Misconduct Commission ("CMC") in relation to the failure of members of the executive management at the BBH to act upon complaints regarding Dr Patel.

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[1] Statement of Linda Mulligan, exhibit 180 paras 164 – 166

[2] Statement of Linda Mulligan, exhibit 180 paras 210

[3] Statement of David Kerslake, exhibit 354, paras 46 – 47, T.5661 – 5663

[4] Statement of Dr FitzGerald, exhibit 225, para 62, T.4205

[5] Statement of James O'Dempsey, exhibit 28, paras 30 – 31, T.638-639, T.641 – 642

3. Subsequent to the announcement of the Bundaberg Hospital Commission of Inquiry, the QNU and its legal representatives provided assistance to the Commission of Inquiry and the CMC by facilitating interviews by CMC investigators of its members, and the provision of statements of its members to the Commission of Inquiry.[6] The QNU, through its legal representatives, have provided 33 statements of its members to the Commissions of Inquiry. 22 of those statements have been admitted into evidence before the Commission of Inquiry and 14 of those members have been called to give evidence before the Commissions of Inquiry. The QNU also provided additional information to assist the Commission of Inquiry in its investigations,[7] and devised a patient key system which was adopted by the Commission.

4. The QNU filed a preliminary submission to the Bundaberg Hospital Commission of Inquiry, a copy of which is attached as Appendix 1. The QNU made a submission to the Forster Inquiry into Queensland Health, a copy of which is attached as Appendix 2.

Scope of these Submissions

5. These submissions are directed towards the terms of reference in paragraphs 2(b) to (e) of the Commissions of Inquiry Order (No 2) 2005 insofar as those

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[6] By letter dated 3 May 2005, Commissioner Morris QC requested the QNU to "provide full cooperation with the Inquiry", and specifically, "to identify those persons ... who are likely to be able to provide useful evidence to the Inquiry, ... [and] to prepare, and provide to the Inquiry, statements of the evidence which such witnesses are able to provide."

[7] The further information provided included suggesting lists of potential witnesses and documents to obtain on 16 May 2005. Many of the suggested witnesses were interviewed by Inquiry staff and ultimately gave evidence, and many documents the QNU suggested should be obtained were ultimately tendered in evidence.

terms of reference apply to evidence before the Commission concerning the Bundaberg Base Hospital ("the BBH").

6. The QNU is confident that the Commission, consistent with the thoroughness of its examination of issues during the public hearings, will conduct a thorough analysis of all the relevant evidence touching upon such matters. These submissions do not seek to duplicate such a process and are not intended to be an exhaustive or definitive analysis of all the evidence relevant to the BBH.

7. These submissions will attempt to highlight some of the most striking examples of failure on the part of the executive management at the BBH to address concerns raised by nursing staff during the course of Dr Patel's tenure as Director of Surgery and the findings and recommendations it is submitted should follow.

8. Consequent recommendations as to processes for clinical governance will be addressed mainly by reference to the QNU's submission to the Forster Inquiry and the Final Report of Mr Forster. Further submissions will be made as to some systemic issues which have been highlighted in evidence before the Commission.

9. It is not proposed in these submissions to address the questions of whether or not Dr Patel or any other practising doctors should face criminal or disciplinary action as a result of findings of failure in the care of patients. The QNU is confident that the Commission, assisted by submissions by the Bundaberg Hospital Patient Support Group and the Medical Board of Queensland, will address such matters without the assistance of submissions from the QNU. The QNU does not see its role as including passing judgment on the clinical competence of medical practitioners mentioned in evidence before the Commission. The QNU's approach has been to ensure as far as possible that the legitimate concerns of its members as to patient safety were appropriately

investigated by this Commission and other investigative bodies, and that the appropriate bodies pass such judgment. This is consistent with the approach taken by its members at the BBH during 2003 and 2004 when raising concerns regarding Dr Patel. Those members did not purport to be in a position to form conclusive judgments as to Dr Patel's clinical competence, but sought an appropriate assessment of such. As stated by Ms Toni Hoffman to Mr Leck on 20 October 2004[8], Ms Hoffman would have been quite happy to be proven wrong in her fears but wanted independent assurance from outside of the BBH that her fears were unfounded.

Summary of submissions re failure of clinical governance at BBH

10. The failure on the part of the Medical Board to properly investigate Dr Patel's United States registration history meant that an opportunity was lost to refuse registration of Dr Patel as a medical practitioner in Queensland or place appropriate restrictions upon his scope of practice.

11. The failure on the part of Dr Kees Nydam and, thereafter, Dr Keating and Mr Leck, to ensure that Dr Patel was appropriately credentialled and privileged prior to, or soon after, his appointment as Director of Surgery permitted the following consequences:

    (i) Dr Patel was permitted to perform surgery outside the scope of practice of the BBH;

    (ii) Dr Patel was permitted to perform surgery outside his own scope of practice; and

[8] Exhibit 8

(iii) Patients underwent procedures, in particular oesophogectomies, performed by Dr Patel that should never have been undertaken and died or otherwise suffered harm as a result.

12. Mr Leck and Dr Keating failed to take appropriate steps to ensure that Dr Patel was credentialled and privileged or to restrict his scope of practice despite knowledge of adverse outcomes of the patients, concerns voiced by medical and nursing staff and their knowledge as to the lack of credentialling and privileging of Dr Patel.

13. 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.

14. Mr Leck and Dr Keating should have, at the very latest in October or November 2004, at least restricted the scope of practice of Dr Patel. They failed to do so. This was most likely because of the prioritisation of budgetary considerations. Meeting elective surgery targets outweighed concerns for patient safety.

15. Mr Leck and Dr Keating failed to diligently investigate concerns raised by nursing staff as to Dr Patel's practice, apparently motivated by a desire to maintain his services as a surgeon.

16. Dr Keating was prepared to express dishonest opinions as to Dr Patel's level of clinical competence to Dr FitzGerald and the Medical Board so as to retain his services and Mr Leck was prepared to write a dishonest and unbalanced letter of support for Dr Patel to the local newspaper to the same end.

17. Mr Leck and Dr Keating betrayed the public trust incumbent in their positions as District Manager and Director of Medical Services in a way that requires consideration of charges of official misconduct.

18. The audit process of investigating concerns raised in relation to Dr Patel's practice, conducted by Dr FitzGerald, was not conducive to eliciting the full truth but rather fashioned to manage any adverse consequences to Queensland Health.

19. Such circumstances presented a compelling reason for Ms Toni Hoffman to ventilate her concerns outside Queensland Health to a local member of Parliament.

20. The response of Mr Leck, and subsequently the Director General and the Minister, to the public airing of legitimate concerns was to criticize and denigrate such disloyal behaviour.

21. The failure of the Queensland Health executive management at the BBH, and of Queensland Health generally, to appropriately address concerns raised regarding Dr Patel is indicative of a problematic management culture in Queensland Health that requires fundamental reform.

The Three Monkeys

22. The triumvirate of executive management at the Bundaberg Base Hospital exemplified the "three monkeys" management ethos of Queensland Health when addressing concerns as to clinical services and patient safety. Whilst each of the District Manager, Director of Medical Services and Director of Nursing demonstrated characteristics of each of the three monkeys, emphasis can be placed upon the relevant characteristics of each:

- Mr Leck would "see no evil" in the detailed written documentation of concerns from patients and nursing staff regarding Dr Patel;
- Linda Mulligan would "hear no evil", stifling verbal communication of concerns by nursing staff and taking the view that anything that could not be seen in writing need not be heard[9];
- Dr Darren Keating was the true exemplar of all three monkeys in closing his eyes and his ears to the mounting body of evidence casting serious doubts upon Dr Patel's competence and finding himself unable to utter words critical of Dr Patel to his District Manager, Dr FitzGerald or the Medical Board.

Scope of Practice of the Bundaberg Base Hospital

23. Dr Patel was permitted to perform surgery beyond the scope of practice of the BBH. Complex surgical procedures such as oesophagectomies and Whipples procedures were beyond the proper scope of practice of the BBH, in particular because of the nature of the available intensive care facilities.

24. The Intensive Care Unit (the "ICU") at the BBH is a Level 1 Combined Intensive Care/Coronary Care Unit. It did not have the services of a Specialist Intensivist but was medically managed by Dr Carter, an Anaesthetist. The limited number of available appropriately qualified and experienced nursing staff placed practical restrictions on the number of acutely ill patients who could have their needs met in the unit at any one time. It was well recognised at all relevant times that Level 1 Intensive Care Units of the nature of that at the BBH, should generally

[9] Evidence of Mr Leck T.7219, ll.30 – 40

only keep patients who require ventilation for between 24 and 48 hours before transferring them to a hospital with a higher level of intensive care[10]. The BBH ICU could only realistically deal with a maximum of two patients on ventilators at any one time because of nursing staffing levels.

25. The level of post operative care required for patients undergoing complex procedures such as oesophagectomies exceeded the capabilities of the BBH ICU. Such was recognised not only by Toni Hoffman but also by doctors who had practised at BBH prior to and during the relevant period under investigation[11]. Dr FitzGerald's evidence was that one would reasonably expect a reasonably competent Director of Medical Services to realise that such procedures were outside the scope of practice of such a hospital[12].

Scope of Practice of Dr Jayant Patel

26. It is now of course abundantly clear that surgery of such complexity was also outside the individual scope of practice of the surgeon, Dr Patel. He had in fact been restricted from performing procedures including oesophagectomies and Whipples procedures in the United States. Two of the four patients upon whom Dr Patel performed oesophagectomies died shortly thereafter. The other two suffered significant post operative complications. Dr de Lacy gave graphic evidence as to the poor outcome of the second of such survivors, Mr Philip

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[10] Statement of Toni Hoffman, exhibit 4, paras 3 – 6 and statement of Dr Carter, exhibit 265, paras 29 – 35

[11] Dr Jayasekera at T.5973; Dr Baker at T.6358; Dr Joiner at T.5012, l.45 to 5013, l.5; Dr Risson at T.2813, ll.40-45 and T.2811, ll.10-30; Dr Kariyawasam at T.3074, l.30 to T.3075, l.5. (cf. Dr Anderson T.2764-2765). Such opinion was shared by other witnesses including Dr FitzGerald at T.3146, ll.1-15 and Dr De Lacy at T.3603 – T.3604, T.3612, ll.20-30, T.4422, l.5 to T.4423, l.10

[12] T. 3152, ll.15-50

Deakin, and the impact upon his quality of life[13]. The other survivor, Mr Grave, underwent three returns to theatre for post-operative complications, an extended stay in the ICU at Bundaberg and his post-transfer treatment is described in the evidence, including that of Dr Peter Cook.

27. There are real questions as to whether any of these four patients should have undergone oesophagectomies at all. Certainly, none of them should have undergone oesophagectomies at the BBH carried out by Dr Patel. The fact that Dr Patel was not restricted from undertaking surgical procedures of such complexity until after the death of the fourth oesophagectomy patient, Mr Kemps, is tragic and disgraceful. That Dr Patel could be permitted to continue to undertake surgery of this nature for a period over 18 months after specific concerns were raised with regards to it by Toni Hoffman and Dr Joiner in May and June 2003 exemplifies the failure of clinical governance on the part of the executive management of the BBH.

28. The failure on the part of the Medical Board of Queensland to make further enquiries into Dr Patel's United States registration history meant that an opportunity to not register or to restrict Dr Patel's scope of practice upon registration was lost. Such unfortunate failure would not have had the tragic consequences it did but for the failures of those who held management positions at the BBH.

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[13] T.3064, l.30 to T.3065, l.10

Lack of Credentialing and Privileging of Dr Patel

29. The Commission has heard a great deal of evidence confirming the importance of an appropriate process of credentialing and privileging medical practitioners. The importance of such is spelt out in the terms of the relevant Queensland Health policy governing credentialing and privileging[14]. The then Acting Director of Medical Services, Dr Nydam, gave no consideration to any process of credentialing and privileging of Dr Patel before or upon employing him as a Senior Medical Officer, and soon after appointing him to the unsupervised position of Director of Surgery. Dr Keating became well aware of the lack of any process of credentialing and privileging of surgeons upon commencing in the position of Director of Medical Services soon after. The requirement for appropriate credentialing and privileging of a surgeon in such circumstances is manifest. The need that Dr Patel be appropriately credentialed and privileged with regard to the service capabilities of the BBH and its ICU, should have been seen as even more acute by any diligent Director of Medical Services upon concerns being raised by Toni Hoffman and Dr Joiner in May and June 2003 in relation to the two patients who underwent oesophagectomies during that period, followed by the voicing of concerns by Dr Peter Cook in relation to the second of those patients.

30. The inability on the part of Dr Keating to secure a nominated representative of the relevant college to sit on a credentialing and privileging committee does not excuse such failure in the circumstances. The need for such a process being manifest in relation to any surgeon, combined with the mounting chorus of alarm

[14] Exhibit 279

regarding Dr Patel's practice and in particular his willingness to practice outside the scope of practice of the BBH, required an appropriate response on the part of Dr Keating and Mr Leck, not a slavish adherence to the terms of a written policy. Evidence has been given by appropriately qualified persons that a practical and available option was to seek the participation of an appropriately qualified surgeon, either from the local or from a hospital in Brisbane. Such an approach would have been infinitely preferable to doing nothing.

Mr James Phillips (P34)

31. On 19 May 2003, Mr Phillips underwent an elective oesophagectomy performed Dr Patel. An anaesthetist reported to ICU staff that the patient had no obtainable blood pressure during the last 45 minutes of surgery. The patient was obviously critically ill when admitted to the ICU and ultimately died on 21 May 2003. During the course of the patient's time in the ICU, Dr Patel informed medical and nursing staff that the patient was stable.

32. In late May or early June 2003[15] Toni Hoffman, accompanied by the then Director of Nursing, Ms Goodman, met with Dr Keating to voice concerns arising from the above events. Toni Hoffman expressed her concerns about surgery such as oesophagectomies being undertaken at the BBH given the lack of appropriate ICU facilities for post operative care for such patients. She expressed her concern that Dr Patel would describe a patient as stable when they were obviously critically ill. She voiced further concerns as to Dr Patel's behaviour and the apparent lack of modern clinical knowledge. The Commission would accept

[15] Statement of Toni Hoffman, exhibit 4, para 10; Dr Keating states on or about 30 May 2003 at para 48 of his statement exhibit 448.

the evidence of Ms Hoffman that at this meeting she raised the issue of Dr Patel undertaking oesophagectomies outside the scope of practice of the BBH[16].

33. Dr Keating's response to such concerns raised by Ms Hoffman at that time was completely inappropriate and inadequate. Ms Hoffman states that she was told by Dr Keating that Dr Patel was a very experienced surgeon and that she was required to cooperate with him and work together, that there was an expectation that the BBH would continue to provide surgery to the people of Bundaberg and that Dr Patel was experienced and used to performing those types of surgery[17]. Dr Keating states that he suggested to Toni Hoffman that she make an appointment with Dr Patel to discuss the issues raised by her, explain unit capability and capacity and the need to work together as a team[18]. Given the nature of the issues raised and the confronting personality of Dr Patel, it is of no surprise that any attempt at rational discussion of such issues and cooperation with Ms Hoffman was flatly rebuffed by Dr Patel. It was inappropriate in the circumstances to expect Ms Hoffman to be able to successfully resolve such a situation with Dr Patel. It was an inexcusable abdication of responsibility on Dr Keating's part to proceed in such a fashion. The matters raised with him at that time should have led him to facilitate an appropriate process of credentialing and privileging of Dr Patel and to properly define the scope of practice of Dr Patel and the BBH with regards to complex procedures such as oesophagectomies.

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[16] Although Dr Keating claims a lack of recollection of this issue being raised (para 48, Exhibit 448), at no time prior to the commencement of the Commission hearings did he voice dissent with the contents of Ms Hoffman's correspondence to Mr Leck in October 2004 referring to such an issue having been raised (Exhibit TH10 and TH37)

[17] Exhibit 4, para 11.

[18] Para 48 of exhibit 448.

34. Ms Hoffman recalls a further meeting soon after with Dr Keating in the company of Dr Joiner during which she once again raised concerns about oesophagectomies being carried out at the BBH in light of her understanding that Dr Patel was to undertake another oesophagectomy. Dr Joiner's recollection was unclear as to having accompanied Toni Hoffman to any meeting with Dr Keating and as to exactly when in relation to the dates of procedures regarding Mr Phillips and Mr Grave that he had two meetings with Dr Keating to discuss associated issues. The Commission would accept Ms Hoffman's recollection as to having met with Dr Keating and Dr Joiner, despite Dr Keating's denial of such, given Dr Keating's lack of dissent to Ms Hoffman having clearly stated that such a meeting occurred in her correspondence with Mr Leck[19].

Mr James Grave (P18)

35. Mr James Grave underwent an elective oesophagectomy performed by Dr Patel on 6 June 2003 and was admitted to the ICU later that day. He returned to the operating theatre on 12 June 2003 and 16 June 2003 for abdominal wound dehiscence and on 18 June 2003 for leakage from the jejunostomy site. Prior to the third return to theatre, steps had been taken to find a bed in a Brisbane Hospital for the patient. Dr Patel did not cooperate in the process required for transfer.

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[19] Statement of Toni Hoffman, exhibit 4, TH10 and TH37 which was available to Dr Keating at the very latest on or about 22 October 2004. Notwithstanding some variations in the accounts of Ms Hoffman, Dr Joiner and Dr Keating as to the exact chronology of conversations with Dr Keating on such topic, it is most certain that Ms Hoffman and Dr Joiner raised concerns with Dr Keating on at least 3 occasions as to the capability of the BBH to appropriately care for patients undergoing oesophagectomies.

36. Toni Hoffman communicated her concerns as to Mr Grave, in the context of her continuing concerns of Dr Patel operating outside the BBH scope of practice, by e-mails to the then Director of Nursing[20] and to the Director of Medical Services, Dr Keating[21].

37. It was in the context of his concerns as to the circumstances of Mr Grave, that Dr Joiner again raised concerns with Dr Keating as regards to the capacity of the BBH to properly care for oesophagectomy patients[22]. His evidence[23] is enlightening when depicting the nature of Dr Keating's dealings with Dr Patel. Dr Joiner attended a meeting with Dr Keating and Dr Patel regarding Mr Grave. Dr Joiner states that he and the intensive care staff had formed the view that the patient required ongoing intensive care support and should be transferred to an intensive care unit at the Royal Brisbane Hospital. At the time that decision was made, it was ascertained that a bed was available in the RBH ICU so that the patient could be transferred. Dr Patel confronted Dr Joiner and threatened to resign if the patient was transferred to the RBH. At the meeting with Dr Keating and Dr Patel, Dr Keating was informed that an ICU bed in Brisbane had been arranged but that Dr Patel was not agreeable to the patient being transferred to Brisbane. Presented with the sound clinically-based arguments for transfer of the patient on the one hand and the unreasoned but adamant refusal on the part of Dr Patel to the patient being transferred, a compromise was reached at the meeting that the patient would remain for another couple of days and his clinical

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[20] Statement of Toni Hoffman, exhibit 4, TH2.

[21] Statement of Toni Hoffman, exhibit 4, TH3.

[22] T.5013 – T.5014.

[23] T.5015 – T.5016.

condition be reviewed. The fact that Dr Keating would permit a compromise of care of the patient to mollify the recalcitrant Dr Patel is an inexcusable abdication of responsibility on his part. It exemplifies the approach of Dr Keating throughout the controversy regarding Dr Patel in that he was prepared to make decisions compromising the clinical care of patients in light of a fear that to do otherwise would result in the loss of the services of Dr Patel to the Hospital.

38. Mr Grave was eventually transferred to the Royal Brisbane Hospital on 20 June 2003. In late June or early July 2003, Dr Peter Cook, Intensivist, and communicated his concerns regarding surgery of such complexity and being undertaken at the BBH, including verbally to Dr Keating. Dr Keating states that such conversation occurred on 1 July 2003, and that Dr Cook expressed concern about this type of operation being performed at Bundaberg in that it required robust intensive care backup[24]. Dr Keating says that he told Dr Cook he would discuss such concerns with the Directors of Surgery and Anaesthetics and with the Credentials and Privileging Committee at the Hospital. No such functioning committee in so far as surgery was concerned was then in existence. Dr Keating claims to have relied upon the opinions of Dr Patel and Dr Carter to conclude that oesophagectomies could be safely performed at Bundaberg Hospital[25]. The failure on the part of Dr Keating, in light of the manifestly unfavourable outcomes for Mr Phillips and Mr Grave and the concerns raised by a specialist intensivist, to take appropriate steps to credential and privilege Dr Patel and define an appropriate scope of practice for the BBH is inexcusable.

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[24] Exhibit 448, para 52.

[25] Exhibit 448, para 55.

Other Warnings Ignored

39. During 2003, every one of six patients at the BBH who had a peritoneal dialysis catheter placed by Dr Patel suffered complications, including acute and chronic infections and migration of catheters requiring further surgery, mostly related to the incorrect external positioning of the catheters. On 17 December 2003, Mr Eric Nagle (P30) underwent surgical intervention to address the migration of his peritoneal catheter. This additional surgery was required because of the incompetence of Dr Patel in inserting the catheter, yet was performed by Dr Patel. The patient died as a result of haemopericardium due to perforated thoracic veins during the insertion of a permacath by Dr Patel. The patient would not have required this additional procedure had his peritoneal catheter been in position correctly in the first place. Renal Unit Nurses, Ms Robyn Pollock and Ms Lindsay Druce, reported their concerns on 10 February 2004 to the then acting Director of Nursing, Mr Patrick Martin[26]. Mr Martin spoke to Dr Keating on the same day to relay such concerns[27]. Mr Martin relayed to nurses Druce and Pollock that Dr Keating required further statistics regarding procedures undertaken by Dr Patel highlighting all renal related cases uneventful compared with the number of adverse events which had recurred as a result of an intervention[28]. Dr Keating took no immediate steps to clarify the significance of the information that had been presented to him which would have informed him

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[26] Statement of Lindsay Druce, exhibit 67, para 17. Statement of Robyn Pollock exhibit 70, para 30.

[27] Statement of Patrick Martin, exhibit 139, paras 26 - 27.

[28] Statement of Patrick Martin, exhibit 139, PM3.

of the alarming fact of a 100% failure rate on the part of a surgeon undertaking such a procedure.

40. Dr Miach has given evidence that he supplied Dr Keating in about April 2003 with the results of the Renal Unit Nurses' investigations demonstrating 100% complication rate in relation to the insertion of peritoneal dialysis catheters. It is not completely clear on the evidence whether such document would have been that which now forms exhibit 18 or exhibit 69. Dr Miach's evidence is that when he again raised such issue with Dr Keating on 21 October 2004, Dr Keating denied having earlier spoken to Dr Miach regarding the matter or seeing any such document. The Commission would prefer the evidence of Dr Miach in this regard. In any event, even according to the account given by Dr Keating, at the time he was following up on the most recent concerns raised by Toni Hoffman on 20 October 2004 with Mr Leck, he failed to question Dr Miach as to the significance of such information and claims that even at that stage not to have realised that the information indicated 100% failure rate in such a procedure. Dr Keating claims to have failed to advert to the possibility that such information would be evidence indicative of a general lack of clinical competence on the part of Dr Patel.

41. Dr Keating showed a repeated inability or unwillingness to address concerns raised by nursing staff in relation to the clinical practice of Dr Patel. When concerns were raised by Gail Aylmer, the Infection Control Clinical Nurse Consultant, as to rates of wound dehiscence in mid 2003, she was placed in the invidious position as a nurse of having to question an apparently experienced surgeon as to the possible courses of wound dehiscence noted in relation to his patients. Ms Aylmer should never have been placed in such a position and Dr

Keating should have taken the obvious and appropriate steps of having such an issue examined in an appropriate mortality and morbidity committee by appropriate clinicians or at least reviewed by an appropriately qualified surgeon[29]. This was yet another example of Dr Keating seemingly not wanting to become involved in examining concerns regarding Dr Patel's clinical confidence and not taking appropriate steps for proper review of such concerns.

42. Similarly, after receiving a report sourced from three nurses who witnessed serious breaches of aseptic technique on the part of Dr Patel, Dr Keating was prepared to dismiss the matter on the basis that Dr Patel denied such behaviour. Dr Keating demanded statistical data to support the assertion that there was a problem with Dr Patel's aseptic technique[30] despite the available eye witnesses who could verify a very serious breach of aseptic technique.[31]

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[29] Statement of Gail Aylmer, exhibit 62, para 3.

[30] Statement of Gail Aylmer, exhibit 59, para 19.

[31] See statements of Waters, Yeoman and Turner (exhibits 195 – 197)

Toni Hoffman raises concerns with Mr Leck in March 2004

43. The Commission would accept the evidence of Mr Leck that he discussed the matters raised with him (and confirmed in writing) by Ms Hoffman in March 2004 with both Dr Keating and Ms Mulligan. Not only is it likely that such matters would be discussed by the District Manager with the Director of Medical Services and the Director of Nursing, but Mr Leck's account of such conversations was detailed and plausible. In particular, his detailed recollection of the nature of the response from Ms Mulligan had the ring of truth[32]. It exemplified the management style of Ms Mulligan that if a concern was not raised officially and adopted in writing, then it could be disregarded.

44. The nature of the concerns communicated directly to Mr Leck at such time, notwithstanding Toni Hoffman's communication that she did not wish the matter to be treated as an official complaint, would have caused any reasonable District Manager in Mr Leck's position to question the advice he was receiving from Dr Keating that the matter was a mere personality conflict and to consider some type of appropriate peer review of Dr Patel's surgical competence. At the very least, it would have caused a reasonably diligent District Manager to ensure that the long overdue process of credentialing and privileging of Dr Patel proceed as a matter of haste and that the scope of practice of the BBH be urgently reviewed in light of the matters raised.

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[32] "I went to talk to Linda about it and I said I had received this correspondence from Toni but that Toni didn't want me to do anything with it, and Linda said that her usual response in that situation would be to hand the letter back and ask the staff member to give it to them when they were prepared to lodge a complaint.", T.7219, ll.30 – 40.

Lack of Nursing Leadership

45. From the time of her commencement in the position of District Director of Nursing, Ms Linda Mulligan had the responsibility for providing leadership to the nursing staff of the BBH, being accessible to staff who wished to voice concerns or seek her assistance and to advocate for the nursing staff with executive management. As a nursing professional Ms Mulligan had professional responsibilities in addition to managerial responsibilities. It is clear that she failed to fulfil these responsibilities of her position. She adopted the role of a manager rather than a nursing leader[33]. She made herself inaccessible to nursing staff, placing restrictions on the ways in which she could be contacted and essentially remaining invisible to most of the nursing staff[34]. She did not do rounds of the wards and if staff wanted to see her they had to make appointments. Toni Hoffman in her statement says "We had to make appointments with her secretary and had to give a reason for why we wanted the appointment. The appointments were often cancelled after they were made."[35] She discouraged open discussion of concerns ventilated by nursing staff at meetings[36].

46. In a hospital the size of the BBH, there was no practical reason why the Director of Nursing could not play a visibly supportive role and provide leadership to the nursing staff. Her cessation of regular nursing rounds upon taking up her position removed the opportunity for nursing staff to ventilate concerns with her

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[33] Statement of Gail Aylmer, exhibit 59, para 43

[34] Statement of Toni Hoffman, exhibit 4, paras 78-81; statement of Jennifer White, exhibit 71, paras 31-32

[35] Statement of Toni Hoffman, exhibit 4, paras 78 – 80

[36] Statement of Gail Aylmer, exhibit 59, para 43; statement of Toni Hoffman, exhibit 4, para 77

in an informal way. She did not choose to take a proactive role in visiting nursing staff in e.g. the ICU after becoming aware of events that must have been traumatic for nursing staff e.g. following the death of Mr Kemps.

47. Ms Mulligan regularly received reports from the after hours nurse manager and monthly cost centre reports for the ICU which should have led her to take a more proactive approach in investigating those stresses being placed upon the ICU and nursing staff by Dr Patel operating outside of the scope of practice of the ICU.

48. The extent of Ms Mulligan's failures to provide nursing leadership left nurses feeling unsupported by management and Ms Hoffman in the position that she felt that she had to look to officials of the QNU for such nursing leadership.

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49. In a meeting with Mr Leck and Ms Mulligan on 20 October 2004 and in subsequent correspondence, Ms Hoffman raised detailed concerns in relation to Dr Patel's behaviour and clinical competence including reference to particular patients. The failure of the executive management to act swiftly and decisively at such time was inexcusable and had tragic consequences, eg for Mr Gerard Kemps. The concerns of executive management should have been heightened by the subsequent interviews of Drs Berens, Risson and Strahan[37]. The failure to discuss the matters raised with Dr Miach is inexplicable. Dr Keating's advice to Mr Leck that there were no substantial matters of concern requiring any immediate action was either dishonest or grossly incompetent.

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[37] Exhibit 448, DWK 62-64

50. It is clear that the approach of management in response to the matters raised by Ms Hoffman was to attempt to arrange a review by a hand picked doctor suitable to management who would report only to the executive management of the BBH. It was not until mid December that there was any official contact with the office of the Chief Medical Officer and not until January 2005 that there was official advice of the complaint to zonal management.

51. The executive management's inertia in response to the matters raised by Ms Hoffman contributed directly to the unfortunate result for Mr Gerard Kemps.

52. At the very latest following upon the interviews of medical practitioners in early November 2004, Mr Leck and Dr Keating should have taken action, if not to suspend Dr Patel from practice entirely, than to at least limit his scope of practice by way of prohibiting him from undertaking complex surgery such as oesophagectomies. Their failure to do so constituted a gross breach of the trust invested in them by way of their positions.

53. Mr Leck and Dr Keating as District Manager and Director of Medical Services respectively, both held an appointment in a unit of public administration within the meaning of s.21 of the *Crime and Misconduct Act* 2001. It is submitted that their failures as particularised above involved breaches of the trust placed in them as holders of the respective appointment within the meaning of s.14 of the Act. It is submitted that such conduct could amount to a disciplinary breach providing reasonable grounds for termination of the services of such a holder of an appointment and thus can amount to official misconduct within the meaning of s.15 of the Act. It is submitted that the evidence before the Commission is sufficient for referral of both Mr Leck and Dr Keating to the CMC for investigation of charges of official misconduct.

54. In a telephone conversation with an officer of the Queensland Health Audit and Operational Review Branch on 17 December 2004[38], Mr Leck stated that the district would need to handle Ms Hoffman's complaint carefully as Dr Patel was of great benefit to the district and they would hate to lose his services as a result of the complaint. It is an irresistible inference from all the evidence that the manner in which the executive management responded to Ms Hoffman's complaint was coloured by the executive management not wishing to lose the services of Dr Patel as a surgeon. Any surgeon was better than no surgeon at all in the context of budget imperatives driven by the need to meet elective surgery targets for the financial year. Dr Patel's value to the BBH in maximising the throughput of elective surgery procedures was well known to both Mr Leck and Dr Keating and such was expressed to Dr FitzGerald in his subsequent investigation. The e-mail from Dr Keating to the Nurse Unit Manager of the Operating Theatres, Ms Gail Doherty, of 8 February 2005[39], lends support to the view that the executive management were desirous of retaining the services of Dr Patel at least until 30 June 2005, notwithstanding the seriousness of any concerns being raised as to his clinical competence. Ms Doherty said in evidence that the only response she received when she raised the issue of excessive overtime and staff fatigue was this email from Dr Keating[40]. She gave evidence that, if Dr Patel had been suspended from practicing as a surgeon in late 2004

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[38] Exhibit 225 GF10

[39] Exhibit 72 (also admitted as exhibit 501) and see the Statement of Gail Doherty, exhibit 509, paras 24 - 26

[40] T.7403 ll.10-15

or early 2005, that "we certainly would not have met targets if he had been suspended"[41].

55. It was in this context that Ms Hoffman eventually saw no alternative but to raise her concerns outside the Queensland Health system with a Member of Parliament.

Mr Gerard Kemps (P21)

56. Mr Kemps underwent an oesophagectomy carried out by Dr Patel on 20 December 2004. The Commission received evidence from nursing staff, including Mr Damien Gaddes, Ms Jenelle Law and Mr Martin Brennan, and doctors, including Dr Berens, Dr Kariyawasam and Dr Carter, as to the circumstances of Mr Kemps' operative and post-operative treatment. For the reasons explored elsewhere in the submission, Mr Kemps should never have undergone such a procedure at the Bundaberg Base Hospital, and certainly not at the hands of Dr Patel.

57. Mr Kemps death was a "reportable death" within the terms of s.8(3)(d) of the *Coroners Act* 2003. Drs Berens and Carter sought the advice of Dr Keating as to whether such death should be reported to the Coroner. Dr Keating abdicated his responsibility as Director of Medical Services to advise Dr Berens and Dr Carter that such death should be reported and failed to take any steps to report the death himself.

58. In circumstances where Dr Berens and Dr Carter acted conscientiously in seeking the guidance of the Director of Medical Services as to whether the death should

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[41] T. 7400 -7401

be reported and were motivated partly by concerns that reporting such death might cause further distress to Mr Kemps' family in light of his impending funeral, it is not submitted that the Commission should make recommendations adverse to those doctors.

59. Dr Keating's failure in such regard is more serious because of his position of responsibility in responding to Drs Berens' and Carter's request for advice. It is submitted that there is sufficient evidence to justify referral of this matter to the CMC for consideration as to whether or not a charge of official misconduct should be laid against Dr Keating for failing to advise Dr Berens and Dr Carter that the death should be reported and failing to take any steps to report the death himself. Alternatively, it is submitted that there is sufficient evidence for consideration as to whether the matter should be referred to the Commissioner of the Police Service for prosecution of Dr Keating for an offence pursuant to s.7(2) of the *Coroners Act* 2003.

Executive Management's attempts to retain the services of Dr Patel

60. The conduct of Mr Leck and Dr Keating throughout the whole period of time that concerns were raised in relation to Dr Patel was indicative of a desire to retain his services as a general surgeon so as to meet budget imperatives, regardless of any legitimate concerns as to patient safety. The extent to which they were prepared to disregard patient safety and the length they were prepared to go to to retain Dr Patel's services are starkly demonstrated by their conduct in early 2005.

61. Dr Keating expressed dishonest opinions as to Dr Patel's clinical competence and judgment in conversations with Dr FitzGerald and in written communications to the Medical Board considering Dr Patel's re-registration. Mr Leck authored a dishonestly unbalanced letter of support for Dr Patel to the local newspaper for the express purpose of attempting to retain Dr Patel's services as a surgeon.

62. After Mr Messenger's statements in Parliament had been publicly reported, the Acting Director of Nursing, Deanne Walls, called a meeting of ICU staff on the 23 March 2005. This meeting was attended by the District Manager, Mr Leck. Mr Leck expressed anger about nurses breaching the confidentiality provisions of Queensland Health's Code of Conduct. Mr Leck referred to a departmental Industrial Relations document to the effect that staff breaching confidentiality could be imprisoned for two years and lose their jobs[42]. He stated that he was appalled that such a senior surgeon of the hospital could be treated in such a way that denied him natural justice[43]. Mr Leck berated the nurses and said that he had it on good sources that the letter was leaked by an intensive care nurse[44]. Ms Karen Jenner gave evidence that "I was intimidated[45]. He was quite angry"[46] and "I think his whole manner was threatening"[47]. "He told us that we had caused a rift between medical and nursing staff, that the general public would

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[42] Statement of Toni Hoffman, exhibit 4, para 167

[43] Statement of Toni Hoffman, exhibit 4, para 168

[44] Statement of Karen Jenner, exhibit 508, para 15

[45] When pressed during cross examination at T.7394 ll.28-50 as to what was intimidating about Mr Leck's behaviour, she responded "The fact that he came unannounced to the ICU. We had no idea he was coming. That we got this lecture and that he left. I'd never met Mr Leck previous to that despite working at the hospital for two years, and to go to a meeting thinking it's going to be something that's completely different, to sit there, cop this huge, big lecture about all the stuff that he mentioned and then for him just to leave is quite intimidating when that's not what you're expecting the meeting to be about".

[46] T.7394 ll.49-50

[47] T.7395 ll.1-10

never look at ICU staff the same way again ... and that the person who leaked the letter couldn't be trusted"[48]. Mr Leck left without giving any of the nurses an opportunity to respond to his comments or to discuss their concerns about Dr Patel[49].

63. Mr Leck later that day had a meeting with Level 3 Nursing staff. He reiterated that the leak was a breach of the Code of Conduct. "He was visibly angry and upset. He was saying that he knew that it was a nurse that was responsible for the leak"[50]. He went on to say that "a nurse had gone behind our backs and released this information before the report was released and they would be reprimanded"[51]. There would be serious repercussions[52]. Nursing staff felt extremely "intimidated"[53] and "powerless"[54] as a result of the comments made by Mr Leck. Ms Robyn Pollock wanted to respond to Mr Leck "... but I didn't because I felt intimidated ... I felt chastised after he left, and I hadn't done anything wrong. I was very concerned for whoever had sent the letter to Mr Messenger. I felt that if it was known who leaked the letter, that person would lose their job."[55]

64. It is significant that these meetings occurred in circumstances where there was an apparent expectation on the part of Mr Leck that the media might make

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[48] T7393 ll.30-40

[49] Statement of Toni Hoffman, exhibit 4, para 169; T.7393 ll.40-48

[50] Statement of Robyn Pollock, exhibit 70, para 48

[51] Statement of Robyn Pollock, exhibit 70, para 48

[52] Statement of Margaret Mears, exhibit 507, para 11

[53] Statement of Robyn Pollock, exhibit 70, para 49

[54] Statement of Gail Alymer, exhibit 59, para 46

[55] Statement of Robyn Pollock, exhibit 70, paras 48 - 49

contact with members of the nursing staff to inquire as to those matters referred to in the letter of Ms Toni Hoffman[56] that had been tabled in Parliament the previous day[57]. Attendees at the meetings included Ms Hoffman and other nurses named in the letter[58]. It is reasonable to infer that Mr Leck intended to discourage, by threats and intimidation, those present at the meetings from discussing matters concerning Dr Patel with anyone outside Queensland Health.

65. Mr Leck's letter to the Bundaberg News Mail, 28 March 2005 while clearly supporting Dr Patel[59] expressed Mr Leck's view that the fact that allegations had been made public was "reprehensible"[60].

66. An email from Mr Peter Leck to Mr Dan Bergin, dated 7 April 2005, indicates that Mr Leck was prepared to threaten staff with reprisals for raising issues in a public forum. He refers to the staff member as "the culprit who leaked this information" and refers to them being "on very dangerous ground". He is prepared to use the Code of Conduct to "deliver some firm and scary messages"[61].

67. At the Staff Forum attended by Mr Leck, Dr Steve Buckland and the Honourable Gordon Nuttall MP on the 7 April 2005 Mr Nuttall and Dr Buckland told nursing staff that, because of the release of material in Parliament by Mr Messenger and the departure of Dr Patel from Australia, results of the Queensland Health

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[56] Exhibit 4 TH37

[57] Statement of Karen Jenner, exhibit 508, para 15; T.7387 ll.9-16

[58] Karen Stumer, Karen Fox, Karen Jenner, Vivienne Tapiolais: Statement of Karen Jenner, exhibit 508, para 15

[59] "Dr Patel is an industrious surgeon who has spent many years working to improve the lives of ordinary people in both the United States and Australia. He deserves a fair go."

[60] Exhibit 473

[61] Exhibit 477

investigation that had been underway would not be released[62]. Ms Margaret Mears states "It was very clear - made very clear to us that the information from Dr Gerry Fitzgerald inquiry would not be released"[63]. Nursing staff felt that they were being criticised as being disloyal[64]. Ms Margaret Mears states: "During the meeting, Mr Nuttall said that the only way that we could stop the rubbish that was going on at Bundaberg Base and in Bundaberg was if we were to vote Mr Messenger out"[65].

68. Ms Karen Jenner, in response to Dr Buckland saying that he supported his staff one hundred percent and would not tolerate his staff being tried by the media and being denied natural justice, asked Dr Buckland if he "supports his staff one hundred percent then where is the support for the nurses who made the multiple formal complaints about Dr Patel..."[66]. Ms Jenner stated: "His response was words to the effect - he sort of said to me, "Well, what part of 'there's going to be no inquiry don't you understand?'", that - once again, that Dr Patel wasn't in the country and he couldn't - he didn't have a right of reply, and he hadn't been given natural justice, so that was it. There was nothing more that they could really do regarding Dr Patel"[67].

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[62] Statement of Gail Alymer, exhibit 59, para 47

[63] T.7376 ll.9-20; Statement of Margaret Mears, exhibit 507, paras 12 - 15

[64] Statement of Karen Jenner, exhibit 508, para 18

[65] T.7375 L.34

[66] Statement of Karen Jenner, exhibit 508, para 18

[67] T.7384 l.40- T.7385 l.5

69. Dr Buckland acknowledged in his evidence that, with the benefit of hindsight, he and the Minister had not handled the meeting well[68].

Dr FitzGerald's investigation

70. Dr FitzGerald's conduct in relation to the clinical review instigated as a response to Ms Hoffman's complaint was indicative of a preparedness on his part to "manage" the situation in a manner that would not reflect adversely upon the hospital management or Dr Patel and facilitate the desire of the executive management to retain Dr Patel's services. In February 2005 interviews of nurses were conducted. Ms Karen Jenner states: "They told us that they were gathering information to see whether or not an investigation would be necessary ... We were told quite clearly that it wasn't an investigation at that stage"[69]. The report initially authored by Dr FitzGerald failed to include the serious findings as to Dr Patel operating outside the scope of practice of the BBH and the failure of the executive management to address concerns raised about Dr Patel over a lengthy period of time. The admitted approach of Dr FitzGerald to only include positive comments in relation to Dr Patel and deliberately not include negative ones necessarily presented a skewed report of the true situation.

71. It seems clear that subsequent steps on the part of Dr FitzGerald and Queensland Health were driven only as a result of the growing public exposure of the true situation and recognition on the part of Dr FitzGerald and his superiors that their response needed to be heightened in light of the growing public controversy. In

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[68] Statements of Dr Buckland, exhibit 335 para 34 and exhibit 337 paras 10 -13

[69] T.7390 ll.20-50; Statement of Karen Jenner, exhibit 508 paras 13 - 14

the absence of public disclosure by Mr Messenger of matters in Parliament, it is a reasonable inference that the process of response to Ms Hoffman's complaint may well have finished with the preparation of the confidential audit report of Dr FitzGerald, with the real adverse findings by Dr FitzGerald never finding their way into print. The addition of the memo to the Director-General containing those adverse findings would appear to have been responsive to the matters being raised in Parliament and advice being sought by the Director-General as to the process of his review.

72. It is a reasonable inference that, but for the depth of negative feeling ascertained by the Director-General and the Minister for Health on their visit to Bundaberg on 7 April 2005 and the knowledge obtained by the Director-General through an internet search regarding Dr Patel's registration on the same date, the matter would have concluded as was flagged to staff on that date, ie Dr FitzGerald's report would never have been released, the investigation would have ceased and the whole matter been buried. The announcement of a further review on 9 April 2005 was clearly a response to the realisation on the part of the Director-General and the then Minister that adverse publicity would necessarily result when the information regarding Dr Patel's registration became public knowledge.

Additional Submissions on Systemic Issues

73. The QNU submissions to the Queensland Health Systems Review (the Forster Inquiry) is included as Appendix 2. We urge upon the Commission consideration of the whole of such submission and the recommendations submitted therein. We refer in particular to the following aspects of that submission which have been highlighted and exemplified by evidence given before the Commission.

Chronic Underfunding of Queensland Health Services

74. The Commission has received evidence which puts beyond doubt those propositions submitted in Appendix 1 and Appendix 2 by the QNU that the Queensland public health system has been chronically underfunded for many years, with consistently lower expenditure per capita than in other States and Territories[70]. Queensland Health has placed an undue emphasis upon achieving greater and greater efficiency outcomes with insufficient emphasis placed upon the quality of care provided and whether health outcomes are satisfactory. By producing a situation where Queensland has the lowest number of medical practitioners and nursing practitioners per head of population than any other State[71], emphasis on efficiency gains has had a negative impact on quality of care as doctors and nurses are placed in situations where they are unable to deliver an optimal standard of nursing care. Frustration at being unable to provide appropriate standards of care has led to medical practitioners and nurses leaving the Public Health system or decreasing their hours of work because they can no longer cope with unrealistic work demands and the consequences such have upon their ethical obligations as health professionals[72]. Doctors and nurses within the Queensland Health system are working harder and being paid less than their interstate counterparts, becoming increasingly frustrated by the level of care that they can provide their patients and leaving the Public Health system in many cases after being burnt out by the system. The inescapable conclusion is

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[70] See eg Statement of Dr Buckland, exhibit 336 paras 64, 77 & 78; Exhibit 310 Extracts from the Productivity Commission's report on Government Services 2005

[71] Statement of Dr Young, exhibit 209

[72] See eg the evidence of Dr McNeill at T.4748-4749

that there can be no real solution to the crisis existing in the Queensland public health system without a greater allocation of public monies to that public health system.

Queensland Health's Culture of Secrecy

75. The Commission has a body of evidence before it which confirms and exemplifies submissions previously made by the QNU as to the culture of secrecy in Queensland Health and the need for improved openness, transparency and accountability in Queensland Health. The obsession with secrecy in Queensland Health has largely been derived from a combined imperative to "put a lid" on controversy and dissent and at the same time manage the budget imperatives of continuing to do more with less. Greater openness and transparency is necessary for there to be a genuine community debate in relation to priorities for our Queensland Health system. The evidence before the Commission in relation to the Queensland Health management of information concerning waiting lists and the measured quality program are only examples of the past approach which must be changed.

76. The evidence before the Commission has also provided examples of abuse of the cabinet exemption provisions of the *Freedom of Information Act* 1992. Attached as Appendix 3 to these submissions is a submission of the QNU on the review of the *Freedom of Information Act* 1992 to the Legal, Constitutional and Administrative Review Committee dated 14 May 1999. Submissions with regards to s.36 of the Act appear at page 7 of that document.

The Code of Conduct

77. The evidence shows instances of the Queensland Health Code of Conduct being used to intimidate nurses in an attempt to stifle discussion about concerns nurses had in Bundaberg.

78. As well as the specific events referred to above, there has been a general concern amongst Queensland Health staff as to reprisals from management in response to them raising issues. In his evidence to the Commission, Dr Nankivell stated: "The people in Queensland Health are terrified of the code of conduct, particularly the nurses, because the nurses are much more vulnerable. Doctors, if they get sacked, can always go to the private sector. Nurses are - because they're a more vulnerable group, are terrified"[73].

79. Toni Hoffman was concerned that on making the complaint in October 2004 her career was over[74]. Enrolled nurse Jenelle Law, in referring to the death of Mr Kemps, stated: "I was so distressed with what had happened that I wrote a statement early in January 2005 ... It took me quite a while to work up the courage to hand it in after I had written it as I feared for my job." She concludes "I have been concerned that I will lose my job. A few weeks ago, around the end of April start of May 2005, the tension over the Inquiry and the media attention

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[73] T.2958

[74] T.171: "I was very well aware that by making this complaint, even just to Peter Leck and Linda Mulligan at that particular time, that I would never get a chance to progress my career in Queensland Health...My belief was that I would never get an opportunity to act up into a higher position, I would never be given the opportunity to go to conferences or any of the things that enable you to progress in your profession. I knew that my making this complaint, that that would be the end of my career and it may even be the end of my career at that hospital.

just became too much. I broke down because I was so upset. Counsellors have since been brought in to speak to us"[75].

80. Nursing staff were concerned about reprisals which operated as a disincentive to make complaints and raise issues. Ms Robyn Pollock stated her feelings towards speaking out after an incident where Mr Peter Leck and others from the executive team accused staff of the Renal Unit of leaking information to the head of the renal patients support group: "I became so guarded in what I said to Richard and to others after this experience. That treatment was a huge disincentive to speaking out to management"[76]. As to the meeting where Mr Peter Leck accused nurses of leaking information to Mr Messenger in March 2005, Ms Gail Aylmer stated: "I was concerned that if nurses were made the scapegoat for this situation, then nurses in the future would be very reluctant to advocate for the patient."[77]

81. The lack of leadership support by Queensland Health management at BBH and management inaction in responding to concerns raised by nursing staff caused the nurses great anxiety and distress, especially as further incidents occurred. Registered Nurse Karen Fox pinpoints the cause of the major depressive disorder she is currently suffering as resulting from "the events I witnessed on 27 July 2004 [the death of Mr Bramich], and exacerbated by subsequent events at the BBH concerning Dr Patel. My condition deteriorated during the time Dr Patel

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[75] Exhibit 160, paras 18 - 25; Jenelle Law clarifies in cross examination that until she spoke to her solicitors she thought she would lose her job (T. 2214, l.55)

[76] Exhibit 70, para 47

[77] Statement of Gail Aylmer, exhibit 59, para 46

continued to work at the hospital and I ultimately needed to cease work for a period of time earlier this year"[78].

82. It is the right of all Queensland Health staff and citizens to raise concerns in the public domain about the conduct of public institutions including hospitals and other health facilities. It is the department's role to deal with these concerns in a timely and appropriate manner or to refute them. Misuse of the Code of Conduct and legislation must cease if we are to create a positive, problem solving and open culture in Queensland Health it must not be used to silence criticism and debate.

83. Recommendations:

(i) It is essential that the Code of Conduct be reviewed and amended to allow for discussion without fear of disciplinary action.

(ii) It is recommended that a penalty to be imposed for the inappropriate use of this document by Queensland Health management.

(iii) Amendments must be made to the *Health Services Act* 1991 and the *Whistleblowers Protection Act* 1994 to remove doubts held by QNU members as to whether they can approach the QNU, and other appropriate bodies, to raise and discuss matters of concern without the fear of disciplinary action or criminal prosecution.

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[78] Exhibit 485, para 9

Amendments to the *Whistleblowers Protection Act* 1994

84. The QNU agrees with the recommendations put forward by the Forster review as to changes to the *Whistleblowers Protection Act* 1994:

(i) Whistleblowers should be able to lodge Public Interest Disclosures with Members of Parliament and have protection under the Act;

(ii) The media should not be approved as one of the bodies to whom Whistleblowers can lodge Public Interest Disclosures and have protection under the Act; and

(iii) Any person not just a public officer should be afforded protection for disclosing danger to public health and safety.

(iv) In addition it is submitted that whistleblowers should be able to lodge Public Interest Disclosures with their relevant professional and / or industrial organisation, eg the AMAQ and QNU.

Amendments to the *Health Service Act* 1991

85. The QNU submits that in addition to changes recommended by Mr Forster to the *Whistleblowers Protection Act* 1994, it is necessary to amend the provisions relating to confidentiality contained in the *Health Services Act* 1991. Section 62A of the *Health Services Act* 1991 presently makes it a summary offence for employees to disclose to another person any information "if a person who is receiving or has received a public sector health service could be identified from the confidential information". The exceptions in which such information can be disclosed are numerous, but unlikely to be of assistance to a clinician who is confronted with having to "blow the whistle" in the interests of advocating patient safety.

86. In particular, it seems quite absurd that section 62I requires the written authorisation of the Director-General of Queensland Health before a disclosure to prevent "serious risk to life, health or safety" can legally be made. Similarly, disclosures in the "public interest" pursuant to section 62F must first be authorised, in writing, by the Director-General.

87. Section 62A may even operate to prevent a clinician from obtaining professional, industrial or legal advice concerning occurrences in Queensland Health.[79]

88. It is submitted that the current provisions are plainly unbalanced and serve as a disincentive to clinicians who feel ethically bound to act in a particular way in the interests of their patients. While it is not disputed that there should be proper protections for the confidentiality of patient information, this should not operate in any way which may fetter patient safety. At the very least, there should be amendments that allow clinicians to disclosure confidential information to:

(i) prevent risks to life, health or safety; and

(ii) obtain professional, industrial and legal advice.

89. Furthermore, it is submitted that the threat of criminal sanction is inappropriate in respect of clinicians who hold appropriate professional registration. Section 62A should not apply to registered clinicians on the basis that they are subject to professional disciplinary proceedings if they make unethical disclosures of patient information.

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[79] A written authority pursuant to section 62F was finally given by the then Director General Dr Buckland on 16 May 2005 to enable Queensland Health employees to communicate freely with the QNU and its legal representatives in respect of any official inquiries into the Bundaberg Base Hospital after an exchange of correspondence in which it was implied by Queensland Health that the union's members could not communicate any information to the union or the lawyers engaged to represent them which could identify patients.

Complaints Management & Resolution Reform

90. Effective management and resolution of complaints is of great concern to members. The QNU's ultimate submission in this regard is that there is a need for complaint management and resolution reform. The experience of the nursing staff at the BBH is that complaints and concerns raised by nursing staff regarding clinical outcomes were not adequately addressed by Queensland Health Executives. The internal complaints process was not promoted and not well known by staff. As an illustration, Michelle Hunter, indicated that while she knew that the BBH had access to the Queensland Health intranet, she did not know of web pages that gave guidance as to how to go about making a complaint[80].

91. On the whole the QNU supports the risk management and clinical governance recommendations in Chapter 9 of the Forster Review, the Final Report of findings of the Queensland Health Systems Review, tabled in Parliament on Friday 30 September 2005.

92. As detailed in the Forster review, the QNU supports and advocates for the adoption of a complaints model that provides for local complaint resolution with an escalation process to an independent complaints body. However, the QNU submits there should be a reduction in time frames regarding the escalation of complaints in the recommended Complaints Management & Resolution Model. The nominated total period of 30 days for escalation of the complaint to an independent complaints body is too long in the current environment where patient and staff safety are compromised by staff shortages. Furthermore, the

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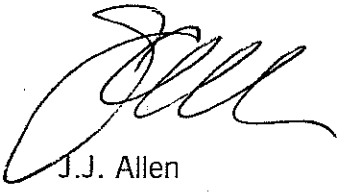
[80] T.2046, l.7

QNU recommends that such reform be implemented across both the public and private sectors.

93. The QNU recommends that an adequately funded patient advocacy group be established to support patients in making complaints through this process.

94. Any new legislative framework should explicitly provide that complaints may be made as of right by medical and nursing staff as well as patients (cf s 59 *Health Rights Commission Act* 1991).



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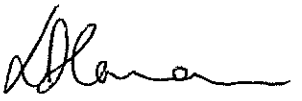

L.D.Coman

Counsel for the QNU

28 October 2005