PUBLIC

THE PARLIAMENTARY SELECT COMMITTEE ON TRANSFER OF CARE DELAYS (AMBULANCE RAMPING) MET IN COMMITTEE ROOM 1, PARLIAMENT HOUSE, HOBART, ON TUESDAY 6 FEBRUARY 2024

The committee met at 9 a.m.

CHAIR (Dr Woodruff) **-** Good morning Amanda. I will introduce the members of the committee who are here, Simon Wood, Anita Dow and Michelle O'Byrne online. I am Rosalie Woodruff and before we start today I need to run through some information about the evidence you will be providing. This is a committee of parliament and the work that we do here is covered by parliamentary privilege. Anything you say is covered by parliamentary privilege. That is so that the committee can get the best and most accurate information possible for us to make a really good report**.** It means that anything you say today you can speak freely to the committee and you have no fear of being sued or any court action as a result of what you say here. If you say even the same things you've said here outside in public in a statement, then you are not covered by parliamentary privilege.

It is a public hearing today and there may well be members of the public and journalists who are watching and that means that your evidence is going to be recorded. If you want to make part of the evidence to us today in private, then you will need to let me know so that the committee can organise for that. You've already signalled to me previously that you do want to go in camera and we will do that later in the session. Other members, Amanda has already signalled that we will go into an in camera session later in the session. Do you understand what I've said?

Ms DUNCAN - I do. Thank you.

CHAIR - You've got something to swear. Could you please read that out?

Ms AMANDA DUNCAN, NURSE AND MIDWIFE, LAUNCESTON GENERAL HOSPITAL, WAS CALLED, MADE THE STATUTORY DECLARATION, AND WAS EXAMINED.

CHAIR - Amanda, would you just like to say your title for people who are watching. Then I believe you've got an opening statement you would like to start with.

Ms DUNCAN - I'm Amanda Duncan. I'm a registered nurse and midwife employed by the Tasmanian Health Service at the Launceston General Hospital.

CHAIR - Would you like to read a statement?

Ms DUNCAN - Can I just clarify one thing before we start?

CHAIR - Yes.

Ms DUNCAN - Evidence that I have been provided by state service employees - are they also protected with the information that they have given me under parliamentary privilege in the evidence that I provide today?

CHAIR - If you are speaking the evidence of other people, it would probably be better that they are not named and you give that to us in camera. I think that is the correct process and it would certainly be fair for them not to be named in public if they have not given that written consent.

Ms DUNCAN - Thank you. I do have quite a lengthy statement to get through and for the purposes of this I wrote it to ensure complete accuracy to the best of my belief.

CHAIR - That's okay. Just take your time.

Ms DUNCAN - I understand the nature of what I am about to share may be distressing to both members of the community and state service employees. I apologise for any potential distress my statement may cause especially those who have lost a loved one at the Launceston General Hospital.

I have worked in the sector for almost 10 years. Despite my own personal experiences as an employee and as a patient of the Launceston General Hospital, I have been shocked by what I have discovered whilst reviewing Magistrate Court of Tasmania documents and by listening to the number of experiences shared by current and former state service employees of the LGH.

As a registered nurse and midwife employed by the Tasmanian Health Service at the LGH I am bringing to light allegations of serious misconduct. Among these are the falsification of medical certificates of death by the LGH's former executive director of medical services, Dr Peter Renshaw. I have received 11 reports from doctors and nurses who have disclosed alleged misconduct relating to the death of a patient including falsified medical certificates of death in ward 5A, ward 5B, the intensive care unit, the operating room suite and the Emergency Department at the LGH.

I was involved in an unsuccessful resuscitation of a patient in which other nurses and I believe was a case of doctors protecting doctors, given that the conduct of the anaesthetist prior to the death. I believe this matter could have resulted in a coroner's investigation but didn't. I reviewed more than 55 Magistrate Court of Tasmania coronial investigation reports of deceased individuals who died at the LGH. Amongst these I discovered two deaths which were not reported to the coroner by the LGH.

THS policy outlines, to the best of my understanding, deaths must be reported to the coroner. In other Magistrate Court of Tasmania coroner's report, the coroner stated he disagrees with the medical certificate of death and post-mortem cause of death. In total there are 15 deceased patients who I am concerned may be impacted.

I am of the belief my evidence is in addition to previous evidence the committee has heard. I will explore these matters individually with the committee including reports from doctors and nurses. I will reserve some evidence until after the live stream has concluded to protect the privacy of the deceased and their family. I will also provide the committee with evidence of other alleged misconduct involving: Dr Renshaw's refusal to pay overtime to junior doctors in the ED and other departments within the LGH; a breach in the code brown policy the day of the Hillcrest Primary School tragedy; misconduct involving Dr Renshaw accessing the clinical notes of an employee who accessed the Emergency Department as a patient; concerns regarding the care call policy in the ED; the Department of Health state-wide

complaints management oversight unit breaching the privacy of a consumer which involved two patients who accessed the LGH ED; and concerns regarding the role of the Integrity Commission and its scope to investigate state service employees.

Along with allegations I have with me written documentation as evidence for the committee which I will refer to throughout this session. I hope my evidence may bring validation for families who have suspected something amiss with their loved one's death and or the legal documentation they received from the LGH. I also hope that truth and justice may follow. People deserve dignity in life and in death their families deserve truth.

Witness reports from doctors and nurses regarding the falsification of medical certificates of death: Regarding the death of a patient in the Emergency Department at the LGH, multiple doctors and nurses involved in the unsuccessful resuscitation have stated that they feel the patient's death could have likely been avoided if the patient had been reviewed in a timely manner and resuscitation occurred on a hospital bed. Extensive documentation was completed by medical and nursing staff. Medical and nursing staff report they expected a coronial investigation would be undertaken investigating the death in the ED.

Multiple staff involved suspected the coroner would likely make a scathing finding against the LGH regarding the person's death. Whilst I won't go into specific details of the case publicly, I will note doctors and nurses have stated to me the cause of death Dr Renshaw documented on the deceased's medical certificate defied basic common sense. Further, staff stated to me the nature in how Dr Renshaw made this determination was in their view unethical.

Former junior doctors reported to me Dr Renshaw would at times attempt to coerce them into incorrectly documenting a cause of death in the Emergency Department on the deceased's medical certificate of death. When junior doctors refused, Dr Renshaw allegedly informed them that he writes the letters of recommendations for all junior doctors who want to apply for traineeships across the nation. Doctors who refuse Dr Renshaw's coercive requests have reported to me Dr Renshaw would hug them in the corridors. Some speculated this behaviour was to suck up to and groom doctors into silence.

Further investigations should be undertaken to determine if this alleged conduct also occurred in other departments in the LGH. However, I note former junior doctors have moved on to other hospitals or moved interstate.

Another allegation brought forward to me was that Dr Renshaw's conduct was culturally entrenched at the LGH. A senior doctor reported to me the words to the effect of 'call Dr Renshaw, he'll fix it' were graffitied on the laminated protocol in an acute care department.

Multiple nurses have alleged to me 'the only time we ever see Peter Renshaw on the wards was when he came to change a patient's cause of death'. The statement suggests that Dr Renshaw had a reputation for amending medical certificates of death.

Former LGH doctors have reported to me when they were reviewing deceased patients' notes retrospectively for learning purposes, they had inadvertently discovered the cause of death, which they had appropriately determined and documented on a medical

certificate of death at the time of death, had been amended by Dr Renshaw without their knowledge.

I note that the Tasmanian Health Service Death of a Patient Including Coroner's Notification Northern Protocol has a flow chart for death reporting in SRLS processes, which is a Safety Reporting Learning System, known as an instant report. The flow chart states:

> EDMS receives an automatically generated email from SRLS advising either: Medical certificate of death review, or, report to the coroner's review.

The flowchart goes on to ask:

> Is the document completed duly and correctly? Yes or no. If no, to enter corrections, you as the author of the SRLS can enter them yourself and click save, or in the author's absence or unavailability, the relevant EDMS can make necessary corrections on your behalf.

I note in brackets it says: Original author is notified via SRLS communication email of the change.

I'm requesting the Department of Health provides clarification as to whether automatic emails were generated and sent to the author of the SRLS as part of the database, or is it the email notification to the original author reliant on the integrity of the EDMS or delegate to manually notify the author in writing via email.

Additionally, are all medical practitioners given THS emails, including locum doctors who may be required to report a cause of death? I have been informed locum doctors may not necessarily be provided with THS email logins. If this is the case, if a locum doctor completes an SRLS death notification, who is notified, if anyone, of potential corrections to the SRLS?

Further, do all medical staff, including THS employees, have appropriate time available to review emails, or can email notifications regarding corrections to a death report in SRLS be lost in a mountain of unread emails - therefore not adequately notifying the original author?

I will discuss a death in the operating room suite, which to my understanding there was no coronial investigation, and I personally witnessed this. I don't feel the evidence below provides any identifying details of the patient, as I believe the family were not provided with an open disclosure of the events, which I believe, led to the cardiac arrest.

A patient was escorted into the post-anaesthetic care unit by a senior anaesthetist after a simple procedure. On arrival, the patient was severely bradycardic and hypertensive. The primary PACU nurse voiced concerns immediately to the anaesthetist, who was providing small incremental doses of the medication which was not improving the patient's condition. The PACU nurse in charge and I reinforced those concerns, as we immediately commenced drawing up emergency medications in the likely event of a cardiac arrest if left untreated.

The anaesthetist was ignoring our urgent request to administer more aggressive medications to the patient to prevent cardiac arrest. The patient's primary nurse reached for the emergency alarm to call for further medical assistance. I witnessed the anaesthetist slap the

nurse's hand away, shaking his head, stating 'no'. The in-charge nurse and I immediately escalated the situation to an emergency code blue in response to the deteriorating patient. Concurrently, the patient went into cardiac arrest. Resuscitation commenced, which was unsuccessful after more than 90 minutes of CPR.

Dr Renshaw, the EDMS, was notified as per protocol. Immediately after the death was announced, other nurses and I verbally raised concerns to ORS management that we felt the death was likely preventable given the conduct of the anaesthetist prior to the cardiac arrest. An incident report, known as an SRLS, was completed - it is my understanding - by an RN which outlined our concerns.

As Peter Renshaw held the position of both EDMS and medico-legal officer, who I believe had the ability to edit and reject SRLSes as identified in the Commission of Inquiry into the Government's Responses to Institutional Child Sexual Abuse. I am not confident any internal investigation into the anaesthetist's conduct was undertaken as a result of the SRLS.

A few days after, I was informed of the cause of death. The findings came as no surprise, given the medical events prior to the death. I verbally questioned the anaesthetist over his conduct, voicing concerns that multiple nurses, including myself, felt the death may have been preventable with adequate intervention.

The response from the anaesthetist was:

> Peter Renshaw and I believe the patient would have died at home that day anyway. We gave the patient a kinder death.

This remark has disturbed me ever since.

I note the THS death of a patient, including coroner's notification, under section 2.4 stipulates:

> If there is any question about whether the case is reportable or not, the medical officer should discuss the case with the consultant looking after the patient. If doubt persists, a senior member of the medical team looking after the patient should discuss the case with the on-call EDMS. If necessary, the on-call EDMS may then discuss the case with the coroner's office and then provide them with medical advice.

The policy also states:

> Deaths caused by a medical error must always be reported. It makes no difference whether the death occurs on the operating table or ward. Additionally, if the death is to be investigated by the coroner, this must be communicated to staff and relatives. The SRLS system will automatically notify the EDMS, medical director of state-wide Mental Health Services and medico-legal officer.

Nurses and I who were involved in the unsuccessful resuscitation were not notified if the death underwent a coronial investigation. Minimal details were communicated us. We were kept out of root cause analysis meetings. We were not informed of any outcomes from the

mortality and morbidity meetings, which Dr Renshaw chaired regarding this patient and we were not informed if the patient's family received an open disclosure about the events which occurred prior to the person's death. I was unable to find a coroner's report on the Magistrates Court of Tasmania's website regarding this patient. Therefore, I am of the belief there was no coronial investigation into this person's death.

I am of the view a coronial investigation ought to have been undertaken. This would have provided scrutiny of how the clinical management was handled. Other ORS nursing staff and I would have welcomed a coroner's investigation. Those of use involved felt strongly this could have been a case of doctors protecting doctors. Based on a THS policy, we as nurses had little scope to advocate for the deceased. There was little guidance from management as to how we could raise concerns beyond the EDMS and the consultant; not necessarily as a failing on their part but due to there not being available information to guide us further. As nurses, we rely on the integrity of doctors to report a death to the coroner.

When reviewing Magistrates of Tasmania coronial investigations, I discovered a death which the coroner states: 'The former director of surgery failed to report to the coroner.' The report notes the director of surgery stated to the coroner: 'Since the patient did not have any surgical procedures, I was unaware that it was our duty to report her death to the coroner.' I note the patient was admitted as a surgical patient.

The coroner suggests in his report that appropriate training be undertaken by all doctors to ensure they know the requirements of reporting a death to a coroner. I am requesting the Department of Health clarify training has been and is still being provided to all medical staff regarding their responsibilities surrounding the reporting of deaths to the coroner. After a substantial number of witness reports came to me, I reviewed more than 55 record of investigation into deaths by the Magistrates Court of Tasmania; the patients who died at the LGH. I note these documents are available to the public by the internet. Out of respect for the deceased and their families I will provide the committee with my evidence after the live stream has concluded. However, I will note key findings in two separate coronial investigations. In both instances coronial investigations were only undertaken by a coroner after the deceased's family lodged complaints to the Health Complaints Commissioner, which then prompted the Health Complaints Commission to make a referral to the coroner. I have removed the patients' names and substituted them with 'patient' to honour privacy.

In one of the deceased's coronial reports the coroner, Simon Cooper, states he disagreed with the cause of death. I will not disclose the medical terms used but Simon Cooper reports:

> I do not consider that the patient's death was due to 'x' as the medical certificate of death indicated, nor as the post-mortem report suggested.

The report goes on to state:

> I am of the view that the patient's death was entirely avoidable. The patient died because of poor medical treatment.

In response to this report, I would like to make the recommendation to the Department of Health to determine who wrote the medical certificate of death as this was not included in

the coroner's findings. Another magistrate's report written by Simon Cooper regarding another deceased patient states:

> The fact the patient's death was not reported by the LGH in accordance with the requirements of the Coroner's Act 1995; in fact the patient's death was not reported for over two years and only then by the Health Complaints Commission.

I note, I believe this is now the second death the LGH failed to report to the coroner. Coroner Simon Cooper goes on to write:

> There is suggestion in the patient's medical records that contact was made with the coronial division and advice received that the patient's death was not one reportable in terms of the Coroner's Act 1995. The note in the medical record is to the effect that a registrar had a discussion with the coroner on call.

I will not identify the medical advice the coroner on call reportedly provided the registrar publicly, however, I will note Coroner Simon Cooper states:

> If 'x' advice was given, it was wrong.

Additionally, Simon Cooper stipulates in the report that patient documentation was requested by the coroner but was not provided by the LGH, stating:

> The delays associated with this investigation, the resulting additional expense and stress for all parties, are entirely the fault of the LGH.

I am requesting the Department of Health clarify who at the LGH needs to provide the coroner with this information and investigate why documentation was not provided. I am aware some health practitioners attempted to contact a magistrate about Dr Renshaw's conduct. However, allegedly, further evidence was required. I note acquiring documentation can be challenging to retrieve retrospectively without a coronial investigation or when patients' identification details cannot be recalled by health practitioners.

Based on the Tasmanian Health Service policy, I am of the belief Dr Renshaw had control over SRLS open disclosures, data entry to the Australian Bureau of Statistics, as the executive director of medical services and as the medico-legal adviser. Further, Dr Renshaw developed and authorised the death-of-a-patient policy along with the nursing director of quality patient safety services, and he chaired the mortality and morbidity meetings. Based on the overwhelming number of people who could provide witnessed accounts of Dr Renshaw's conduct and Magistrate Court of Tasmania coronial investigation reports, I believe further inquiries should be undertaken including our referral to Tasmania Police.

I and other health practitioners have concerns the data relating to the death and coronial investigations at the Launceston General Hospital are potentially misleading and may be skewing national data. More importantly, I believe there are a significant number of families who are unaware their loved one, now deceased, may have been impacted by these alleged failures.

Further allegations of misconduct is the underpayment of junior medical practitioners. Former LGH emergency department medical staff have brought forward additional allegations regarding Dr Renshaw's conduct. It has been reported to me that Dr Renshaw refused to approve paid overtime to junior doctors in the ED and in other departments at the LGH. I note Dr Renshaw reviewed and approved the timesheets for all junior doctors in the LGH. This duty was not undertaken by the director of each department. Reportedly, Dr Renshaw stated to some doctors he believed overtime work was a result of interns and registered medical officers' inability to time manage. It is also reported Dr Renshaw would use the guise that overtime is unsafe. I am not disputing overtime doesn't become unsafe for practitioners. However, the reality is overtime was worked by former junior doctors frequently at the LGH and Dr Renshaw was unwilling to approve financial remuneration.

When junior doctors questioned Dr Renshaw about overtime not being paid, he allegedly stated 'overtime needs to be pre-approved'. However, I have been informed no such mechanism was in place to pre-approve overtime. Allegedly Dr Renshaw had told some ED junior doctors if they were involved in an active resuscitation of a patient in the emergency department at the time their shift was due to conclude, they were to walk away from the resuscitation and go home. Ethically I doubt any doctor would do this. I suspect if they did they would likely be reported to AHPRA for potential negligence.

I am aware individual doctors have worked more than 500 hours of overtime whilst employed as junior doctors at the LGH which went unapproved and unpaid. Eventually some doctors stopped documenting overtime on their timesheet as it seemed redundant to do so as it was never approved. Based on the number of junior doctors employed by the LGH and the significant number of overtime hours worked by individual former junior doctors, and speculating that the Tasmanian Health Service may be in debt to former junior doctors and owe hundreds of thousands of dollars as a result of Dr Renshaw's unwillingness to approve overtime, I am of the belief that AMA representatives were aware of Dr Renshaw's conduct. However, I cannot advise the committee what actions, if any, the AMA undertook to resolve this matter as former junior doctors report they have never received retrospective financial remuneration.

I can confirm timesheets have been kept as evidence with Dr Renshaw's markings in red pen. It is my expectation the Department of Health investigates this matter and appropriately remunerates those impacted.

Regarding employees accessing the emergency department as patients who have had their digital medical records accessed inappropriately by the former EDMS, Dr Peter Renshaw, and I have consent from the individual who was impacted by this to share this with the committee and also publicly. Employees and other members of the community have reported not feeling comfortable accessing the emergency department out of fear fellow health practitioners may inappropriately access their medical records. Some of these concerns arose after an employee accessed the emergency department as a patient. After the individual heard corridor rumours from colleagues that Dr Renshaw accessed their digital medical records, reportedly because he didn't like the individual, they requested the Department of Health undertake a DMR audit. The Department of Health confirmed their medical records had been accessed by Dr Renshaw. I have sighted an apology letter the individual received from Dr Renshaw, who admits in the letter he breached his code of conduct and accessed the employee's medical records after a prior conflict.

Other employees have voiced concerns their medical records have been accessed by colleagues, something which health unions and the Health Complaints Commissioner might be able to speak further on.

The next matter is a breach in the code brown protocol involving the transfer of care of a paediatric patient from Tas Ambulance to the operating room suite the day of the Hillcrest Primary jumping castle tragedy. The following allegations may be distressing. I will say no member of staff is alleging patient outcomes may have been different. On December 16 the EDMS, Dr Renshaw, announced the activation of a code brown, an external disaster, in response to the tragedy involving multiple children severely injured by the jumping castle at Hillcrest Primary School. During a code brown, the emergency department, the operating room suite, and intensive care unit are to remain on standby for potential casualties. The operating room suite is to safely transfer stable patients to the ward and halt elective and non-urgent emergency theatre cases in preparedness for potential casualties.

On the date of the Hillcrest tragedy, the operating room suite transferred post-operative patients safely back to the wards, and any pre-operative elective and non-urgent cases were also returned to the ward. However, I have received multiple reports from staff members, and I have a copy of an incident report to substantiate this, which states operating room suite management, including the director of surgery, the nurse unit manager and the clinical nurse co-ordinator, made the determination to proceed with elective and non-urgent cases an hour after the code brown was announced. This was despite the code brown protocol remaining active at the time of the decision. I am informed theatre staff raised concerns with management about their decision to ignore the LGH's own code brown protocol. Management reportedly responded with, 'Just trust us.'

After elective and non-urgent cases recommenced in operating theatres whilst the code brown was still active, the operating room suite received contact that Tas Ambulance needed to divert to the LGH as a paediatric casualty, who was being transferred to the Royal Hobart Hospital, was critically unstable. Approximately five minutes after ORS management were notified that a paediatric patient was being diverted to the LGH for emergency surgery, an obstetric code blue was announced over the hospital's PA, requiring immediate transfer of a woman from the maternity unit to theatre for emergency life-saving surgery. Theatre nurses reported it was by sheer luck, not careful design, that a patient was in the anaesthetic room and had not yet been anaesthetised in the emergency theatre, therefore allowing the paediatric patient to be received by the operating room suite from Tas Ambulance for emergency surgery. Other theatres were reportedly occupied by patients undergoing elective surgeries. Staff have reported feeling distressed as elective cases were prioritised over potential external casualties and potential internal emergency surgeries during the active code brown, both of which did occur.

Work health and safety of staff appears to have also been overlooked on this day. I want to reiterate that no member of staff has alleged that patient outcomes for any patients on the day of the Hillcrest tragedy were adversely impacted as a result of management's decision making.

Based on other incident reports I have cited, the operating room suite has a pattern of breaching the LGH emergency protocols. This includes a code red where a patient was transferred into an active fire zone despite the chief warden's clear directive not to transfer patients. Some staff have expressed grave concerns to health unions and to myself regarding

patient safety in the ORS, including the safety of patient transfers of care from Tas Ambulance during an active code brown.

In response to the breach of the code brown, an SRLS incident report was submitted by a staff member. The incident report was reviewed and rejected by the director of surgery, the nurse unit manager, and the clinical nurse coordinator, the quality patient safety and services, as per the documentation I have with me. I note two of the individuals who breached the code brown policy were involved in reviewing and rejecting the incident report. Based on this information I suspect the secretary of health and the health minister might be unaware that the LGH breached its own policy, and to date, there has been no investigation into the matter.

I will also note, staff who have raised patient safety concerns to management have been verbally cautioned with potential ED5 code-of-conduct investigations for harassing management. It is my recommendation to the Department of Health that they investigate the allegations into the breach of the code brown the day of the Hillcrest tragedy, and all other breaches and patient safety concerns staff have.

Care calls in the emergency department: As we have been made well aware, there has been and continues to be an array of negative patient experiences, both in the emergency department and in other departments of the THS. Thankfully, Tasmanian journalists have elevated the voices of those patients with negative experiences and reported these stories in the media.

In response to concerns, the Department of Health extended the care call policy across THS hospitals to empower patients to escalate their own care. However, I have received reports from patients who have attempted to make care calls in the ED and have had the same treating doctor attend the care call, rather than at the EDMS or a senior medical officer in charge.

I am of the understanding mothers who have advocated for their unwell babies in the ED have initiated care calls only to have security present to the call. I contacted the statewide complaints management oversight unit regarding care call protocols, including how patients are informed of who should be attending those care calls and what to do in the event the care call is not adhered to by the THS.

I received this response:

> If a care call process appears to not have been actioned, the individual initiating the care call may raise their concerns with a staff member, nurse, midwife, doctor, ambulance, paramedic or other staff member. If they feel their concerns have not been responded to adequately and they are still worried, the individual can ask to speak to the person in charge of the shift or area to initiate a subsequent care call outlining their concerns and dissatisfaction with the process.

Professionally, I reject this statement. If the care call protocol is not adhered to by the THS, the onus should not be on a sick and potentially deteriorating patient to reattempt seeking help to ensure a review of their care by the EDMS is undertaken. It cannot be expected that all patients have the capacity to physically mobilise, in addition to needing to think sequentially, to seek help, especially in a chaotic emergency department.

I am aware of cases of former ED patients presenting to the Mersey Community Hospital or driving to the Hobart Private Hospital to seek emergency care, as they no longer feel they receive adequate care at the LGH emergency department.

In regards to the role of the Integrity Commission: A patient who lodged a complaint regarding their care in the emergency department of the LGH was internally investigated. The nursing director of the emergency department had written a response letter to the patient's complaint. It stipulated:

> Unfortunately, due to ambulance ramping and overcrowding in the ED, you were placed in the waiting room for your entire presentation.

I note the patient was in extreme pain due to a ruptured appendix.

Further, the letter stated:

> I am very sorry you were spoken to rudely by a member of the nursing staff during your time in the ED. I certainly apologise that the attitude of the nurse made you feel distressed. I understand the circumstances of your presentation were difficult, as it is documented in your medical records that you were, at times, uncooperative, yelling out loud, and using bad words.
>
> It is also documented you were screaming out you had severe pain. I do acknowledge that some patients who are experiencing severe pain may find themselves feeling anxious, frustrated, angry, or feeling misunderstood and demoralised. I am saddened to read that your experience deters you from attending the ED at the LGH. In the future, I would like to assure you that you are welcome to attend the ED if you are acutely unwell and you will be afforded the appropriate care and treatment that is available to all people in our community.

CHAIR - Can I just clarify that was a letter from -

Ms DUNCAN - The director of nursing of the emergency department. The director of nursing of the ED was required to write an apology to the patient for the letter sent in response to their complaint. Additionally, the nursing director of the emergency department was required to undertake values-based training with all other nursing directors, as stated by the former LGH CEO, Jen Duncan, in a formal meeting, which I was present for.

The patient was concerned others in the community may have received similar letters in response to their complaints. The apology and values-based training was, in the patient's view, unsatisfactory in ensuring the conduct hadn't occurred to other complainants previously and wouldn't occur to other complainants in the future.

The matter was then escalated to the Integrity Commission by the patient. As documented, the Integrity Commission responded:

> The commission does not investigate all complaints. Section 35 1C of the Integrity Commission Act 2009 allows me to refer complaints to other organisations for various reasons. I am referring your complaint back to the

secretary of the Department of Health, Kathrine Morgan-Wicks, for action. This is because the secretary is better placed to deal with the complaint and the allegations are not against a senior public officer.

The process is dizzying and fatiguing, especially to patients recovering from health conditions. In response to the Integrity Commission referral back to the Department of Health, assistant secretary, Shane Gregory, sent a letter to the complainant via the state-wide's complaint management oversight unit. However, this letter was sent to the incorrect complainant. The individual who received the letter was understandably concerned that a response she was awaiting from Shane Gregory may have also been sent to the wrong individual in the community. Concerns were understandable, given the personal and medical information included details about a child. I have with me supporting written documentation from the two complainants, Shane Gregory, and an acknowledgement of the error from the health complaints management oversight unit.

Simple but significant errors are occurring within the Department of Health for complainants who have attempted to progress complaints. Myriad patients who have accessed the THS had stated the complaints process is disempowering and seems rather redundant. It is documented Tasmania has approximately a 51 per cent literacy rate of people aged 15-72. Taking that into consideration, along with patients who are exhausted and fatigued by their health and the health system, I am concerned that there is under-reporting by patients who are unsatisfied by the Tasmanian Health Service. Among many other things, there needs to be an inclusive, simple and accessible complaints management process.

Based on the evidence other consumers, health-professionals and I have provided throughout the ambulance ramping inquiry, the gender bias in health inquiry and the maternal child and reproductive inquiry, I am aware there are still many facets of the health system which have not been examined or investigated. Staff employed by the Department of Health have reported they have not raised concerns out of fear of professional and personal repercussions, stating they need their job to put food on the table and a roof over their family's head. Healthcare consumers have expressed similar concerns about the many failures in the public health system. This is evident in a significant proportion of patients contacting journalists to make public their experiences of accessing the health service. Many do so in attempt to stop their experiences happening to others.

Whist I acknowledge that there are positive lived experiences from patients who have accessed the Tasmanian Health Service, I am acutely aware of far too many who have had poor experiences. Unfortunately, negative experiences far outweigh the positive experiences and have too often resulted in preventable deaths as per findings in Magistrate Court of Tasmania coronial investigations.

In the midst of all these inquires, it is important to remember that every person has a story and it is tragic many of these stories have been cut short due to the failings of the health system which is designed to protect us.

Respectfully, how many parliamentary inquiries into failings in different facets of the healthcare system will it take to ensure people are not dying or suffering adverse outcomes due to failures in our health system?

Whilst I'm of the understanding that Dr Peter Renshaw no longer works at the LGH but maintains his AHPRA registration, the culture he fostered continues to exist according to senior doctors. In response to mounting concerns, I am requesting the Tasmanian government implement a Tasmanian commission of inquiry into the health system failures. Based on the information I've provided, I believe THS policies and legislation, such as the Coroner's Act 1995, must urgently be reviewed. Employees need to feel safe in raising concerns without fear of losing their jobs or receiving ED5 code of conduct as threatened by some in management.

Complaints and parliamentary inquiries should not be the norm in a first-world country. It is crucial all patients have accessible support to an organisation which can walk the complaints journey with them independently of the Department of Health. Institutions have lawyers, employees have unions, but patients are left to their own devices to navigate a complex and frankly convoluted system. It is unfair, it is unjust, and it goes against the morals, ethics and values of what we as health professionals sign up to when we pledge to care for the community and do no harm.

To conclude, I implore the federal and state governments to foster and provide a safe, ethical and effective environment for us as health professionals to do our job as we set out to do. Safe, accessible, equitable and timely health care should not be wishful thinking but guaranteed for all people. This is why I feel a commission of inquiry into health system failures is needed to overhaul a broken system. Please help us help them.

CHAIR - Thank you, Amanda, for that very shocking amount of evidence that you've provided to the committee. I acknowledge how carefully you've prepared yourself today and how thoughtfully you've provided that information. I also acknowledge the obvious real and ongoing distress for yourself and the other staff members who are clearly impacted in an ongoing way by the huge range of things you've presented to the committee.

There's a lot to discuss, not all of it is appropriate to talk about right now in the committee. Before I have some questions for you, I want you to recap what you said at the beginning about the numbers of people who you think have been, just that information at the beginning.

Ms DUNCAN - There have been 11 reports from doctors and nurses who have disclosed alleged misconduct relating to the death of a patient including falsified medical certificates of deaths in ward 5a, 5b, the intensive care unit, the operating room suite and the emergency department at the LGH. There are two deaths which were not reported to the coroner by the LGH. In total there are 15 deceased patients who I am concerned may be impacted. Some of these individuals I have their names from the recollection of doctors and nurses. However, some patients were unable to be identified at the recall of doctors' and nurses' memory.

CHAIR - Thank you. What you've presented is a whole range of information about the Launceston General Hospital surrounding the emergency department, some of which obviously speaks to the extreme pressure in the emergency department and to ambulance ramping and that whole incredible pressure cooker environment. How does that make you feel when you go to work - you're still working at the LGH, aren't you?

Ms DUNCAN - I'm still employed at the LGH. I'm not actively working there at the moment. It's frustrating and it's really challenging. I worked in the emergency department just

up until the point of the COVID-19 outbreak. I was only working in a casual sense, which was quite frequent and involving quite a lot of double shifts. I commend the staff there who work full time, .8, .6 in those roles because it is fatiguing and exhausting.

CHAIR - What you've talked about here is a culture which you have said very clearly - the information that you get from staff who are working there now - that things haven't changed. Although Dr Renshaw is not working there and a lot of the allegations you presented today relate to him, they are not just in relation to him. They're in relation to other people. Do you believe that the culture remains, of that dangerous and, well, you've alleged sort of criminal misconduct, essentially?

Ms DUNCAN - Yes. I think it's the nature versus nurture concept, really. I mean, Dr Renshaw was the lead of an entire hospital and he had a lot of control as the EDMS and as the medico-legal adviser. Just because he is no longer actively working there, the culture and some of those people, especially in senior and middle management, remain, and that culture has been fostered for decades. So, multiple staff, including the senior doctors and nurses, have expressed that whilst there have been some policy changes since the commission of inquiry into institutional child sexual abuse, culture is still very much the same.

CHAIR - What I've heard you say in the range of evidence that you've presented is an enormous pressure from Dr Renshaw but also other senior clinical and nursing staff to keep the process of moving people through going, it seems, regardless of the cost; regardless of the cost to the risk to patients, regardless to the cost to the processes of the department and the protocols, even in the terrible example of the code brown situation in relation to the Hillcrest tragedy; and also junior doctors and people not being paid properly in order just to keep everything going. Can you talk about that sort of situation, the pressure? Where do you think it's coming from? Why has this culture developed?

Ms DUNCAN - My honest answer is I believe it's coming from the Tasmanian government; especially when looking at an emergency department, you have to examine the entire hospital and how it functions. It's kind of like a footy team, I suppose. You don't just look at one player. You look at the entire team and how it functions and who leads it. I know I can speak to where I have worked in the areas in the LGH and I know, for example, the operating room suite, there is a lot of pressure from the government to complete elected cases to ensure appropriate funding is required so management are working very hard to try to decrease the elective surgery waitlist but I believe it is affecting emergency situations and patient safety. I also have with me a document of a nurse in the post anaesthetic care unit who documented how long from a patient being ward ready post operatively until the time a nurse can collect them from the ward, what that time was in a 24-hour window. I believe it was 25 hours that patients were kept in the operating room suite in the post anaesthetic care unit. Therefore, utilising resources of nurses and then that backlogs in the theatres, and then elective cases are unable to continue progressing and that is not necessarily the fault of ward nurses and management. It's because there is bed block, and they don't have patients to discharge. There is no way of transferring them back.

Another example is when I worked in the emergency department, a common culture which interstate doctors and agency nurses quite frequently comment on is that ward nurses at times decline to take patients from the ED who were outside what we call 'dangers parameters', and this can sometimes be expected due to the patient's presentation. I transferred a patient who was undergoing chemotherapy and was neutropenic as a result and had an infection. It

was known about. There was a management plan put in place. The patient had a slight temperature, which would be expected, and the ward had - once transferring the patient and also in front of the patient - the ward declined to accept the patient as they wanted the patient to have the appropriate parameters for the ward. I understand this to a degree, as it is then additional work for the ward nurses. They might have to make phone calls to doctors. In this instance they didn't need to. Therefore, I declined to take the patient back to the emergency department. It is inappropriate, I believe, to be sending ward-ready patients to the wards and then them being declined at times. I think junior nurses and potentially agency interstate nurses might not understand that culture that apparently is one only at the LGH.

CHAIR - Thank you. You've mentioned many times in your evidence, people, nurses, yourself included, who have made complaints and even who have wanted to participate in root cause analysis assessments or who have made complaints under an SRLS, and they've been shut down, not listened to, dismissed, told to go away and be quiet. What sort of level of confidence does the staff have about the reporting system that's in place for you to escalate that beyond your immediate senior person who - let's face it - is responsible for making decisions about your employment. What confidence do you have that you can go elsewhere in the THS and be heard?

Ms DUNCAN - It's very frustrating and I don't feel a lot of the staff feel comfortable putting their name to an incident report, as it at times can result in nurses and doctors or any staff member at the LGH being potentially targeted and may experience some form of professional repercussions. Also, as I mentioned, the process is dizzying and fatiguing for patients to lodge complaints. It is also very confusing for health practitioners how to escalate those concerns if senior management, like EDMS, is rejecting those incident reports. Where do you go from there?

CHAIR - Okay, so you don't feel there is a system in place that staff have confidence in and that can escalate the incredibly serious issues that you are talking about, that you allege have resulted in deaths going not reported to the coroner or people dying because they didn't get the care and treatments they needed in a timely fashion?

Ms DUNCAN - It is hard to speak on behalf of everyone, but simple incident reports, I am sure people do not have an issue, but when it is of an ethical nature or potentially a criminal matter, there are definitely concerns about making those incident reports.

CHAIR - I am aware of the time and that you would also like to give some evidence in camera. There are a couple of other things that I wanted to ask you before we did that, and I also now seek the agreement of the members to possibly go until 10.30 a.m. to finish our committee hearing today. I don't know if members are able to stay for that, is that possible?

Mr BEHRAKIS - I can go until 10.30 a.m. but I'll have to leave quickly after that.

CHAIR - Michelle, Anita?

Members - Yes.

CHAIR - If it is okay with you, we will extend the hearing.

Ms DUNCAN - Yes.

CHAIR - My other question related to the Integrity Commission and the circularity of the situation where a patient made a complaint, first of all, to the hospital and got an apology letter which they felt was deeply inadequate from - I think you said - the nurse unit management?

Ms DUNCAN - Nursing director of the emergency department.

CHAIR - On the basis of that they went to the Integrity Commission because they believed there was a serious matter of misconduct. The Integrity Commission, you said, decided they would not investigate because it wasn't a matter of misconduct by a senior public servant officer. That appears to suggest circularity where an investigation into a matter by a senior public officer is not, or that person was not senior enough, but is part of a system where they are acting, or a culture where they are acting, in a way which is causing misconduct or falsification of failure to report about serious matters. Can you speak about what you think about the role of the Integrity Commission, which seems to have a very small scope of what it considers relevant to investigating?

Ms DUNCAN - As I said, I think the process is dizzying. The patient started with reporting to the Launceston General Hospital's complaint's management oversight unit and there were some internal investigations. It was then escalated to the Integrity Commission, who then just referred it back to the Department of Health. There is quite a lot of confusion, and I was confused by what constitutes as a senior public officer, so how are patients supposed to know what that definition looks like? I also note, what I don't understand is why the Integrity Commission referred the matter back to the Department of Health, rather than raising the recommendation to refer on to the Health Complaint's Commissioner.

We had initially looked at doing that, but there was also confusion for the patient as the Health Complaints Commissioner, I believe, stipulates on their website that there's an attempted process to manage the complaint internally. The patient felt that had been somewhat achieved personally but were concerned about others in the community who may have previously received letters from the nursing director of the Emergency Department, or potentially will receive complaints in the future from the nursing director of the Emergency Department.

There's quite a lot of confusion as to whom you report to and what jurisdiction do they have over complaints. As I said, that can be very challenging to patients who are unwell or who may not have the skills to know how to access these governing bodies.

CHAIR - We have complaints that could come from patients and staff. Yesterday, the secretary of the Tasmanian Health Service told us that if staff have complaints, they should feel free to make them to her as the secretary. Do you want to make any comments about that process that she has recommended or a process she has recommended?

Ms DUNCAN - Firstly, I would like to thank Kathrine Morgan-Wicks for the effort that she has been putting into the Department of Health, especially since the commission of inquiry. I personally have felt comfortable raising concerns to Kathrine Morgan-Wicks. However, I think sometimes the terminology of 'secretary of Health of the Department of Health' can be quite intimidating to staff members, who may feel concerned if they don't professionally know Kath, that it may come back to resulting in professional repercussions. I just think there

potentially needs to be discussions about what that could look like. But, I would hope that people feel comfortable raising concerns, but I think that at present that is not necessarily happening directly to Kathrine Morgan-Wicks, and I would hope that when staff members raise concerns to health unions or the AMA they also escalate concerns appropriately to the secretary of Health.

CHAIR - Kathrine Morgan-Wicks is a secretary. She will not be forever the secretary of the THS. It could be an entirely different person. You have had personally good experiences with her. That is really great to hear, but the minister for Health himself has also said that in relation to complaints or concerns about coronial matters, the sorts of things that you have presented today, that staff should report them directly to the secretary of the department. Do you think that is the appropriate mechanism? Do you want to comment on that?

Ms DUNCAN - Personally and professionally I would say that it is not. Again, I do not feel that it is appropriate the for the Department of Health to investigate potentially criminal allegations and misconduct internally. I think there is a lack of transparency that has been demonstrated over a long period of time, and for matters like this it might be one avenue of many avenues when reporting misconduct allegations. I think concerns would be raised by staff that potentially matters would be just swept under the rug like they have been previously.

CHAIR - Have you or anyone else you are aware of raised these matters yet with Tasmania Police? You talked about them earlier.

Ms DUNCAN - I am aware that some people have reported to Tasmania Police on other matters, but it is my understanding at present that no one has directly reported to Tasmania Police. I myself have only finished the process of reviewing Magistrate Court of Tasmania documents, and I am happy to refer that onto police. I am aware that patients' families may be going through their own investigations, but no, at present I am only aware of doctors contacting magistrates for advice.

CHAIR - There are some very serious matters you have raised today. I want to say on behalf of the committee that we have heard your testimony, and we thank you for the incredible body of work that your testimony provided to us today. It is critically important. It is important for the loved ones of people who have died to have, as you say, truth and justice. If the allegations that you have presented were shown to be true, then it is incredibly important that there is justice and there is a proper investigation of the matters that you have raised to us. As a committee we will take advice and consider the appropriate steps that we need to take in this space.

I understand that you have extra evidence to give in camera, but you have also made a number of specific recommendations to the Department of Health, and the committee will consider probably passing those on to the Department of Health, whether we do it when we do that in the report or earlier than that. Some of them, in my judgment, would need to go to the department earlier than the end of our report. Finally, you've made a very strong case for the government to call for a commission of inquiry into health system failures in Tasmania.

Again, on behalf of the committee I just want to say thank you for the work you've done bringing this to light on behalf of the patients and staff that you've spoken to at the LGH over many years, many different people. It is not our role to be able to make a view on whether there should be a commission of inquiry, but I can say that the serious matters that you've raised

have to be investigated. There is clearly a culture that remains at the LGH and it is a pressure culture, which ambulance ramping is a part of that and people who are paramedics and patients on the ramp are part of the harmful situation that occurs too often for patients and staff there.

We need to go in camera now. I don't see any other members with their hand up and looking at the time I will now move that we finish the recording, and we go into the camera to hear the rest of your evidence.

The committee suspended at 10.15 a.m.