STATEMENT OF TONI ELLEN HOFFMAN of address known to the Queensland Nurses' Union

Qualifications and Experience

1. I have been a Registered Nurse since 1979 and hold a midwifery endorsement. I have been employed since my registration primarily in Intensive Care. I obtained an Intensive Care Certificate in 1981 through Kings College Hospital in London. I also hold the academic qualifications of Bachelor of Nursing from Monash University (1997), Graduate Certificate in Management from QUT 2003, and a Masters in Bioethics from Monash University 2003.

2. Since obtaining my Intensive Care Certificate in 1981 I have worked in Intensive Care Units in the Harley Street Clinic in London, Tasmania, Nambour General Hospital and Saudi Arabia. In June 2000 I commenced in my current position as Nurse Unit Manager of the Intensive Care Unit of the Bundaberg Base Hospital.

Intensive Care Unit

3. The Intensive Care Unit at the Bundaberg Base Hospital ("the ICU") is a Level 1 Combined Intensive Care/Coronary Care Unit with five funded beds. As Nurse Unit Manager, I am the Cost Centre Manager for the unit and have responsibility for staffing, looking after stock, making sure patients are cared for and monitoring of nursing standards. I am responsible for recruitment and retention of appropriately qualified and experienced nursing staff on the unit. The unit employees 15 fulltime equivalent nurses which equates to about 20 personnel as some nurses work part-time. Generally, three Registered Nurses are rostered to each 12 hour shift. We now have two 12 hour shifts each day. The first shift commences at 7.00 am and continues until 7.30 pm that

evening. The nightshift commences at 7.00 pm and continues until 7.30 am the next morning. Because of the limited number of available appropriately qualified and experienced nursing staff, there are limits to the number of acutely ill patients who can have their needs met in the unit. We also do not have the type of backup available to Intensive Care Units which have a rating greater than a Level 1 Intensive Care Unit such as 24 hour radiology call services and 24 hour pathological services.

4. I am aware that the College of Intensive Care Physicians publishes a classification system and accompanying guidelines for three levels of Intensive Care Unit. Level 3 units are well resourced units located in tertiary referring hospitals such as the Royal Brisbane and Princess Alexandra Hospitals. The Bundaberg Base Hospital because of its limited resources has a Level 1 Intensive Care Unit.

5. The guidelines indicate that Level 1 Intensive Care Units should only keep patients who require ventilation for between 24 and 48 hours before transferring them to a better equipped hospital. In reality, the Bundaberg Base Hospital could only deal with a maximum of two patients on ventilators at any one time because ventilated patients require one on one nursing care from a dedicated Registered Nurse who must not leave the bedside. If there are two ventilated patients in the unit, all three Registered Nurses rostered on shift are utilised; one nurse for each ventilated patient, and the third nurse as a "runner". There are actually three ventilators located in the unit, however, the third ventilator is generally required for best practice reasons as a backup in the event of failure or malfunction of one of the other ventilators.

6. In addition, the Bundaberg Base Hospital Intensive Care Unit does not have a specialist intensivist. The most senior doctor is a specialist anaesthetist. Hospitals in Brisbane to which we refer patients have specialist intensivists on staff.

Dr Patel

7. I recall Dr Patel commencing in his position as Director of Surgery in early 2003. I believe I may have been on holidays at that time and that he had been working for some weeks before I met him.

8. Soon after that time I began to become concerned about the number of patients suffering post-operative complications following surgery conducted by Dr Patel.

9. On 19 May 2003, I was present when a patient, P34 arrived in the Intensive Care Unit following an oesophagectomy by Dr Patel. I was present when there was a handover by the anaesthetist and theatre nursing staff. I recall it being reported the patient had had no obtainable blood pressure during the last 45 minutes of surgery, and recall Dr Alison McCready (the anaesthetist) commenting "*It was a very expensive way to die*". I remember that while the patient was in the ICU, the patient required 25 milligrams per minute of adrenalin and 100% oxygen. The patient had fixed and dilated pupils. Dr Patel stated to nursing staff and documented in the chart that the patient was stable and maintained such a position throughout the time that the patient was in the Intensive Care Unit. I believe he also told the family that the patient was stable, but cannot now recall the source of this recollection other than it was information received by me in the ordinary course of my acting as the Nurse Unit Manager of the ICU. It was obvious however that the patient was

extremely ill and indeed the patient progressed to brain death. The course of treatment for this patient was very difficult in that he required dialysis and there was constant conflict between the anaesthetist, Dr Patel and the physicians about his care. The Director of Anaesthetics and Intensive Care Unit was away at this time and Dr Younis was left in charge. He appeared to be reluctant to question whether or not we should be doing such large operations in the hospital. I was also concerned that whilst nursing staff were reporting an accurate picture of the extremity of the condition of the patient to his relatives, this was in direct conflict with information Dr Patel was giving the family that the patient was stable.

Early report of concerns to Director of Medical Services

10. As a result of my concerns regarding the treatment of this patient I spoke to the Director of Medical Services Darren Keating on two occasions in late May or early June 2003 to voice such concerns. At one of these meetings I was accompanied by Glennis Goodman (the then Director of Nursing), and on another occasion, by Dr Joiner, a General Practitioner, who would perform locum anaesthesia for the hospital. I expressed my concerns about surgery such as oesophagectomies being performed at the Bundaberg Hospital which lacked appropriate Intensive Care facilities for post-operative care for patients undergoing such major surgery. I also expressed concerns that Dr Patel would describe patients as stable when they were obviously extremely ill.

11. I recall Dr Keating saying that Dr Patel was a very experienced surgeon and that we were required to cooperate with him and work together. He said that there was an expectation that the Bundaberg Base Hospital would continue to

provide surgery to the people of Bundaberg and that Dr Patel was experienced and used to performing those types of surgery.

12. I recall at the first meeting with Dr Keating when I was accompanied by Glennis Goodman, I attempted to paint an overall picture of the problems we were encountering in the Intensive Care Unit with Dr Patel including our observations as to the way Dr Patel interacted and spoke which indicated that something was not quite right. I also recall advising that Dr Patel appeared to be very old fashioned in his treatments and that he would write things in the chart like "patient stable" when the patient was actually extremely unstable. I recall Dr Keating saying that we had to allow that Dr Patel was from another country. I specifically recall advising Dr Keating that it was more like that we were coming from "two different planets".

13. The two meetings I had with Dr Keating on this occasion (the first accompanied by Glennis Goodman, and the second by Dr Joiner) were meetings that occurred within a day or a couple of days of each other. They occurred after the incident involving the patient P34 on 19 May 2003, but before the admission to the Intensive Care Unit on 6 June 2003 of another patient, P18, after he underwent an oesophagectomy.

Patient P18

14. In the week of P18's admission on 6 June 2003, I recall Dr Patel made a loud comment upon exiting the Intensive Care Unit one day that we should warn the staff who were working on Thursday and Friday that he would be in the unit for the whole two days while his oesophagectomy patient was in the unit. I took from his comment that he did not trust the ICU nursing staff or medical staff to care for his patient.

15. I should mention that previously there had been numerous occasions when there was conflict between orders for medical treatment between Dr Patel and the anaesthetic medical staff. The nursing staff were unnecessarily dragged into this because of conflicting medical orders being made. I should mention that it is usual practice in Australia for patients admitted to an Intensive Care Unit to have their conditions managed by the Intensive Care medical staff, and that the surgeons who performed operations upon those patients would have a consulting role only. I am aware, however, that the system is different in the United States of America in that surgeons retain control of the medical treatment of their patients after they have been admitted to an Intensive Care Unit post-surgery. This is simply a reflection of different models of care being employed in the different countries and a reflection in particular of the fact that Australia leads the world in respect of Intensive Care practice. For example, the first specialist intensivists in the world received their qualifications in Australia, and Australian qualified intensivists are world leaders in terms of research.

16. My recollection of the comment made by Dr Patel is assisted by the fact that another nurse present in the ward also heard the comment and documented it in a letter addressed to myself which at some later time I subsequently passed onto the Director of Nursing. Attached and marked "TH1" is a copy of the letter I received from Kay Boisen RN dated 3 June 2003 documenting this incident.

17. The oesophagectomy patient (P18) was subsequently admitted to the ward on Friday 6 June 2003. P18 had undergone surgery performed by Dr Patel which was of the same extensive and complicated nature which I and Dr Joiner had

suggested to Dr Keating only a short time previously should not be performed in the Bundaberg Base Hospital because of limited facilities and resources.

18. Prior to working at Bundaberg Hospital I had considerable experience working in Level 3 Intensive Care Units caring for post-oesophagectomy patients. I can say that it would be usual practice for a post-oesophagectomy patient to be discharged from an Intensive Care Unit to a general ward after 2 or 3 days. P18 ended up having a prolonged Intensive Care Unit experience before ultimately being transferred to the Royal Brisbane Hospital on 20 June 2003, 14 days after surgery.

19. On 12 June 2003, P18 was returned to theatre for wound dehiscence. Wound dehiscence is when a patient's surgical wound comes apart. The surgical wound in P18 case had been sutured together. Wound dehiscence is one of our clinical indicators which indicates that something is wrong and we strive to ensure that the rate of wound dehiscence is kept low. One of the reasons for the occurrence of wound dehiscence is infection, however, I recall many of the cases of wound dehiscence in Dr Patel's patients had no indications of infection. Some of the reasons for the episodes of wound dehiscence given by Dr Patel as related to me by the Nurse Unit Manager for theatre were inferior suture material or that he had left junior doctors to sew the patient's surgical wound up at the end of a case.

20. On 15 June 2003 P18 was returned to theatre for a second episode of wound dehiscence. He was returned to theatre a third time on about 18 June 2003 after it was decided to wait another 24 hours before transferring the patient to Brisbane. A bed had been found for the patient at a Brisbane hospital at that point in time, however, the surgeon at that hospital required that Dr Patel

speak to him personally before accepting the referral of the patient. Dr Patel refused to speak to the surgeon in Brisbane. I am aware of his refusal to speak to the Brisbane surgeon because I was present in the ICU when this was discussed between Dr Patel and a junior doctor (whose identity I do not now recall) who had been liaising with the Royal Brisbane Hospital by telephone. Subsequently I was informed by an anaesthetist that Dr Patel had gone to see Dr Keating and that a decision had been made to wait another 24 hours and reassess the patient before transfer to Brisbane.

21. The patient was then returned to theatre for the third time that night, and subsequently there was an acceptance by Dr Patel that the patient needed to go to Brisbane. By that stage the Royal Brisbane Hospital no longer had a bed which it could offer to the patient. In addition, the Princess Alexandra and Mater Misericordiae Hospitals were unable to accept the patient due to a lack of available beds. I am also aware that the Prince Charles Hospital indicated that they would like to help but they did not have the facilities to care for a patient who had had such major surgery outside of the expertise of the Prince Charles Hospital.

22. I am also aware that the junior doctor, when making enquiries of the Princess Alexandra and Royal Brisbane Hospitals, was questioned by the surgeons who he spoke to as to why such complicated surgery was being performed at Bundaberg Hospital when we did not have an intensivist on staff.

Written Concern

23. At this point in time, I put my concerns regarding this patient into writing by emailing the Director of Nursing Glennis Goodman. Attached and marked

"TH2" is a copy of the email sent by me to Glennis Goodman at 12.03 pm on 18 June 2003.

Email to Director of Medical Services on 19 June 2003

24. The next day, 19 June 2003, P18 condition continued to be perilous, and I again put my concerns in writing, this time to the Medical Superintendent, Dr Darren Keating. In my email I outlined the situation as it currently existed in respect of the care of P18, noting that he had been returned to theatre twice for wound dehiscence since he underwent an oesophagectomy on 6 June, and that he had again returned to theatre the previous evening for repair of a leaking jejunostomy. A jejunostomy is a tube which is inserted into a patient to feed the patient directly into their digestive system. I noted that he was becoming more haemo dynamically unstable. I had a concern over the lack of sufficient ICU backup to care for the patient, and that both the Royal Brisbane and Princess Alexandra Hospitals had expressed concerns about this surgery being done at the Bundaberg Base Hospital without backup. I noted that there remained unresolved issues concerning the behaviour of the surgeon in the unit, and that there were presently no beds to be found anywhere in the State to transfer the patient. I stated my belief that we were working outside of the scope of practice for a Level 1 Intensive Care Unit, and that the behaviour of Dr Patel in the unit needed to be discussed.

25. Attached and marked "TH3" is a copy of the email sent by me to Dr Darren Keating at 12.52 pm on 19 June 2003. There exists a facility on the Queensland Health email system whereby you can check when an email sent to another Queensland Health Officer has been opened. I recently checked to ensure that the email I sent to Dr Keating had in fact been opened and

receipted by him and the email system noted that this email had been opened and receipted by Dr Keating at 1452 hours on 19 June 2003.

26. In my email to Dr Keating dated 19 June 2003, which was primarily concerned with clinical matters, I also stated: "*The behaviour of the surgeon in the ICU needs also to be discussed, as certain very disturbing scenarios have occurred.*"

Sexual Harassment Complaint

27. This was a reference by me to the fact that I had received a complaint from one of the female Registered Nurses employed in the Intensive Care Unit that she had been subjected to sexual harassment by Dr Patel. I received that complaint verbally from Registered Nurse N.P.O. around the same time that P18 was an inpatient in the Intensive Care Unit. N.P.O. came to me and said that Dr Patel had asked her for her telephone number over the top of a patient whilst they were both attending to a patient. She stated that she had given him her telephone number but that he had gone on to continually telephone her and harass her and that he would come into the Intensive Care Unit to hang around her and that it made her uncomfortable.

28. I contacted the Human Resources Manager Ms Cathy Fritz and passed the complaint onto her for her to deal with. I am aware that Ms Fritz referred the matter to Dr Keating because she subsequently told me that that was part of the action that she had taken. I can fix the date that I spoke to Ms Fritz about NPO complaint as 24 June 2003 because I have a copy of an email that I sent on that date to my line manager, Director of Nursing Glennis Goodman. I told the Director of Nursing of the complaint as well as the Human

Resources Manager because the Director of Nursing is my direct line manager. Attached and marked "TH4" is a copy of the email sent by me to Glennis Goodman at 11.43 am on 24 June 2003.

29. I was subsequently told by an Intensive Care Unit nurse that Dr Patel had later come into the unit and remarked "*You can't do anything in Australia without getting into trouble*". I do not now recall the identity of the nurse who told me this.

30. On 3 July 2003 I received an email from the Infection Control Coordinator, Gail Aylmer. The email indicates a concern about the number of episodes of wound dehiscence that had occurred over the previous 6 to 8 weeks. The email was sent to myself, Liz Allen who is the Day Bed Manager for the hospital, Sharon Baxter who was a Clinical Nurse in the surgical ward, Di Jenkin who was the Nurse Unit Manager of the surgical ward, Faye Kuhnel who was the Nurse Unit Manager of the emergency department, Gwenda McDermid who was the Nurse Unit Manager of day surgery, Ann Robinson who was Nurse Unit Manager of the family unit, Karen Smith who was the Elective Surgery Coordinator, Joy Tilsed who was a Registered Nurse in a surgical ward, Jennifer White who was the Nurse Unit Manager of theatre, and a Janice Williams who I do not know, at least by that name as it appears on the email. The email asks us to gather any data regarding incidents of wound dehiscence and come to the seminar room without medical staff on Monday 7 July at 9.00 am to investigate the situation further.

31. I do not have any present recollection of attending a meeting on 7 July 2003 regarding this issue.

32. Attached and marked "TH5" is a copy of the email received by me from Gail Aylmer at 12.13 pm on 3 July 2003.

Patient P39

33. On 9 September 2003 I had occasion to email both the Director of Nursing Glennis Goodman and the Director of Medical Services Dr Darren Keating concerning a patient, P39, who was admitted to the ICU on 29 August 2003 following a motor vehicle accident suffering major chest injuries, multiple fractured ribs and splenic injuries.

34. P39 had been managed in the unit on continuous positive airways pressure (CPAP) for a number of days, but had developed complications including atrial fibrillation and fainting attacks. He required drainage of accumulated blood in his chest cavity and on 9 September 2003 I was informed as the Nurse Unit Manager of the ICU that he would proceed to theatre the next day for drainage of the blood in his chest cavity and possibly the insertion of an intercostal catheter and ventilation. I was concerned because this patient would most likely require a lengthy period of ventilation. The patient had already been in the unit 12 days and was in poor health.

35. Of greater concern, however, was that I was told that Dr Patel and the ICU Director, Dr Martin Carter, had come to an agreement by which Dr Patel would only operate if Dr Carter agreed not to subsequently transfer the patient to Brisbane. I do not now recall who told me of this agreement. It may have been Dr Carter, however I am unsure. I do, however, have a clear recollection of receiving that information in the course of my carrying out my duties and role as the Nurse Unit Manager in charge of the Intensive Care Unit. I put my concerns in writing and sent them to both the Director of Nursing & Medical

Services after discussing my concerns verbally with Dr Carter. I do not now have a specific recollection of what Dr Carter said to me on this occasion about my concerns; however, this was only one of numerous occasions when I discussed concerns with Dr Carter regarding keeping patients in the unit who should be transferred. The general theme of what Dr Carter told me during these conversations was that we had to work with Dr Patel.

36. Attached and marked "TH6" is a copy of the email sent by me to Glennis Goodman with a cc to Dr Darren Keating at 12.38 pm on 9 September 2003 regarding this matter.

37. The next day I sent a rather informal email to the Assistant Director of Nursing, Carolyn Kennedy, concerning the same situation. It was about that time that Glennis Goodman retired as Director of Nursing, hence I made a reference to myself going the same way as her as I could not stand the Intensive Care Unit anymore. I note that the operation upon P39 was proceeding (I believe I spoke to Ms Kennedy in the morning when she did her rounds about that matter), and that the unit already had one other patient on ventilation and four other patients. Attached and marked "TH7" is a copy of the email I sent to Assistant Director of Nursing Caroline Kennedy on 10 September 2003.

Dr Qureshi

38. In November 2003 for approximately 4 weeks I acted up in the position of Assistant Director of Nursing. During this time on a weekend when I was on call as the most senior nurse, I received a phone call from the after hours Nurse Manager, Jan Maresse, that Dr Qureshi had assaulted a patient. I was told that he had examined the female patient's breasts inappropriately and

placed his hands in her underwear in the Renal Unit. I telephoned Dr Darren Keating to report this matter and he instructed me to telephone Dr Qureshi to ask him to telephone Dr Keating and also to notify all areas of the hospital that Dr Qureshi would need a chaperone when examining female patients from that point on. This I did.

39. Around that time I also received complaints from two of the nursing staff from the Intensive Care Unit regarding inappropriate behaviour by Dr Qureshi. One of the nurses, , advised that on three occasions Dr Qureshi had squashed up against her against a wall. She said the first two times she thought it was perhaps capable of innocent explanation but felt uncomfortable after the third occasion. I do not now recall who the second nurse was.

40. Attached and marked "TH8" is a copy of an email sent by me to Dr Darren Keating on 6 November 2003 regarding the behaviour of Dr Qureshi.

41. Some months later, in about March 2004, I was orientating the newly appointed Director of Nursing, Linda Mulligan in her office when Dr Keating came in to inform Ms Mulligan what the latest development was in respect of Dr Qureshi. He advised that the police had come to tell him that they were to go and arrest Dr Qureshi in respect of a complaint of sexual assault made by a patient, but that afterwards the police had discovered that Dr Qureshi had absconded from his place of residence and the police were looking for him. By this stage, it was known that there were a number of complaints of a sexual nature that had been made against Dr Qureshi. There had also been concerns raised about his level of clinical competence at a Medical Services Forum Meeting in mid to late 2003 by Dr Miach. I recall Dr Miach using the words

"totally incompetent". I myself had observed Dr Qureshi in the ICU and noted his poor communication skills and apparent lack of knowledge regarding assessment of patients and basic knowledge to order appropriate medications and treatment. As a result nursing staff consulted other doctors to check orders made by Dr Qureshi.

42. When Dr Keating relayed the present situation to Linda Mulligan and me about the police seeking Dr Qureshi, I commented something to the effect of "*I wonder who checked his references*?". To this, I recall Dr Keating saying that he had failed to check Dr Qureshi's references and that in hindsight he had not handled the Dr Qureshi issue well.

43. I was subsequently informed that the police had not been able to locate Dr Qureshi and that he had in fact absconded from Australia. I was privy to this information because someone came into an Executive meeting and announced this. At the time I was present in my capacity as outgoing Acting Director of Nursing when I was still orientating Linda Mulligan to the permanent position of Director of Nursing. I had acted as Director of Nursing for a short period of approximately 3 weeks prior to that time.

Concerns

44. By the end of 2003, I had been present on a number of occasions when patients had been transferred to the ICU from theatre when a verbal handover was given by nursing staff to the effect that something had gone wrong during the surgery by Dr Patel. I was told by ICU nursing staff of other occasions when this occurred. In each case, however, the surgical error described by the nurse verbally was not documented in Dr Patel's theatre notes. The errors included nicking a spleen with a scalpel, nicking a bladder with a scalpel, and

perforation of the bowel. I do not now recall the names of those patients. I have since attempted to identify patients where there have been serious complications as a result of surgery or interventions by Dr Patel. In this exercise, I have only concentrated on auditing deaths which have occurred in the ICU and other incidences of which I have had independent recollection or resulted in quite serious results for the patient. As a result, I am unable to now identify the patients where there was an inconsistency between the reports of theatre nurses and Dr Patel's documentation.

45. On 25 February 2004 I sent an email to the then Acting Director of Nursing Patrick Martin expressing concern that Dr Patel had scheduled an elective apronectomy on a patient by the name of P49 who required ventilation post-surgery. This resulted in there being three ventilated patients on Sunday morning, a dangerous situation.

46. Attached and marked "TH9" is a copy of the letter sent by me to Acting Director of Nursing Martin on 25 February 2004.

47. At around this time the Director of the Intensive Care Unit Dr Martin Carter had some conversations with myself and with Mr Patrick Martin the Acting Director of Nursing in which Dr Carter advocated the employment of more permanent nursing staff members and the elevation of the status of the ICU from a Level 1 unit. I recall he made some suggestions about recruitment of staff which were unhelpful. I should mention that appropriately qualified and experienced Intensive Care nursing staff are relatively in short supply. I pointed out to Dr Carter that our statistics indicated that overall the unit was only 75% full and did not indicate a need for a consistent increase in the number of staff. There was, however, a need for surgical staff to

appropriately liaise with the Intensive Care Unit about the availability of beds before undergoing major surgery and a need to not conduct major elective surgery during busy periods.

Dr Miach's directive

48. Also around this time I became aware that Dr Miach had given instructions that his patients were not to be operated upon by Dr Patel. Dr Miach is the Director of Medicine at the hospital (patients are either medical patients or surgical patients thus Dr Miach was the equivalent to Dr Patel for non-surgical patients). I don't now have any record of when I became aware of exactly when I heard of this instruction or how I heard this; however, I believe it is likely that I obtained that information from attendance at a Medical Services meeting.

Meeting with the District Manager February 2004

49. In early 2004 I acted as Director of Nursing for a period of approximately 3 weeks before Ms Linda Mulligan took up her appointment as the permanent Director of Nursing. During that period towards the end of February 2004, I sought a one on one meeting with the District Manager, Peter Leck, and I had a meeting with him in his office. In that meeting I raised with him the concerns that the Intensive Care Unit was having with ventilated patients, and in particular, with Dr Patel's patients.

50. During the meeting I gave him a document headed "ICU ISSUES WITH VENTILATED PATIENTS". Attached and marked "TH10" is a copy of a document which contains the exact text of the document I gave to Peter Leck at my meeting with him towards the end of February 2004. I had kept the word processing file with the document on it and later in the year after a patient by the name of P11 died, I added notes about his case to the end of the document, and that is the document which is attached. The part of the document which constituted the content of the document I handed to Peter

Leck in February 2004 has been identified by me in the attached document: it is the section between the arrows. That is, the document handed to Peter Leck contained all of the text from the title "ICU ISSUES WITH VENTILATED PATIENTS" down to the sentence "I have accompanied Dr Jon Joiner to meet with Dr Darren Keating when the issue of doing oesophagectomies has arisen in the unit".

51. In that document, I specifically raised concerns regarding the insulting behaviour of Dr Patel toward nurses in the ICU, the giving of conflicting orders for medical treatment, Dr Patel's lack of communication with myself as Nurse Unit Manager of the ICU, and the creation by Dr Patel of an atmosphere of "fear and intimidation" in the unit. I documented that Dr Patel had threatened to go "straight to Peter Leck" because he had "earned him half million dollars this year".

52. I also specifically documented that on several occasions Dr Patel had refused to transfer his patients to Brisbane, even after they had deteriorated and had been in the ICU for much longer than 24-48 hours, and that I had voiced my concern regarding the level of care required for some of Dr Patel's patients several times.

53. I indicated to Mr Leck that I was making him aware of these issues informally and I didn't wish him to take any formal action at that time. At that time Dr Patel was not communicative with me and I wanted to go back into the Intensive Care Unit (I was then acting as Director of Nursing) and see if I could talk to him and come to some sort of working arrangement.

54. As I have mentioned above, there was a period of time when I was orientating Ms Linda Mulligan into the position of Director of Nursing. During this time

I was careful not to make adverse comments about Dr Patel as I wanted to be able to come to her in the role of Nurse Unit Manager of the Intensive Care Unit in the event I was not be able to sort something out with Dr Patel, or if the problems continued. I did not want to prejudice the incoming Director of Nursing's mind regarding Dr Patel.

55. I do recall, however, that during the orientation period, Linda Mulligan said to me that she had heard that Dr Patel was "excellent clinically", to which I replied with words to the effect "*that wouldn't be how I would see it*".

Various Patients

56. On 8 April 2004, a patient by the name of Ms P14 underwent an operation by Dr Patel. Dr Patel had assessed her and booked her for a sigmoid colectomy for cancer of the sigmoid colon, however, during surgery she was found to have ovarian cancer. I have since been told by the Chief Health Officer for the State of Queensland, Dr Gerald Fitzgerald, that he has found that Dr Patel didn't perform any appropriate staging investigations by way of CT scans on cancer patients. I am aware that a number of cancer patients operated upon by Dr Patel were subsequently found to have metastatic lesions elsewhere in the body which, if identified by a staging CT scan, may have dictated other forms of treatment, perhaps less invasive treatment which may have allowed the patients to have a greater quality of life.

57. On 11 April 2004, P14's wound fell apart and she suffered a complete evisceration of her intestines. I was aware that this occurred because I saw the patient and was involved in some care of the patient prior to transfer back into theatre.

58. A patient by the name of P41 was another patient who suffered an episode of wound dehiscence after undergoing a colectomy by Dr Patel.

59. A patient, P1, died in the Hospital on 6 July 2004 after the insertion of a catheter by Dr Patel on 29 June 2004. During the insertion of the catheter, Dr Patel perforated the patient's internal jugular, and possibly also the patient's trachea. I don't have any personal recollection of this case, and it may have been that I was on leave, however I subsequently noted this patient's case in my written complaint to Peter Leck dated 22 October 2004 after looking at the discharge summary for all patients who died in the Intensive Care Unit.

60. On 10 July 2004, a patient by the name of P37 underwent a laparotomy for a hernia and subsequently developed a haematoma in the ward, and I recall it was reported to me by one of the Intensive Care Unit nursing staff, Karen Stumer, that Dr Patel had attempted an evacuation of the haematoma without any analgesia. I reviewed P37's file and noted that Dr Patel's notes consistently say that the patient was well.

61. P17 was a patient upon whom Dr Patel performed a very complicated procedure called a Whipple's procedure. This is a procedure involving the removal of the head of the pancreas. This patient was an inpatient in the Intensive Care Unit for a considerable period of time, approximately 12 days. I recall that he had been sent to the Radiology Department whereupon he arrested and died. I subsequently saw his Death Certificate which stated that he died of "Klebsiella pneumonia and inactivity". I am now aware that this type of procedure was a procedure which Dr Patel had been prohibited from performing by authorities in the United States of America.

ASPIC Meeting 14 April 2004

62. Attached and marked "TH11" is a copy of the Minutes of a Meeting of the ASPIC clinical forum held on 14 April 2004. ASPIC stands for "Anaesthetic, Surgical, Pre-Admission, Intensive Care". It is a forum held monthly attended by the Nurse Unit Managers of each of those areas and the Medical Directors of each of those areas, and in addition, Dr Patel as the Director of Surgery, usually attended.

63. The Minutes document that there was a discussion regarding long term ventilated patients still being kept in the ICU and that this had caused the overtime budget to blow out. The need for further proactive discussion to be had about transferring of ventilated patients was noted. I was the person who raised these issues at the forum. It should be noted that I was somewhat frustrated at this time that I had, for nearly a year, been raising my concerns about the practice of keeping ventilated patients in our ICU for more than the recommended 24 to 48 hours, and yet no directive or instruction had been given to Dr Patel from his medical colleagues or line superiors to limit the practice.

64. The incidents of wound dehiscence was also raised as a concern at the meeting and minuted. In particular, it was minuted that staff felt there had been an increase in wound dehiscence but that there were no statistics available at that time. There was also concern about whether all incidents of wound dehiscence were being captured by the coders who enter data for our statistics. The Minutes note that "*A definition of wound dehiscence was also requested*". There had been concern that certain words including the term "*dehiscence*" were not being used on discharge summaries by junior doctors on instructions

from Dr Patel. I do not now have a specific recollection as to whether this was specifically discussed amongst the persons present at this meeting on 14 April 2004, however I can say that this was widely discussed by the junior doctors and nursing staff in the Intensive Care Unit and surgical wards at and previous to that time. It should be noted that the Director of Medical Services, Dr Darren Keating attended the meeting on 14 April 2004.

65. I was personally present on a number of occasions when junior doctors stated that they had been told by Dr Patel not to use the word "dehiscence" in discharge summaries. I cannot now recall with any certainty the identity of doctors who made that statement in my presence, however, I believe that Dr David Risson may have been one of those doctors.

66. In addition, nurses whose identify I can not now specifically recall, brought to my attention that they had had conversations with junior doctors in which they indicated that Dr Patel did not wish them to use certain words when completing discharge summaries.

Concerns about various patients prior to the death of P11

67. Throughout the first half of 2004, there were a continuous series of issues with Dr Patel and his patients. I cannot now recall each and every episode of concern. It was after a particularly concerning incident occurred on the night of 27 July 2004 that I sought to audit the charts of those who had died in the Intensive Care Unit and those who had particularly concerning outcomes, and I identified a number of patients for inclusion in a written complaint for the District Manager Peter Leck.

68. The first patient was a patient by the name of P12. P12 was a person with many co-morbidities who had been admitted to hospital for a perforated

duodenal ulcer, which essentially is a bleeding stomach ulcer. During the time that he was in the ICU he had several trips back to the theatre and was receiving a lot of medical treatment including a very high dose of adrenalin. I recall that there were a number of discussions between anaesthetists in the unit and Dr Patel, and between nurses and Dr Patel, some of which I witnessed personally during which the issue of transfer to Brisbane was discussed. Dr Patel refused to transfer the patient to Brisbane despite him having an obviously acute abdomen. I recall that Dr Patel kept saying that the patient had sepsis caused by an infection in his chest and that he didn't have bleeding or infection in his abdomen. The patient was ventilated for many days in the Intensive Care Unit and ultimately transferred to Brisbane.

69. A patient by the name of P27 was a patient who had fallen from a height and was a very critical patient. Dr Patel delayed the transfer of this patient to Brisbane despite the patient obviously requiring long term ventilation and care beyond the resources of a Level 1 Intensive Care Unit.

70. On 7 February 2004, a patient by the name of P32 had a bowel obstruction, resection and anastomosis performed by Dr Patel. He was transferred to Brisbane on 11 February 2004. For the purpose of my providing a written complaint about Dr Patel to the District Manager, I looked at P32's Royal Brisbane Hospital discharge summary and noted that the day after his transfer to Brisbane a laparotomy was performed which showed perforation of the bowel and soiling of the peritoneal cavity. The discharge summary which I read was suggestive of a surgical error.

New Director of Nursing

71. Linda Mulligan commenced as Director of Nursing at the Bundaberg Base Hospital around 15 March 2004, and after an initial period where I assisted to orientate Ms Mulligan into her new role, I returned to the Intensive Care Unit as Nurse Unit Manager. Shortly after that all of the Level 3 nursing officers which included all Nurse Unit Managers of various wards including the Intensive Care Unit, received an email asking us to attend individual meetings with Ms Mulligan limited to an hour. Attached marked "TH12" is a copy of the email received by Level 3 nursing officers from Linda Mulligan dated 23 April 2004.

72. I recall that I attended one such meeting and there was a lot to tell Ms Mulligan about the operation of the ICU. The meeting was limited as to time, however, I recall that I touched upon various issues related to Dr Patel, and in particular, the issues regarding ventilated patients being kept in the unit for longer than necessary. I do not now recall the extent of what I told Ms Mulligan during this initial meeting, however, I believe I would have only touched upon relevant issues because the meeting was limited by her in time.

73. Subsequently it became apparent to the Level 3 nurses including myself that Ms Mulligan had determined to be less accessible to us and that Ms Mulligan appeared to be concentrating on bureaucratic and pernickety measures without concern for big issues or wishing to be informed about what was actually going on clinically in various wards, and in particular, the ICU. For example, Ms Mulligan instituted a new form called a "File Note" that she wanted the Level 3 nurses to use to document interactions with staff members. There was confusion over the appropriate use of this new form and Ms Mulligan had to

subsequently clarify the use of the form because some Level 3 nurses were using the "File Note" form for their communications with Ms Mulligan.

74. Ms Mulligan also gave us a template letter which we were told (at a meeting of Level 3 Nurses with Ms Mulligan on 3 May 2004) we had to use every time we received any type of complaint about a staff member, including matters which were of a minor or trivial nature which would perhaps be better dealt with as a manager in a different way. The template letter was a letter which had contents which included what is described as a "lawful direction" with the threat of disciplinary action that the recipient of the letter must not discuss allegations with any staff member or the complainant. I recall that I raised a concern I had regarding this template letter with Ms Mulligan at the meeting in that I was concerned about the potential isolation of nurses in such a position given that many nurses working at the hospital, particularly ones who have come to the hospital recently, do not have family or friends outside the hospital who they could turn to for support. The process was then clarified by Ms Mulligan by indicating that if a complaint had been made against me then it would be a very serious matter for me to seek support from Gail Aylmer (who was present at the meeting and used as an example by Ms Mulligan) and that if I spoke to Ms Aylmer about any matter then I would be "severely disciplined".

75. Attached marked "TH13" is a copy of the template letter.

76. In March 2004 at the Level 3, 4, 5 and 6 meeting we were told that the Assistant Director of Nursing Caroline Kennedy was no longer our line manager and that in particular, as regards complaints management, we should direct all complaints directly to the Director of Nursing Linda Mulligan, and

not the Assistant Director of Nursing. Linda Mulligan sidelined her Assistant Director of Nursing so that she had no responsibility for our management. She removed the Assistant Director of Nursing's ability to sign off on documents submitted by us such as leave approval forms and the like. In addition, when Ms Mulligan went on leave she arranged for nurses outside of the hospital to replace here as Acting Director of Nursing rather than have Ms Kennedy act as the Director of Nursing. It has been my experience in the past and at different facilities that in general the Assistant Director of Nursing would act up as the Director of Nursing in the absence of the Director of Nursing, and the system instituted by Linda Mulligan was unusual in this respect.

77. Linda Mulligan attended most of the Level 3, 4, 5 and 6 meetings as well as the Nursing Heads of Department meetings. In those meetings, Ms Mulligan acted in a bullying fashion towards about half a dozen of the attendees including myself. By bullying I particular mean the manner of speech employed by Ms Mulligan and the sarcasm expressed which ensured that the message was conveyed that no further discussion on a particular topic would be entered into however, there were many, many instances of the exercise of power by Ms Mulligan.

Inaccessibility

78. At the end of 2001 there was a review of the nursing structure of the Bundaberg Base Hospital, as I recall, by the Director of Nursing from Toowoomba Hospital. I understand that one of the outcomes of that report was that the Director of Nursing and Assistant Director of Nursing at the time should be more accessible to the Level 3 Registered Nurses. The Director of

Nursing and Assistant Director of Nursing then commenced doing rounds of each ward and we saw the Director of Nursing one day and the Assistant Director of Nursing the next day, so that there was a senior Level 4 or 5 nurse in the ward each day from Monday through to Friday. After Ms Mulligan commenced, she never did any rounds of the wards, and other than my taking her through the ICU initially when I was orientating her to the hospital, we rarely saw Ms Mulligan in the Intensive Care Unit. I believe that it may have been as few as four occasions when Ms Mulligan was seen in the Intensive Care Unit from her appointment until the present date.

79. Ms Mulligan's office was in the Executive area of the hospital on the second floor of the hospital building behind a glass partition which was not open to the public or members of nursing staff. Ms Mulligan was rarely seen in other areas of the hospital, and most of my staff would not have been able to recognise her had she walked though the Intensive Care Unit.

80. It was difficult to gain access to Ms Mulligan. We were required to make appointments. We had to make the 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.

81. We could not telephone Ms Mulligan directly. She took her free set number off the internal contact details listing available to us on our email network. We had to first ring her secretary to be put through to her and would have to explain to her secretary why we wanted to speak to her. The secretary would then check to see whether Ms Mulligan would speak with us.

82. We would receive summonses to attend at the Executive area of the hospital at short notice to speak to Ms Mulligan. These were often regarding trivial

matters and caused considerable inconvenience because it is sometimes very difficult to leave the Intensive Care Unit to its own devices at short notice, having regard to nursing staffing issues. I recall on one occasion I was summonsed to Ms Mulligan's office to be asked why she hadn't been notified of the status of a nurse employed in the Education Centre who had been taken ill. Ms Mulligan hadn't been informed of the status of that ill nurse because Ms Mulligan was not present at work on the day when the nurse was taken ill, and was not included on an email which I sent to the other Level 3 nurses to advise them of her status. I made a number of appointments during 2004 and early 2005 to speak with Ms Mulligan concerning Dr Patel. Some of these appointments, as I recall, were cancelled by her. I do not now have a record of the dates upon which we met, however, I requested and was recently supplied with a listing of dates from Ms Mulligan's diary from her Executive Secretary. Attached and marked "TH14" is a copy of that list.

83. I believe that some of those dates were dates which were cancelled by Ms Mulligan; for example, I think the meeting listed for 11 May 2004 was one such meeting which was cancelled. I cannot now be sure. I had other meetings which are not listed in that list. For example, the night after a patient by the name of P11 died (he died on 27 July 2004), I attempted to make an appointment to see Ms Mulligan but was told by her secretary that she could not see me for two weeks. I do recall speaking with Ms Mulligan, however about P11, and indeed one of the rare occasions when Ms Mulligan did appear in the Intensive Care Unit, was an occasion when I cornered her in the office and asked her to speak to some staff members who were then on shift who had had involvement in the P11 case. I left those staff members to

speak to her and I am aware they spoke to her about their concerns about P11 and also to try to get some feedback about the permanency or otherwise of the 12 hour shift roster which had been implemented in the unit but which had not been given final permanent approval and which issue was thought by nurses to be an issue being held over them because they generally all very much liked the 12 hour shift arrangements and wished them to continue.

84. During my meetings with Ms Mulligan concerning Dr Patel, I recall that she intimated that it was only a "personality conflict". In particular, at one of my meetings with Ms Mulligan in mid 2004, she gave me a book which had a chapter in it on how to deal with difficult people. It is a small book with a black cover. The last time I noticed this book it was on the Director of Nursing's bookshelf in her office. It was some sort of textbook written in either the 1960s or 1970s but was not a textbook which I recognised. Ms Mulligan directed me to a part of the book on how to deal with difficult people. I later returned the book to her.

Written report re P40 March 2004

85. On 28 March 2004 I received a written report from one of the Level 1 Registered Nurses in the Intensive Care Unit, Kay Boisen concerning incidents which occurred on 4 and 5 March 2004 concerning patient P40. The report illustrated the reluctance of Dr Patel to transfer patients. I gave a copy of the report to Linda Mulligan shortly after I received it. I think I had a discussion with Linda Mulligan about the incident as well, however I now do not have any specific independent recollection about the discussion that we had. Attached and marked "TH15" is a copy of the report given to me by RN Kay Boisen dated 28 March 2004.

The P11 Incident on 27 July 2004

86. On 27 July 2004 there was a very distressing event which occurred in the Intensive Care Unit concerning a patient by the name of P11. Dr Patel had interfered in the transfer of this critically ill patient to Brisbane and had also intervened in his care to the extent of attempting to perform a pericardiocentesis. At the time, there was another patient in ICU who had a perforated bowel following a colonoscopy performed by Dr Patel. I documented my concerns regarding the P11 incident at the end of text that I had previously prepared outlining my general concerns about Dr Patel which I had previously given to Peter Leck in February. I initially emailed this document to the Acting Assistant Director of Nursing Patrick Martin for his comment, before attaching it to a sentinel event form which I completed with the assistance of Dr Jane Truscott (who is a Registered Nurse with a doctorate) who was at that time the Acting Quality Control Officer for the district. Dr Truscott came to the unit to speak to me about the event and subsequently told me that she gave the sentinel event documentation to the Director of Medical Services Dr Darren Keating.

87. Attached and marked "TH16" is a copy of the document I prepared and "TH17" is a copy of the email received from Acting Assistant Director of Nursing Patrick Martin replying to the email I sent to him attaching the statement on the same day (30 July 2004).

88. Dr Truscott had actually heard about the P11 incident and had contacted me to discuss it. It was arranged that she would come to the ward and help me fill out the sentinel event form and documentation which she then said that she would deliver to the Director of Medical Services, Dr Darren Keating.

89. I did not receive any feedback regarding the sentinel event documentation for at least 1 month, and indeed I have never received any official feedback. After at least 1 month I heard from Dr Truscott that the sentinel event form had been downgraded by Dr Keating, ie, that it had been deemed not to be a sentinel event.

90. The day after P11 died, I recall speaking to Dr Strahan. Dr Strahan is a visiting physician at the hospital. He had previously been the Director of Medicine at the hospital but left about 3 years ago. He has his own private specialist practice as a physician in Bundaberg. I recall that I had just found out that P11 had died and I was in my office in tears when he walked in. I then had a detailed conversation with Dr Strahan about my concerns about Dr Patel. I recall him saying that when he had ethical problems like that he went and spoke to Dr Theile, who was a senior member of the medical profession in Bundaberg. Dr Theile doesn't work at the Bundaberg Hospital and I did not have access to him, of course. Dr Strahn asked me to let him go away and talk to some other people before getting back to me. I don't know who he spoke to but I assume that he spoke to a number of doctors because a couple of days later, on Friday, he came back and saw me and said "*there is widespread concern, but that no one is willing to stick their neck out yet*". I distinctly remember him saying those words to me and they have stuck in my memory.

91. The morning after P11 died I also saw Dr Carter in the foyer and stated to him that we had to do something to stop Dr Patel interfering anymore in the care of patients. I recall that Dr Carter was non-committal in his response.

92. I subsequently had various conversations with the Director of the unit, Dr Martin Carter. Attached and marked "TH18" is a follow up email I sent to Dr Martin Carter on 4 August 2004 in which I stated I hoped that we could prevent a repetition of events by recognising when we need to transfer people to a better equipped hospital and to stop Dr Patel's disruption of care provider team patients.

93. After P11's death, Dr Martin Carter gave me a copy of his statement (headed "Case Report – P11") regarding P11's care in which he states the following areas of concern:

1. *The delay in the arrival of the retrieval team. Request logged at 1620, despatched at 1930 and arrived at 2300.*
2 *Lack of coordination of care - 2 surgical teams involved. Mixed messages being conveyed to the family over the advisability of transferring the patient.*
3 *Pericardial paracentesis being performed without any indication (see CT & PM report)*
4 *Lack of radiology support - CTs not reported until 30/8/04*"

94. The first area of concern noted (delay in the arrival of the retrieval team) was as a result of interference by Dr Patel in the process. The second area of concern being a lack of coordination of care and two surgical teams being involved is a reference to the fact that P11 was in fact not Dr Patel's patient at all; he was Dr Gaffield's patient and Dr Patel took it upon himself to go into the ICU to interfere in his care. The third area of concern refers to the pericardial paracentesis performed by Dr Patel. The fourth area of concern is a reflection of the resources available in a hospital the size of Bundaberg and

another indication for appropriate transfers to be made to tertiary referral hospitals in Brisbane. Attached and marked "TH19" is a copy of this statement.

95. I received reports from the Registered Nurses who remained on shift after I left the unit prior to P11's death and they were all very concerned and upset. As a consequence I took it upon myself to do all I could to draw the matter to the attention of appropriate persons.

Contact with Coroner

96. In addition to completing a sentinel event form which I believed should have received appropriate attention by Dr Patel's superiors, I telephoned the Coroner's office at Bundaberg and asked to speak to the Coroner. I did this because I was told that P11's case was to be a Coroner's case and in fact that police had attended the unit after his death. I have had previous contact with the Coroner's office concerning permissions to harvest organs for donation. I was put through to Neil Lavering who I believe was an Acting Coroner. I told him in broad terms that we had a very ill patient and that Dr Patel had interfered in his care and that the patient had died. I also told him that we were concerned with Dr Patel's overall performance to which he commented to me words to the effect of "*Well that confirms some of the things I've been thinking about what has been going on at the hospital*". He then said that he would await all the statements and documentation from the investigating police. I believe it was during the course of 29 July 2004 that I spoke to Mr Lavering.

Contact with Police

97. Later that night I also telephoned the Bundaberg station of the Queensland Police Service and spoke to, I think, an Inspector Williams. I drew his attention to the fact that we had had the death of a patient in the hospital and that I believed that it was due to a doctor's negligence. Whilst I cannot recall exactly all of the content of our conversation I recall that it was a fairly in depth and lengthy discussion and I specifically recall the Inspector asking me whether we had morbidity and mortality meetings at the hospital (which we did not) and whether there were any other mechanisms at the hospital which would pick up instances of negligent death. It was left on the basis that he would revert to me and I believe he spoke to me on one other occasion however after that time I didn't have any further contact with him and assumed that he had been caught up in investigations related to the death of Caroline Stuttle.

RFDS

98. I also spoke to the head doctor of the Royal Flying Doctor Service Queensland (RFDS), Dr Gerald Costello regarding my concerns about the death of P11. Attached and marked "TH20" is a copy of the email and attached statement which I sent to Dr Costello on 17 August 2004.

99. I did not receive any feedback from Dr Costello.

Employment Assistance Scheme

100. Because of the effect of the P11 incident on a number of members of my staff I attempted to contact the Employment Assistance Service (EAS) of the hospital to debrief them. I rang the number and was told that there was no one available to assist because they were short staffed.

Linda Mulligan

101. Subsequently I sent an email to Linda Mulligan the Director of Nursing on 26 August 2004 attaching a detailed statement regarding the care of P11 and outlining my concerns. Attached and marked "TH21" is a copy of the email and attached statement that I sent Linda Mulligan on 26 August 2004.

102. In the email I sent attaching the report concerning P11 I also advised that a thoracotomy had been booked and that I was concerned that such large scale surgery was being scheduled on a Friday when there may not be staff available on the weekend. On 26 August 2004 I received a reply from Linda Mulligan 5.12 pm in which she advised that she'd had confirmation from Dr Keating that the case was "not a thoracotomy" but rather a "wedge resection".

103. Ms Mulligan in her email also stated that she appeared to have conflicting information about the P11 incident and remarked as follows:

"*This highlights to me the issues/strategies with communication that you and I have discussed previously are not resolving and further action needs to occur*".

Attached and marked "TH22" is a copy of the email from Linda Mulligan dated 26 August 2004.

104. I subsequently checked to see whether or not the patient who had been booked for the thoracotomy did in fact have a thoracotomy operation. It is apparent that he died. According to the theatre list printed 24 August 2004, the procedure was listed as "left thoracotomy, wedge resection ** allergy **". (Attachment "TH23").

105. According to Dr Patel's surgeon's report, the diagnosis and operation performed was "(L) upper lobe wedge resection", but the details of the

operation indicated "thoracotomy incision over sixth rib ...". (Attachment "TH24").

106. The theatre booking request originally filled out and signed by Dr Patel on 12 August 2004, however, indicated that the procedure was "left thoracotomy wedge resection". (Attachment "TH25")

107. I have an email sent by myself to Karen Fox dated 30 August 2004 which pinpoints that I had another meeting with Linda Mulligan on that date. I believe that I spoke to Ms Mulligan at this meeting about the issues concerning Dr Patel and in particular, the incident concerning P11. I say this because I recall that on every occasion I spoke to Ms Mulligan around that time, I raised these issues with her. Attached and marked "TH32" is a copy of the email from me to Karen Fox dated 30 April 2004.

108. Attached and marked "TH33" is a copy of the minutes of a Level 3, 5, 6 meeting attended by Ms Mulligan, which also documents that on 25th August 2004, ongoing issues in the ICU were discussed, including "staff stress over a medical incident".

109. After P11's death I sought advice and professional guidance from the Queensland Nurses' Union of Employees and spoke to the local organiser, Vicki Smyth. She telephoned me back and informed me that she had spoken with their in house legal officer, Judy Simpson, and requested that I forward a copy of a statement regarding the death through to Ms Simpson so that it could be forwarded to my professional indemnity insurer and be checked by Ms Simpson prior to provision to other parties. It was also arranged that I would have all staff involved in the incident to complete a statement as per the QNU guide for making statements, keeping them factual and leaving out emotional

statements or opinions. It was also requested that I ask any staff who are QNU members to contact Vicki Smyth so that appropriate notification could be sent to the professional indemnity insurers.

110. On 3 September 2004 Kym Barry and Vicki Smyth from the Queensland Nurses' Union came to the Intensive Care Unit to speak to staff. About 6 to 8 ICU staff met with Kym Barry and Vicki Smyth on 3 September 2004 and aired their grievances about the state of the patients coming through the ICU and the behaviour of Dr Patel. Kym Barry indicated that she would go and speak to the Director of Nursing Linda Mulligan about the issues.

111. I recall that later that day, Kym Barry came back to the ICU and spoke to me. I recall Kym telling me that Linda Mulligan had said that I was the only person she'd received complaints from and Kym also ventured the opinion that she thought Linda Mulligan would try to discredit me. We spoke about where we should go from that point. I recall telling Kym that I had gone back over the records of ICU deaths in the past 12 months with a view to auditing them and had made some notes for myself concerning those persons who had died and in addition patients who had had major complications. I indicated that I was very concerned about those matters and I recall Kym saying to me words to the effect of "*You can't collect that sort of information and not act on it*".

112. I determined that I would need to forward the statements I received from ICU staff as I received them through to Linda Mulligan and this I did over the next number of weeks.

113. I then asked the nurses who had been involved in the care of P11 to prepare statements and to liaise with the QNU regarding professional indemnity issues prior to providing those statements to me. As I received those statements I

progressively forwarded them to the Director of Nursing Linda Mulligan. For example, on 3 September 2004 I sent an email to Ms Mulligan attaching a statement I had received from Karen Fox regarding the incident. Attached and marked "TH26" is a copy of the email sent by me to Linda Mulligan dated 3 September 2004 attaching a statement from Karen Fox.

114. I attached the following statements which I received from staff and progressively passed on to Linda Mulligan in addition to the statement from Karen Fox. Most of these statements were subsequently also provided by me to Peter Leck under cover of my letter of complaint dated 22 October 2004, and with the exception of the statement from Kay Boisen, I only have unsigned copies of the statements, and I assume that I have given the original signed copies to either Linda Mulligan or Peter Leck:

Attachment "TH27"	Statement from Karen Jenner
Attachment "TH28"	Statement of Patricia Gould
Attachment "TH29"	Statement of Sharon Cree dated 1/11/04
Attachment "TH30"	Statement not identified on its face, but from, I think, RN Dan Atkin
Attachment "TH31"	Statement of Kay Boisen dated 3/8/04

115. In addition I tried to do something about the situation on a different front in that I was aware that Dr Jane Truscott (a Registered Nurse) was the hospital point of contact for a Queensland Health project called the "Cancer Control Project". I was under what turned out to be the misapprehension that that project would be able to make some delineation as to the types of cancer related surgery, which could be performed at various hospitals and I emailed Jane to advise her that we continued to have ongoing issues in the ICU with complicated cancer operations being undertaken. I thought that this avenue might be a way of stopping these operations from continuing at Bundaberg

Hospital, however I received a reply in a very short space of time, within about 15 minutes, from Dr Truscott that the cancer control project was about identifying gaps in service, not about delineating appropriate surgery for various hospitals. Dr Truscott did ask to meet me about ICU services later that day or that week, and I recall that I did meet with her, however, the discussion centred on what sort of services the ICU could offer in terms of the beds that were available the nursing resources and the equipment. She needed this information in her role as Project Officer to ascertain what facilities were available at the Bundaberg Base Hospital for cancer patients. Attached and marked "TH34" is a copy of an email from me to Jane Truscott dated 8 September 2004 setting out various email correspondence between myself and Dr Truscott.

116. I recall at around this time I was speaking to anyone else in the hospital that might be able to assist in ensuring that the large operations that we were concerned about wouldn't continue to be undertaken. I recall that I was discussing on an almost daily basis with other nurses some of the concerns that had been raised with me by my staff and that I held regarding Dr Patel and the extensive surgery that was being undertaken. In particular, I spoke to the Bed Manager, Liz Allen, the After Hours Nurse Managers Lesley Douglas and Lyn Anderson.

117. On 28 September 2004 I emailed Linda Mulligan advising:

1. I had asked Dr Carter to delay, if possible, routine surgery that may require ICU beds until our last ventilated patient was no longer ventilated;

2. That staff needed to be able to have some days off and were exhausted from several months of high acuity patients and that they had been repeatedly been required to come in on their days off; and
3. That the roster starting 8 November would be short due to an impending resignation and requesting permission to recruit someone from an agency for a couple of months.

118. Our ventilated hours had increased approximately threefold what they had been previously due to the number of patients requiring ventilation and the number of patients who had not been transferred out of the unit to Brisbane after 24 to 48 hours.

119. Ms Mulligan replied, concentrating on the impending resignation of one staff member and advising me that we should avoid paying for agency staff, due to the "current budget status of ICU". Attached and marked "TH35" is an email from me to Linda Mulligan dated 4 October 2004 which sets out the exchange of email correspondence between me and Ms Mulligan commencing with an email from me to her dated 28 September 2004.

120. I then made an appointment to see Linda Mulligan. This was approximately 2 days before my written complaint.

121. In the meeting I was more forceful than I had ever been before in trying to underline to Ms Mulligan my level of concern about the following issues:

1. That I was concerned about the level of complications those patients who were coming through to the Intensive Care Unit had after being operated upon by Dr Patel;
2. That I was concerned about a number of deaths which had occurred;
3. That I was concerned about Dr Patel's behaviour in the unit;

4. That I was particularly concerned about the effect of the P11 incident upon my staff and that they were particularly suffering;
5. That I was concerned about the lack of support for staff members and that I had sought but failed to obtain from the EAS debriefing for the staff; and
6. That I was concerned that Dr Patel had indicated to nursing staff that he was untouchable in that he had earnt a lot of money for the hospital.

122. I recall that Linda Mulligan told me that I needed to go away and put my concerns in writing, later that day I received a call to return to attend a meeting with Linda Mulligan and Peter Leck the District Manager. I left the unit immediately and went to the executive office area on Level 2 at the hospital and was directed by an administrative officer to wait on a chair just outside the glass doors to the executive offices. From there I could see that Peter Leck and Linda Mulligan had noticed my arrival but did not acknowledge my presence and continued talking between themselves and laughing at something whilst I waited. I recall that they made me wait for approximately 15 minutes before Peter came out and asked me to come in.

123. I repeated all of my concerns to Peter Leck and I recall that as I was speaking he made copious amounts of handwritten notes which extended to about 3 pages.

124. I told Peter Leck that I had received advice from the Union that my options included making a complaint to the CMC or writing directly to the Director-General, but that I had decided to attempt to deal with the matter internally. I previously received advice from Kym Barry of the QNU that my options included writing to the CMC and the Director-General. I told Mr Leck that I

wanted an independent chart audit done of Dr Patel's patients otherwise I would be forced to take some other action.

125. Peter Leck asked me to put my concerns in writing and have them to him by Friday. I emailed this through to him together with various statements of ICU nurses on 22 October 2004.

126. On 25 October 2004 Peter Leck emailed me confirming he had received a copy of the information I had forwarded and also requesting a hard copy with a signature including that I sign a document I sent him headed "ICU Issues With Ventilated Patients". This document was a document that I had given to Mr Leck in February that year, but to which I had added parts to after P11's death. The first part of the document which I gave to him in February had not been signed by me at that time. Attached and marked "TH36" is a copy of my email to Peter Leck dated 22 October 2004 to which I attached the documentation I forwarded to Mr Leck.

127. Attached and marked "TH37" is a copy of the letter dated 22 October 2004 addressed to Peter Leck which was attached (and which was ultimately signed and given to him in hard copy).

128. Attached and marked "TH38" is a copy of the document headed "ICU Issues With Ventilated Patients" which I also emailed to him as an attachment and subsequently gave to him in hard copy form signed by me.

129. Attached and marked "TH39" is a copy of an email from me to Peter Leck dated 26 October 2004 which is a reply to an email from Peter Leck dated 25 October 2004.

Seminar

130. Some time after I spoke to Peter Leck and gave him my written complaint dated 22 October 2004, a seminar was conducted by 3 Queensland Health Department officers' from what I understood to be some sort of ethical standards group from head office in Brisbane. I recall that all Level 3 nurses and heads of department were invited to attend the talk held in the seminar room one afternoon. I think this was a number of weeks after I spoke to Peter Leck and gave him my written complaint that this occurred.

131. The talk dealt with confidentiality and whistle blowing and what is regarded by Queensland Health as ethical behaviour and what is not. We were specifically told that it was impermissible for us to tell our Union anything about what goes on in the hospital or any hospital related business. We were told that this was illegal and that if we spoke about anything that happened at the hospital to our Union we would go to jail and lose our jobs.

132. I cannot now recall the exact content of the talk given, nor can I remember the names of the officials who gave the talk, however, I distinctly remember that the talk scared the living daylights out of me. I recall discussing the talk with the Infection Control Coordinator, Gail Aylmer, just after the meeting. I recall Gail saying to me words to the effect of "*I'm so glad you didn't do what you were going to do*". This was a reference to the fact that I had previously made tentative arrangements to go with Kym Barry of the Queensland Nurses' Union to meet with the Health Rights Commissioner, Dr David Kerslake in Brisbane, but ended up deciding not to proceed with this meeting because:

    1. I wanted to allow the hospital management to sort the matter out and do the right thing; and

2. I was attending Brisbane for a conference and the costs of my attendance were being met by the Collaboration for Health Improvement, a group within Queensland Health, and I didn't feel that it would be right to absent myself from the conference in those circumstances.

ICU Statistics

133. In late 2004 I recall being asked separately by Linda Mulligan and Darren Keating to look at statistics for the patients in the Intensive Care Unit. I recall that I had been questioned about the amount of overtime utilised by nursing staff and that I had also raised my concerns about an increased ratio of intensive care patients to coronary care patients, the number of ventilated patients at any one time, and the delays in transferring patients to Brisbane. Attached and marked "TH40" is a copy of an email sent by me to the Director of Medical Services Darren Keating on 1 November 2004 in which I indicated that the Intensive Care Unit statistics indicated:

1. Patient diagnoses remained much the same, however there was an increase in the ratio of ICU patients to CCU patients;
2. There was an increased number of ventilated patients at any one time; and
3. That it had become the norm to wait until the unit had 2 or 3 ventilated patients before attempting to transfer them.

134. I indicated that several issues impacted upon the delay in transferring ventilated patients out of the unit as being:

1. Individual physician/surgeon preference;

2. Unavailability of beds in Brisbane; and

3. Brisbane not wanting the type of patients we had.

Patient Incidents subsequent to written complaint of 22 October 2004

135. On 20 December 2004, there was an incident involving 2 patients, P44 and P21. I was not working in the Intensive Care Unit at the time, however, I became aware of the incidents at a later time, and as soon as I received a written complaint from Vivian Tapiolas, a Level 1 Registered Nurse, I emailed that complaint immediately to the Director of Nursing Linda Mulligan.

136. The substance of the complaint as I understood it was that the patient, P44, had her ventilator turned off so that a bed could be made available at Dr Patel's insistence so that he could proceed with an oesophagectomy/gastrectomy procedure for oesophageal cancer upon P21.

137. It is invariably the practice that brain death testing is performed independently by two different consultants before a decision is made in consultation with family, to turn a ventilator off and withdraw treatment. I recall that I spoke to all of the nurses who were attending P44 during her stay in the Intensive Care Unit, and I reached the conclusion from speaking to them that brain death testing had not been performed upon P44. Because P44 was a ventilated patient, a nurse was required to be present at all times at the bedside, and in addition, nurses need to obtain certain equipment for doctors to perform brain death testing. As the procedure includes taking the patient off the ventilator for a limited period of time in order to raise the patient's carbon dioxide level to a certain level before taking a blood gas measurement, it would not be possible for doctors to perform brain death testing without the knowledge of nursing staff. I do not now recall all of the nurses I spoke to regarding this

matter, however I recall that at the time I checked to see which nurses attended P44 and spoke with all of them. It would be possible to go back and check the clinical chart for P44 and the ICU staff allocation book to ascertain the identity of each nurse who attended P44.

138. Attached and marked "TH41" is a copy of an email received by me from Vivienne Tapiolas dated 20 January 2005 and the attachment being her statement which I forwarded to Linda Mulligan that day.

139. Attached and marked "TH42" is a copy of the email I received from Linda Mulligan confirming that she had received the statement from Vivian Tapiolas concerning P44 and P21 and that she would be forwarding the documentation to Peter Leck.

140. I subsequently had a conversation with Dr John Joiner in the ICU regarding this matter. I can't recall the exact date of the conversation, but believe it was early 2005. In that conversation, Dr John Joiner (who is visiting medical officer who does anaesthetic work at the BBH but has his own general practice in Bundaberg) stated to me that the night before P44's treatment was withdrawn, Dr Patel had left orders to turn off the Ventilator at midnight, but that he, Dr Joiner, had refused to do so.

141. Attached and marked TH43 is an email I received from Linda Mulligan which asked me to send her any further documentation of any further issues that occurred and refers to a discussion had earlier that day. I do not now recall the exact matter that I raised earlier that day, however I can say that at about that time myself and those who provided written statements in support of my written complaint of 22 October 2004 were becoming increasing distressed at the fact that Dr Patel was continuing to operate and that concerning incidents

were continuing to happen while at the same time we had not heard anything back about the progress of our complaint.

142. At some point early in 2005 I tried to identify for myself the patients of which ICU patients had been concerned in the period since the incident concerning the patient P11. The names I came up with are as follows:

1. A patient by the name of P46 who was a patient with a ruptured spleen who underwent a splenectomy and suffered complications and was transferred to Brisbane.
2. A patient by the name of P15 who suffered a haematoma post operatively and was returned to theatre and suffered complications and was readmitted to ICU a number of occasions.
3. A patient by the name of P25 who had a colectomy performed by Dr Patel by whose spleen was nicked during surgery and ended up undergoing a splenectomy.
4. A patient by the name of P29 who underwent an apronectomy and subsequently had several admissions to the ICU.
5. A patient by the name of P20 who was a patient who underwent a laparoscopic cholecystectomy and subsequently developed a lot of complications and was readmitted to the ICU a number of occasions before ultimately being transferred to the Royal Brisbane Hospital.
6. A patient P21, whose care I have already discussed.
7. A 15 year old boy by the name of P26 who suffered a lacerated a femoral vein in a motorcycle accident and was operated on by Dr Patel. As a result of the operation he suffered an arterial blockage, as I understand it, and was ultimately transferred to Brisbane after a time

delay. The next day I was informed that the hospital in Brisbane had reported that the patient's leg had to be amputated in Brisbane. After transferring patients, a follow up call is usually made the next day to see what has transpired; this is usual done by an intern doctor, however, the information is then conveyed to nursing staff including myself.

8. A patient by the name of P38 who was admitted to the ICU and developed pleural effusions which are not normal to develop post operatively; however, I do not now recall the full details of this patient's care other than I was concerned enough in early 2005 to think her care should be audited.

143. On 13 January 2005 I am aware from the document compiled by Cheryl Miller that Linda Mulligan's diary (TH14) has a meeting noted for 13 January 2005 between myself, Di Jenkin and Gail Doherty re "a confidential matter". I recall there was a meeting with those persons present. I recall that it was a discussion regarding concerns about Dr Patel, however I do not now recall the details of what was discussed. I do recall that issues concerning Dr Patel's competence and the surgical scope of practice at the Bundaberg Hospital were discussed with Linda Mulligan on this occasion.

144. In February 2005 I received a call from an Administrative Assistant in the executive area to attend a meeting with Dr Gerald Fitzgerald. I recall that I was given relatively short notice of about 2 working days. On 14 February 2005 I met with Dr Fitzgerald together with Judy Simpson, Legal Officer from the Queensland Nurses' Union.

145. I recall the meeting lasted for at least 1½ to 2 hours, and that Dr Fitzgerald took notes of our conversation in a book. He told me that he wasn't conducting an investigation, only a fact finding mission to decide whether or not an investigation should be carried out.

146. My recollection is that I told Dr Fitzgerald of all of the general concerns I had regarding Dr Patel at that time, including giving him specific examples and elaborating as required in response to the questions that he asked me. I recall that towards the end of the meeting he asked me what I thought should happen in respect of Dr Patel and I told him that I wanted to see him stood down until the conclusion of an investigation. He then said to me words to the effect that it was better to have a surgeon rather than no surgeon at all and essentially asked me to put forward a solution to the problem that would be posed if the Director of Surgery was stood down. I recall suggesting that Dr Gaffield might be able to perform Patel's lists in the meantime. I recall that he commented that they would need to get someone to backfill Dr Gaffield's lists if that were to occur and that there would be tremendous staffing problems.

147. I recall that Dr Fitzgerald did not have a copy of the letter I sent to Peter Leck dated 22 October 2004, nor did he have a copy of the statements I sent to Mr Leck. Dr Fitzgerald said that he had not seen them. I had a spare copy of them and supplied a copy of them to Dr Fitzgerald during our meeting. I genuinely believed that the information that I imparted to Dr Fitzgerald during the meeting should have resulted in the surgery performed by Dr Patel being suspended, however, I am aware that the only thing that happened is that Dr Fitzgerald's team took the charts of the patients identified my letter dated 22 October 2004 back to Brisbane with them.

148. After Dr Fitzgerald and his team had come to the hospital and left, we heard nothing further. We continued to have patients in the ICU on a very frequent basis who had complications following surgery performed by Dr Patel. In March 2005, doctors and nurses began to cooperate to hide patients from Dr Patel.

Hiding Patients

149. In particular, I recall a patient by the name of P33. I recall on 4 March 2005 that P33 came into the ICU for a dialysis Vascath to be inserted. A principal house officer who performed this procedure nicked the carotid artery which meant that the patient then required corrective surgery, preferably by a vascular surgeon. Additionally, P33 was a Jehovah's Witness and refused to accept blood products by way of transfusion. I recall that Dr Patel came to be in attendance but when being informed that the patient belong to Dr Miach, said words to the effect of "*Well I'm not going to touch him*". Dr Patel however then walked next door and asked nurses in the theatre to prepare for an operation to repair the perforated artery. A short time later Dr Miach was in the ward and I witnessed discussion between Dr Miach and Dr Patel in which Dr Miach told Dr Patel that he wasn't to touch P33 and that he was to be transferred to Brisbane. After that time I saw that Dr Patel was hanging around the unit for some considerable length of time, and Dr Miach at one stage came to me and said to me words to the effect of "*Whatever you do don't you leave this patient's bedside, and if Dr Patel goes near him telephone me immediately*".

150. I recall that I stayed at the nurses' station close to P33's bedside for about 6 to 7 hours to ensure that Dr Patel didn't attempt to intervene in his care, and that

he was then transferred to Brisbane, the transfer having been arranged by the junior ICU doctor at Dr Miach's request.

151. During the course of the event concerning P33 I telephoned Linda Mulligan and advised her of a sentinel event. I recall that at the time she agreed with me on the telephone that the unfolding incident was a sentinel event. I subsequently emailed Ms Mulligan and Dr Keating to inform them that the RFDS was coming to Bundaberg to retrieve P33. The next day after P33 had been successfully transferred and had survived (we were very concerned for his survival given his great loss of blood and the limitations upon resuscitation options given his beliefs), I received an email from Linda Mulligan suggesting that I was unfamiliar with the current Queensland Health definition for a "sentinel event".

152. Attached and marked "TH44" is a copy of an email to Linda Mulligan from myself dated 4 March 2005 which includes the text of emails exchanged between myself and Ms Mulligan over the previous two days concerning this matter.

153. I recall being informed of another occasion around that time when a patient who was to have an oesophagectomy performed by Dr Patel was seen in the ward by one of the medical staff doctors who arranged for that patient to be admitted as a medical patient rather than a surgical patient to the Intensive Care Unit so that she could be transferred to Brisbane without Dr Patel's knowledge and to save her from having an oesophagectomy performed by Dr Patel.

Complaint to Member of Parliament

154. Whilst we did not hear anything back from Dr Fitzgerald or any action by management concerning Dr Patel, we had been waiting for Dr Patel's contract to run out and for him to leave early in 2005. The next thing we heard was that his contract had been extended and he would be staying at least until July 2005 so as to meet hospital surgery targets. I recall that Dr Patel himself came into the ICU and told everyone present that he was going to stay until July 2005.

155. The announcement by Dr Patel that he had had his contract extended so that the hospital could achieve its elective surgery targets was the point in time that I decided that I had to do something drastic to stop him from operating and treating patients. At about that time there was an industrial issue concerning nurses at the hospital, and that is that many nurses had been overpaid for public holidays, and the District had sent nurses debt collector's letters. Many nurses were talking to me about that issue and I recall that a lot of them had asked me whether I had spoken to Rob Messenger, who is the State Member for Burnett. I recall that within the previous 2 weeks, Mr Messenger had in fact taken out an advertisement in the Bundaberg *News Mail* requesting employees who had received debt collection notices to contact his office.

156. By this time I had tried to alert the following people to the problems with Dr Patel:

1. The other doctors in the hospital including Dr Carter, Dr Miach, Dr Strahan and Dr Berens;
2. The Director of Medical Services, Dr Darren Keating;
3. The Director of Nursing, Linda Mulligan;
4. The District Manager, Mr Peter Leck;

5. Dr Gerald Costello, the head doctor for the RFDS;
6. Senior nurses from the RFDS;
7. The Acting Coroner;
8. The Queensland Police Service; and
9. The Chief Health Officer for the State of Queensland, Dr Gerald Fitzgerald.

157. I had told all of these people the concerns that I held, the concerns that were held by nursing staff, and the level of distress experienced by the nurses. Then Dr Patel came down to the Intensive Care Unit and told us that his contract had been extended.

158. I felt at that time that I had to do something desperate and there was no one else to turn to, and Mr Messenger's name came immediately to mind because of the other issue concerning the overpayment of wages.

159. I was aware that Mr Messenger was a Member of Parliament, and I hoped that because of the position that he held (being the representative of his constituency) that he would be able to do something to stop the operations proceeding and that I could entrust sensitive information to him.

160. I initially telephoned Mr Messenger and outlined generally my concerns and he asked me to come in to talk to him, and I attended at his electorate office on 18 March 2005.

161. Upon attending at his office Mr Messenger interviewed me. At the beginning of his interview, he asked me if I wished to claim "whistleblower status", and whether I wished to claim that status anonymously. I said that I did want to claim "whistleblower status" anonymously.

162. I provided a copy of my complaint to Mr Leck dated 22 October 2004 to him together with the document that I had provided to Mr Leck headed "Issues to do with Ventilated Patients". When I gave those documents to Mr Messenger I asked him to de-identify the patient particulars contained in those documents before he did anything with them.

163. At no time did I think that Mr Messenger would distribute those documents without de-identifying them, or that he would give copies of them to journalists.

164. I recall telling Mr Messenger of the history of the complaints that we had made and that Dr Fitzgerald had attended at the hospital and had interviewed people. I told him in general terms the nature of our complaints and concerns. I did not, to my recollection, identify any patient whilst telling Mr Messenger of the concerns that I held. I do recall during our conversation telling Mr Messenger that I had joked with nurses in the days previous that there seemed to be nothing more we could do other than "strip naked and hang from a tree outside Red Rooster and scream out to Bundaberg what was happening at the hospital". I asked Mr Messenger to do something to stop the situation from continuing. Mr Messenger said that he was going to Parliament next week and would do something to act upon my concerns. I recall telling him that the issue wasn't political and I didn't want him to treat it in a political fashion and I recall that I even told him that I didn't vote for him. I also recall telling him that I was concerned that patients' confidence in the many good staff at the hospital not be undermined and that I wanted him to do something in as professional a way as possible to resolve the situation. I recall that he said things to me which reassured me at that time.

165. I recall Mr Messenger speaking to me by telephone after my interview with him when he said that he had telephoned Dr Strahan and that Dr Strahan had told him that they were aware of the problems with Dr Patel and said "*We're all hoping this will go away quietly when his contract's up.*" Mr Messenger conveyed to me that he was incensed by that attitude.

166. I recall the day after Mr Messenger raised the issue in Parliament and the matter was reported in the press, Dr Strahan came into me and said to me words to the effect of "*You'll be lucky to keep your job after this*".

District Manager's meeting with ICU staff

167. Also on that same day, the day after matters became public (I believe, it was 23 March 2005) the Acting Director of Nursing Deanne Walls (Linda Mulligan was then on holidays) called a meeting with ICU staff. I thought it was to debrief us and provide us with some support and so I called in a lot of the nurses who were on days off who had been involved in making complaints about Dr Patel. We assembled in the ICU tearoom when Deanne Walls and the District Manager Peter Leck turned up. Peter Leck was visibly furious and angry with us and had brought with him some photocopied documents which he waved around including, from recollection:

1. Some sort of document about what happens to people who go outside the Queensland Health code of conduct;
2. An Industrial Relations manual document which he said outlined that people who breached confidentiality could get 2 years' jail and lose their jobs;
3. Some sort of CMC information leaflet; and

4. I think, one of the Powerpoint documents supplied by the ethical standards people who gave us the talk in late 2004.

168. Mr Leck said that he had it from "very high sources" that the information given to the Member of Parliament had been given to him by a member of the ICU staff and then to the media. He kept saying that he was "appalled". He said that he was appalled that such a senior surgeon of the hospital could be treated in such a way that denied him natural justice. He said that it would divide the doctors and nurses; that it would stop patients coming to the hospital; and that it would erode community confidence in the hospital. He lectured us about the code of conduct and said that there were penalties of imprisonment for whoever took the information to Mr Messenger.

169. We did not get any opportunity to speak to Mr Leck and when he was finished he left.

170. The Acting Director of Nursing, Deanne Walls, stayed around in the tearoom for a little while and after we all sat in silence for a little bit, some of the nurses were making comments like "*How dare he speak to us like that*" and some of them were then telling Di Walls what the situation was. It was clear that she had no knowledge at all about what the nature of the complaints were, and she looked astonished. She ended up saying to us as a group that Peter had said what he had had to say and that we should "let it go now".

171. At around this time I am aware that a complaint of sexual harassment was made against Dr Patel by an intern by the name of Shortly thereafter, Dr Patel resigned and I was told by Jenny White who was a theatre nurse that Dr Patel had come in and said that he'd resigned but that Peter Leck had told him that he could have grounds to sue me for slander.

Contact with Chief Health Officer

172. The following Wednesday morning I telephoned the Chief Health Officer Dr Gerald Fitzgerald and I asked him what the result of his audit was. He was very frank with me and said that my concerns were validated. He said that there was an increase from the usual complication and infection rates. He said that Dr Patel wasn't the worst doctor he'd seen but that he wasn't the best.

173. It subsequently transpired that Dr Patel had had disciplinary action taken against him in the United States. I do recall that at some point during the year 2004, I think, a Level 1 Registered Nurse from the surgical ward had an informal conversation with me in which she said that she'd found the name of a doctor Jayant Patel on a website for the Oregon Medical Board and that it said that that doctor couldn't do pancreatic surgery. She said that she didn't know whether it was the same doctor as Dr Patel and that on the web, there was a lot of Jayant Patels. I recall also that in about mid 2003 I was concerned to check Dr Patel's qualifications and went to the website of the Medical Board of Queensland and did a search and found that his qualifications were simply MBBS from a University in India.

A matter raised in submission to the Inquiry by Queensland Health

174. It has been brought to my attention that Queensland Health's initial submission to the Bundaberg Hospital Commission of Inquiry states at page 26, paragraph 2.4.6(a) that the ICU facility at the Bundaberg Hospital had been assessed under the "Queensland Health Service capability framework" as a "Level 2 ICU facility". I say that as the Nurse Unit Manager of the Intensive Care Unit I have at no time ever been told that we have been assessed as a Level 2 facility. To my knowledge no assessment has been carried out. The

Queensland Health Service capability framework is to my knowledge a relatively new framework, and I recall that at the time when those words started to be talked about, I asked Peter Leck for a copy of the framework, however, he told me that that document was "not out there yet". The Bundaberg Hospital ICU has always been graded as a Level 1 facility. I can say that the unit does not qualify as a Level 2 ICU facility under the guidelines we used and I have not seen the Queensland Health Service capability framework. We are staffed according to the unit's classification as a Level 1 ICU facility.

Patient names

175. In this statement, in the interests of protecting the privacy of patients and the feelings of patients' family and friends, I have referred to patients according to a key devised by my lawyers which I have sighted and which I understand is to be supplied by my lawyers to the Bundaberg Hospital Commission of Inquiry on a confidential basis.

Toni Hoffman
.....
Signed: Toni Ellen Hoffman

Date: 22.5.05

I, Toni Ellen Hoffman do solemnly and sincerely declare that the content of this my statement for the Bundaberg Hospital Commission of Inquiry (this declaration being at the foot of the last page of the statement comprising 59 pages) is true and correct to the best of my knowledge and belief and I make this solemn declaration conscientiously believing the same to be true and by virtue of the provisions of the *Oaths Act 1867*.

Toni Hoffman
.....
(Toni Ellen Hoffman)

Declaration Taken By:

.....
Lawyer
Date: 22/5/05