QUEENSLAND PUBLIC HOSPITALS COMMISSION OF INQUIRY

SUBMISSIONS IN REPLY ON BEHALF OF THE QUEENSLAND NURSES' UNION

A. SUBMISSIONS BY THE MEDICAL BOARD OF QUEENSLAND

Submissions re Mr Desmond Bramich (P11) at Part C, pp.2-11

1. (a) Pages 3-4 "Sr Hoffman gave evidence of very significant concerns relating to Dr Patel's conduct in relation to this patient in her statement and in her oral evidence. The concerns emerged from her chronology as follows:

> "...
> 10. That Dr Patel performed a pericardiocentesis to extract fluid from around the heart. This was contra-indicated from the ultrasound. He did so with a needle and stabbed around the patients heart 50 times (T.141)"

(b) Page 10:

> "No other witness supported Hoffman's account that Dr Patel stabbed the witness (sic) 50 times. This could only be hearsay. Whilst it is clear that Dr Patel applied 10 or more stabbing motions, no eye witness saw 50 motions, as stated (as hearsay) by Hoffman (no other witness corroborates Hoffman's hearsay version)."

(c) These submissions appear to carry with them an implicit criticism of Ms Hoffman's veracity as regards her testimony concerning Mr Bramich. Ms Hoffman never purported to give anything other than hearsay evidence in relation to the ill advised and incompetently executed perocardiocentesis. The only reference in Ms Hoffman's evidence to "around 50 times" is in her oral testimony during the course of a very lengthy and emotional account as to her concerns regarding Mr Bramich, during which she makes it quite clear that she is merely repeating what she has been told by a nursing colleague

who was extremely concerned as to the matter[1]. Any implicit criticism contained in these submissions is unwarranted.

2. (a) Pages 3-4: "Sr Hoffman gave evidence of very significant concerns relating to Dr Patel's conduct in relation to this patient in her statement and in her oral evidence. The concerns emerged from her chronology as follows:

> "...
> 12. That her sentinel event form raising concerns about the patient had been downgraded by Dr Keating (this was incorrect - see evidence of Raven)."

(b) The evidence of Ms Raven on this issue is demonstrably incorrect. Ms Raven[2] claimed that the Sentinel Event form had not been downgraded but there had been an administrative error whereby the separate Sentinel Event form and Adverse Event form were stapled together in error and entered as an Adverse Event in the Register[3]. Such understanding on the part of Ms Raven was based upon what she had been told by others and was proven subsequently to be incorrect.

(c) The evidence of Mr Leck[4] was that he was aware of the receipt of both forms, i.e. a Sentinel Event form and an Adverse Event report and after discussion with the Quality Co-Ordinator (most likely Dr Jane Truscott acting in that position) and Dr Keating, Mr Leck made a

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[1] T.141, ll.30-35

[2] Ms Raven was a most unimpressive witness. If the Commission feels it necessary to make any findings as to the credibility of Ms Raven's evidence, it is submitted that it would be instructive to view the video testimony of her evidence during the afternoon of Day 21 of proceedings, although a perusal of the evidence at T.2247 - 2316 may well suffice in this regard.

[3] Statement of Ms Raven, Exhibit 162, para 39, T.2295 - 2298

[4] Statement of Mr Leck, Exhibit 463, paras 32-36, T.7225

determination that the events described in the Sentinel Event form did not constitute a sentinel event. Whilst such a conclusion was demonstrably incorrect in the circumstances, such evidence is completely consistent with the understanding formed on the part of Ms Hoffman that the Sentinel Event form had been downgraded by Dr Keating, i.e. that it had been deemed not to be a sentinel event, as was reported to her by Dr Truscott[5]. The criticism of the evidence of Ms Hoffman in this regard is unwarranted.

3. (a) Page 11:

> "The issue which is of greater significance is the blocked and/or inadequate drainage. It is submitted that Dr Woodruff's evidence is important on this issue. Given that the time period prior to this discovery is unclear, there is insufficient evidence that the drainage failure can be sheeted home to Dr Patel over other staff. No referral for disciplinary investigation of any individual is justified. It was a team failure."

(b) The opinion expressed by Dr Woodruff that a team failure on the part of medical and nursing staff to note that an underwater seal drain was not working contributed to Mr Bramich's death was, it is submitted, in error and based upon a misunderstanding as to whether the contents of an Adverse Incident Report[6] were of any real significance in relation to Mr Bramich's outcome. In relation to such a contention, the following should be noted:

(i) Dr Woodruff contends that medical or nursing staff should have realized that Mr Bramich had an internal bleed and inadequate

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[5] Statement of Ms Hoffman, Exhibit 4, paras 86 - 89

[6] Exhibit LTR 9 to the statement of Ms Raven; Exhibit 162

drainage but cannot point to anything in the patient's medical record prior to 1300 that should have raised such concern;

(ii) Observations of the underwater seal drainage as late as 1120 record that the ICC is swinging and draining and that consideration has been given to mobilizing the patient;

(iii) There would appear to be a sudden decompensation of Mr Bramich at 1300 consistent with internal haemorrhaging that is not being adequately drained but nothing to alert medical or nursing staff prior to that of those facts;

(iv) The drainage tube is readjusted at that time and it is most unlikely that an absence of water in the drain could have gone unnoticed at that time;

(v) Indeed the fact that the readjustment of the drain produced some outflow indicates positively to the contrary;

(vi) The absence of water in a drain is noted at some undetermined time after Mr Bramich has been transferred to the ICU at 1420;

(vii) There is nothing to indicate that the absence of water in a drain at some undetermined time subsequent to Mr Bramich's decompensation at 1300 and subsequent transfer to the ICU at 1420 in any way contributed to his ultimate demise;

(viii) The Pathologist, Dr Ashby, did not agree that the drainage was not adequate[7].

In the circumstances, there is no evidence to justify a finding of a "team failure" as contended.

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[7] T.2719, ll.30-45

B. SUBMISSIONS ON BEHALF OF LINDA MULLIGAN

1. The content of paragraph 16 of the outline appears to carry with it an implicit criticism of Ms Hoffman for failing to explicitly state verbally or in writing to Mr Leck in late February 2004 that she had formed the view that Dr Patel was "clinically unsound". Such a criticism is not warranted:

   (a) Although Ms Hoffman did not explicitly state an opinion that Dr Patel was "clinically unsound", she did raise with Mr Leck matters of clinical concern relating to Dr Patel at such time (as is clear from the contents of the relevant part of TH10[8]);

   (b) Although Ms Hoffman had formed such a belief, it was not one she was able to hold with certainty (still hoping as late as October 2004 to be proven wrong in her concerns) and in the absence of support from Dr Carter, she did not feel that she had sufficient evidence to ground an official complaint or allegation of clinical incompetence[9].

2. Paragraph 86 of the outline contained an allegation that "a small minority" (unnamed) of an unidentified group (but presumably allegedly nursing staff of the BBH) "chose for reasons best known to themselves, not to voice their concerns to" Ms Mulligan. This regrettable allegation should not receive acceptance by the Commission:

   (a) The suggestion that members of nursing staff, for some unknown reason, chose to hide concerns regarding Dr Patel is flatly contradicted by the weight of evidence:

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[8] Statement of Ms Hoffman, exhibit 4.

[9] T.1378 l.15 - 1380 l.58.

(i) Ms Hoffman raised concerns with the then Director of Nursing, Ms Goodman, and Dr Keating regarding Dr Patel operating outside the scope of practice of the BBH in May and June 2003, in person and by way of e-mails[10];

(ii) Ms Pollock and Ms Druce reported their concerns regarding patients suffering complications following peritoneal dialysis catheter placements by Dr Patel with the then acting Director of Nursing, Mr Martin on 10 February 2004[11];

(iii) Ms Aylmer raised concerns as to rates of wound dehiscence with Dr Keating in mid 2003[12];

(iv) Ms Aylmer and Ms Pollock reported concerns as to Dr Patel's aseptic technique to Dr Keating on 27 November 2003[13];

(v) Ms Hoffman raised specific concerns as to the behaviour of Dr Patel, including clinical matters, in March 2004;

(b) The management style adopted by Ms Mulligan was not one that facilitated a frank and confident communication to her of concerns held by nursing staff[14];

(c) The only member of the nursing staff to whom such an allegation was put by Counsel for Ms Mulligan i.e. Ms Hoffman, strenuously rejected the allegation[15].

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[10] See paras 32 and 36 of the Submissions on behalf of the Queensland Nurses' Union.

[11] See para 39 of the Submissions on behalf of the Queensland Nurses' Union.

[12] See para 41 of the Submissions on behalf of the Queensland Nurses' Union.

[13] See para 42 of the Submissions on behalf of the Queensland Nurses' Union.

[14] See paras 45 and 46 of the Submissions on behalf of the Queensland Nurses' Union.

[15] T.1382 l.28 - 1383 l.4.

C. SUBMISSIONS ON BEHALF OF PETER LECK

1. Paragraphs 112 to 147 deal with "Mr Leck's meetings with the nurses on 23 March 2005". Paragraph 140 reads:

> "The following people were at the first (ICU) meeting. Mr Leck, Ms Walls, Ms Hoffman, Ms Jenner, Ms Marks, Ms Stumer, Ms Fox and Ms Tapiolas. Of those eight people only three, namely Mr Leck, Ms Hoffman and Ms Jenner gave evidence on this topic. Ms Fox gave a 'supplementary' statement but it does not address this issue. Ms Walls, Ms Marks, Ms Stumer and Ms Tapiolas did not give evidence at all. **It can be assumed that the Commission did not call evidence from Ms Walls, Ms Marks, Ms Stumer, Ms Fox and Ms Tapiolas because their evidence would not assist."** (emphasis added)

2. Such a submission is quite disengenuous and lacking in any weight:

    (a) There is nothing to suggest that either Ms Walls or Ms Marks were ever approached by the Commission to provide their recollection of the meeting;

    (b) The Commission and Mr Leck's legal representatives[16] are aware that, notwithstanding the Commission not admitting the following statements into evidence:

        (i) Vivian Ann Tapiolas at paras 34 - 39 of her statement dated 18 May 2005 provides a consistent account of Mr Leck's behaviour at the meeting with ICU nurses, describing Mr Leck as being "incredibly angry", and describing the event as intimidating and creating a very hostile and threatening environment;

        (ii) Karen Lynne Fox at paras 24 and 25 of her statement dated 18 May 2005 provides a consistent account of the meeting and

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[16] A CD containing the statements referred to was provided by the Commission to all interested parties during the Bundaberg sittings of the Bundaberg Hospital Commission of Inquiry

refers to it as being one of the factors that exacerbated her symptoms of anxiety and depression;

(c) Mr Leck's legal representatives did not request that any of Ms Walls, Ms Marks, Ms Stumer or Ms Tapiolas be called to give evidence on the topic;

(d) The submission fails to recognize the nature of, and practical constraints upon a Commission of Inquiry of this type;

(e) No such Jones v Dunkel reasoning is appropriate in these circumstances.

JJ Allen
Counsel for the QNU
1 November 2005