Cairns Hinterland and Hospital Health Service (CHHHS)

Health Service Investigation

Final Report
Private and Confidential
12th December, 2014
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1 Executive Summary

Introduction

This is a report of investigations conducted pursuant to section 190(1) of the Hospital and Health Boards Act 2011 in relation to:

(a) The standard and quality of clinical management and treatment provided to Patient A and (and other matters) at the Cairns Hospital.

(b) Whether the external communications relating to the treatment of Patient A and at the Cairns Hospital were at all times appropriate.

Key Findings

(a) i. The standard and quality of clinical management and treatment provided to Patient A:

In summary, on the evidence made available to the Investigator, on the balance of probabilities:

(a) The clinical management and treatment provided to Patient A was clinically appropriate and reasoned, and generally complied with the relevant clinical and administrative policies and procedures. The standard and quality of clinical management and treatment of Patient A was of an acceptable standard for the information available at the time.

(b) In relation to the management protocol used by CHHHS:

(i) Department of Health guidelines, released on 9 September 2014 by the Communicable Diseases Unit, were circulated to some staff a month later on 8 October 2014, but locally adapted guidelines on Ebola Virus Disease management did not exist at the time of Patient A’s admission. Not all staff interviewed were aware of the Department of Health guidelines prior to the arrival of Patient A, nor were they aware of the status of Cairns Hospital as a hospital designated to receive potential Ebola virus infected individuals.

(ii) The treating clinicians utilised the Princess Alexandra Hospital Ebola management protocol (PAH protocol) as the basis for their decision making and clinical judgement in regard to Patient A’s care and the management of potential risk to other persons because this protocol was assessed to be the most detailed and practically applicable protocol available to them. The
decision to use the PAH protocol was reasonable in the circumstances.

(c) Treatment and other options were appropriately discussed with Patient A by the Infectious Diseases, Emergency Department and other staff.

(d) There were some local staff concerns raised about ongoing patient placement in the Emergency Department, however this was a decision which was the subject of proper consideration by the relevant stakeholder clinicians, was clinically supportable, was not contrary to the patient protocols available to the clinicians, and was the most appropriate option in Patient A’s particular clinical circumstances.

(e) Allowing non-family non-essential visitors into the patient’s isolation room was a non-compliance with the protocol being used to manage Patient A. It ought not to have been permitted, however it did not affect the patient’s clinical care.
(b) i. Whether the external communications relating to the treatment of Patient A at the Cairns Hospital were at all times appropriate:

Clinician A
7. In all of the circumstances, Clinician A's breach of Policy E1 should be considered at the lowest end of seriousness and, in the opinion of the investigator, does not warrant further action beyond formal instruction and training regarding management of media contact.

Clinician B
6. In all of the circumstances, and in particular given that the disclosure was inadvertent, Clinician B’s breach should be considered at the lowest end of seriousness and, in the opinion of the investigator, does not warrant further action.

2. Appointment

Background

5 Media reports were made through a range of print, radio and televised outlets in October 2014 that provided information into the public domain in relation to Patient A. The office of Department Executive B and the CHHHS Executive A raised concerns about:

(a) Health service employees providing information to the media without prior approval by the Health Service Chief Executive;

(b) The appropriateness of the external communications leading to confidential information in the public domain;

(c) If those communications were at all times appropriate and in compliance with Department of Health policy, code of conduct and legislation impacting on the health portfolio with respect to each patient separately; and

(d) The standard and quality of clinical management and treatment provided to each patient separately, and the compliance with relevant clinical and administrative policies and procedures in place at the CHHHS in relation to the treatment of the patients and management of potential risk to other persons.

Authority

6 Pursuant to an instrument of appointment dated 21 October 2014, Christine Foley, Director of Governance, Quality & Safety of St. Vincent’s Aged & Shared Services, St. Vincent’s Health Australia (referred to in this report as “I” or “the investigator”) was appointed by Dr Michael Cleary, Chief Operations Officer, Department of Health pursuant to Part 9 of the Hospital and Health Boards Act 2011 (Qld) (HHB Act) as a health service investigator.
The instrument of appointment required the investigator to work cooperatively with Clinical Reviewers appointed under Part 6 Division 3 of the HHB Act and to have regard to any report provided by the Clinical Reviewers under section 136 (2) of the HHB Act.

Pursuant to an instrument of appointment dated 21 October 2014, Professor Dominic Dwyer, Fellow of the Royal Australasian College of Physicians, was appointed as a Clinical Reviewer to undertake a clinical review in relation to aspects of the investigation relevant to the management and treatment of Patient A at Cairns Hospital, and compliance with relevant clinical and administrative policies and procedures in place at Cairns Hospital relating to the treatment of Patient A and management of potential risk to other persons.

A copy of the instruments of appointment together with the Terms of Reference for:
(c) The investigator
(d) Professor Dwyer
(e) 
are contained in Annexure A to this report.
3. Limitations

11 The investigator has applied her investigative knowledge to determine the facts relevant to the matters within the scope of the instrument of appointment. The findings reached reflect her analysis of the facts available to her, ascertained as a result of her investigations and from the information, opinions and advice.

12 The investigator is not a lawyer and the report should not be relied upon as legal advice. The report does not contain legal conclusions, only findings of fact.

13 The investigator reserves the right to alter the findings reached in this report should information that is relevant to the findings subsequently become available after the date of this report. However, the investigator assumes no responsibility for updating this report for events and circumstances occurring after the date of this report.

14 This report has been prepared exclusively for the Chief Operating Officer, who commissioned the investigation (under a delegation from the Director-General). And the purposes identified in the instrument of appointment and the statutory purposes prescribed in the Hospital and Health Boards Act 2011. It should not be distributed, used or relied on for any other purpose or without the written consent of the investigator. If it is, the investigator does not accept any liability or responsibility for loss suffered by any party.
4. Methodology

Interviews

15 The Investigator and Clinical Reviewers sought interviews from clinicians involved in the treatment of Patient A and [confidential] as well as members of the Department of Health and CHHHS Executive. Patient A was also invited to attend, and did attend, an interview in relation to her care.

16 Interviews were conducted as set out in Annexure B to the report. Interviews were conducted in person at the Cairns Hospital for clinicians currently working in the hospital to minimise disruption to service delivery and the GHD Building for the Medical Practitioners under suspension from employment, Patient A and CHHHS Executive members who ordinarily work in the GHD building. The Clinical Reviewer undertook two interviews with clinicians by telephone as they were not on site at the hospital. The investigator undertook interviews with some members of the CHHHS Executive after the site visit to clarify evidence and findings.

17 The interviews were not recorded.

18 The Investigator and Clinical Reviewers would like to acknowledge and thank the CHHHS Executive and all staff who participated in this investigation. The high level of cooperation and openness provided to the investigator and Clinical Reviewers from all levels of staff has been commendable and greatly assisted in completing the investigation as quickly and diligently as possible.

Documents

19 Pursuant to the powers conferred on the Investigator by section 194 of the HHB Act, the Investigator sought documentation for the purposes of her Investigation from CHHHS and various CHHHS employees.

20 Documents were sought and produced as set out in Annexure C to the report. This included documents not specifically requested by the Investigator.

21 Where the evidence relied upon for findings in this report is contained in a document, the source of that evidence is specifically referenced in the report and a copy of the document is available on request.

Individual officers

22 In accordance with the principles of natural justice, where the conduct of individual officers was considered by the Investigator to potentially be the subject of an adverse finding, each officer was afforded the opportunity to respond to the allegations against the officer.
Expert or clinical evidence

23 The Investigator worked co-operatively with the appointed Clinical Reviewers and had regard to their reports provided under section 136 of the HHB Act in making the finding.

24 Copies of the reports of the Clinical Reviewers are contained in Annexure D to the report.

Assessment of evidence

25 This report sets out the evidence that is credible, relevant and significant to the matters under investigation in relation to each matter. For each matter under investigation, the Investigator assessed the available evidence. Where conflicting evidence existed, considered whether the evidence supported or does not support particular findings on the balance of probabilities, that is whether the Investigator could be satisfied that a matter is more probable than not, but not beyond a reasonable doubt, based on the strength of the available evidence.

26 All evidence provided to the Investigator has been taken into consideration, although the report may not specifically refer to all of the material provided.

Confidentiality of individuals

27 The terms of reference of the Investigator’s appointment states that the names of person providing information to the investigator must be kept confidential and referred to in a de-identified form in the body of the report unless the identification of the person is essential to ensure that natural justice is afforded to any particular person. In this regard, the names of the patients have been retained as they are referenced in the terms of reference of the investigation.
Part A

5. Clinical Management of Ebola

Management of Patient A

Background

On 9 October 2014. On that morning, Patient A check temperature and noted a low-grade temperature. She contacted the Queensland Public Health Unit and advised she had a low-grade temperature and general feeling of unwellness and tiredness.
Patient A presented to the hospital as directed at approximately 1300 hours on Thursday 9 October 2014 where a strategy was in place to greet her and escort her with personal protective equipment (PPE) to the isolation room within the ED for assessment of suspected Ebola virus infection. Patient A was assessed and remained in airborne isolation protection in the ED while blood tests were taken (sent to Brisbane) and while awaiting a result. She was confirmed as having a negative Ebola virus PCR result in the early hours of Friday 10 October 2014. These results were provided directly to Patient A by CHHHS Executive D, not the admitting or treating consultant. Patient A remained in the ED isolation room until a second confirmed negative result was returned (blood collected on Sunday 12 October, and sent to Brisbane via Commercial flight as the usual courier flight was not scheduled until later in the day) and she was discharged home just after midnight, in the early hours of Monday 13 October 2014 for continued ongoing daily monitoring with the local Public Health Unit.

Issues for Investigation

35 The issues for investigation are:

a. The standard and quality of clinical management and treatment provided to Patient A by the Cairns Hospital.

b. Whether the clinical management and treatment provided to Patient A complied with relevant clinical and administrative policies and procedures in place at Cairns Hospital relating to her treatment and management of potential risk to other persons.

Standard and quality of clinical management and treatment provided to Patient A by the Cairns Hospital

Clinical Review by Professor Dwyer

36 Professor Dwyer undertook a number of interviews of CHHHS staff with the Investigator and also independently to determine sequence of events relating to Patient A’s care and management, and contact tracing.

37 There were four significant decision points identified during the sequence of events examined for Patient A’s management. These have been highlighted through the chronology of events and addressed in the findings section of this report.
Review of the patient records of Patient A and sequence of key events and significant decision making points relating to Patient A’s management

Interview with Patient A revealed that:

On the morning of 9 October 2014 Patient A noted a low grade temperature and contacted the Public Health Unit in Cairns. She was directed to come to ED at Cairns Hospital for assessment.

**Significant Decision Making Point - 1.** Decision following discussion with Public Health Unit and Clinician R to bring patient into Cairns Hospital ED Isolation Room for assessment and admission.

Review of the patient records of Patient A revealed that:

She was met by Clinician U with PPE and escorted to ED Isolation Room for assessment by the Clinician R.

**Significant Decision Making Point - 2.** Following initial assessment of the patient in ED Isolation Room and discussion, the decision to continue to manage patient in ED Isolation Room rather than transfer to ICU Isolation Room or Ward Isolation Room.

**Significant Decision Making Point – 3.** Following review of Qld Health draft Ebola virus guideline, discussion with Clinician R, Clinician Q,
Clinician S and other senior medical staff, decision to use Princess Alexandra Hospital “Management of patients with known or suspected Ebola virus procedure” for management of this patient in Cairns Hospital.

RN G entry to medical record 1640 hours 9 October 2014:

“Ebola is spread through contact with infectious bodily fluids e.g. blood. Ebola is not airborne virus, please manage this patient under contact and droplet precautions. This means all staff are to wear a long sleeved yellow gown, P95 mask, goggles and gloves whenever entering this patient’s room. If contact with bodily fluids is anticipated, e.g. collecting blood, please use above PPE as well as a second layer of gloves. Please refer to Management of patients with known or suspected Ebola virus procedure from the Princess Alexandra Hospital for the management of this patient. Please contact Infection Control (internal phone extensions provided) with any concerns during business hours or (mobile number provided) outside of business hours”.

A nurse special, RN H, trained in infection control precautions for this patient was stationed at Patient A’s room to manage care and monitor all entry to the room. A telephone was set up in the patient’s room to facilitate communication. Blood was taken and sent for FBC, E/LFTs, Ebola virus PCR, malaria and dengue testing. Nursing entry RN H at 2000 hours noted “only person to enter room is nurse special when required, contact via phone”.

At 0545 hours on 10 October 2014 CHHHS Executive D documented in the medical record that he visited Patient A to advise her that the first Ebola virus PCR has returned negative, and he discussed options of retrieval to Brisbane while awaiting second test result, continue isolation and monitoring. Nursing entry at 1230 hours noted “all staff who enter room to be observed for correct attire and PPE, visitors are to enter room and staff entry to be kept to only if needed, environment is strictly monitored”.

RN G entry to medical record 1235 hours on 10 October 2014: “This patient remains under contact and droplet isolation despite negative first test. The patient must remain in negative pressure isolation room under isolation with suitable nurse special for duration of her admission or until 2nd PCR returns negative. At this point, the only time contact with the patient or entering the room is required is for a medical officer review. Anybody entering the patient’s room needs to put their name on personnel log outside the room for contact tracing. Please refer to managing patient with known or suspected Ebola virus procedure manual for all aspects of treating and managing this patient including how to clean the room and dispose of linen upon discharge. Please contact Clinician T or myself with any concerns. As previously noted, Ebola virus is NOT airborne. There is no risk to other staff or patients in ED or Cairns Hospital of contracting any virus / bacteria / fungal infection (none of which this patient has returned positive for), if they have no had direct contact with this patient”.

Limited Release
Seen by Clinician T – assessed, “impression that “Ebola virus unlikely, relatively low risk, swab negative, predictive value if test on day zero of disease. In my opinion the risk of Ebola virus disease is not sufficient to justify infection control risks that would result from QAS transfer to plane, then QAS transfer to RBWH. Plan to discuss with CHHHS Executive D, Department of Health Staff A, Department of Health Staff B, await final directive from Department Executive A / CHHHS Executive re decision to transfer, observe or send home. **Call me directly (mobile number provided) if any clinical or infection control concerns**”

Seen by CHHHS Executive D at 1530 hours to discuss options with patient and Clinician T – to stay in ED isolation for three days for 2nd test, to remain in isolation for 21 days or to transfer to Brisbane for isolation. Discussed all implications, patient decided to go with option 1 – to remain in ED isolation for three days and Red Cross contacted to arrange alternative accommodation on her discharge, and continued to maintain patient in isolation.

**Significant Decision Making Point – 4.** Following receipt of first negative Ebola virus PCR, option discussed with Department Executive A, Department Clinician B, CHHHS Executive A, CHHHS Executive D, Clinician T and put to the patient to decide which of 3 options she preferred, patient chooses option 1 which is to remain in ED Isolation Room for 3 days until 2nd Ebola virus PCR test result returns.

11 October 2014 – patient records show remains in isolation with nurse special monitoring environment and policy on restrictions and PPE.

12 October 2014 – patient records show awaiting results of bloods in evening, expecting result after 10pm and patient can go home or stay until morning.

13 October 2014 – 0000hours, patient received 2nd negative result via phone discussion with Clinician T and discharged into Red Cross arranged accommodation.

**Interview with Clinician S**

Clinician S stated that he had started work approximately 1200 hours on Thursday 9 October 2014 and was informed by Clinician E in ED that a patient with possible Ebola virus infection was coming to the ED.

The day was not a usual working day as the College Accreditation Day was being undertaken in the ED. The Clinician S stated he was interrupted with what he was doing with the Accreditation and spoke with Clinician E to confirm patient details and appropriate action plan following discussion with the Department Clinician B and Clinician R. The agreed plan was for Patient A to present to ED and to be escorted to Room 4 Isolation Bay in
ED by RN G wearing PPE and then for Patient A to be assessed by the Clinician R.

The Clinician S stated he returned to Accreditation, and then returned back into ED when Patient A arrived at approximately 1300 hours.

The Clinician S stated that he was aware of the draft Ebola guidelines from the Department of Health which had been circulated the previous day either by the ED network or internally. The document broadly covered clinical management, and came out as a document for consultation in draft, and the Clinician S stated that it was up to clinician judgment if they can apply the guidelines or look for other sources of information.

Then Clinician S stated that when Patient A arrived he witnessed the process in action. Patient A came through the ambulance entrance with a face mask applied, and was escorted to Bed 4 Isolation room. Then Clinician R was in ED and then spent some time assessing her.

Clinician S stated that the PPE was set up, which is normally managed by ED, but although he was not present for specific discussions around PPE he felt that the PPE was appropriate at the time – long sleeve gowns, gloves, masks and eye protection.

During the subsequent few hours, Clinician S stated that he was back and forth managing the Accreditation process and keeping on top of the suspected Ebola patient management.

Clinician S stated that he returned after Clinician R completed the patient assessment around 1400 hours, and he discussed the patient management with Clinician R and an ED Consultant on the floor. Clinician X took bloods on the patient as Clinician R requested an experienced practitioner.

Clinician S stated that there was discussion between himself, Clinician R and Clinician X on the floor about the alternative options for dispositions of Patient A, which were:
(a) Remain in the ED Isolation Room
(b) Transfer to an isolation room in ICU
(c) Transfer to an isolation room on the ward.

Clinician S stated that Clinician R expressed concerns about sending Patient A to an isolation room on the ward.

Clinician S stated that the key consideration in keeping the patient in ED was concerns about exposing more staff to the patient than was necessary.

Clinician S stated that from a clinical perspective there was never any doubt in his mind that the Clinician R was taking responsibility for management of the patient.

Clinician S had a discussion with Clinician D, who discounted the ICU ward as an option as it was not clinically appropriate. Clinician S discussed the matter with Clinician D, and after that discussion Clinician D stated that he
was unwilling to accept the care of the patient. Clinician S stated that he spoke with Clinician D who said that the patient was not sick and could not go to ICU. This subsequently influenced the decision to keep the patient in ED and he did not pursue the option to move the patient to ICU any further.

Clinician S stated that he was not happy with the option of keeping Patient A in ED, as he doesn’t like patients in ED for extended lengths of time, but he felt that it was an extraordinary case taking into account the context, and felt that it was appropriate in this case.

Clinician S stated that it was an unusual case, and Ebola virus planning was not detailed enough at that time. It was unusual for a relatively well patient to be directed to ED or ICU.

Clinician S stated that they wanted to formalize the decision making processes, and had a meeting with the CHHHS Executive D late on Thursday afternoon, 9 October 2014. There were discussions with the Clinician V specifically around the nursing resources, and accessing a nurse special to look after the patient. They met in Clinician S’s office and reviewed events so far, discussed clinical details of the case, again discussed the 3 options for patient placement, considered the pro’s and cons of each option. There was no ICU representative in the meeting, however the Clinician S stated that he relayed the conversation to Clinician D. Clinician S stated that Clinician R reiterated his concerns about the ward isolation rooms.

Clinician S stated that there was a discussion about long stay in ED, issues about maintaining infection control processes, identified key risks – inadvertent breach of infection control processes in the context of the location of the room, and placement in a relatively busy department.

Clinician S stated that there was no concern at the time in relation to the size of the ante room, however on further consideration he felt that it was too small for this type of isolation situation. He stated that he understood that there was an issue with poor visibility of isolation rooms in the wards. In retrospect, Clinician S stated that Clinician R had reasonable grounds not to send the patient to the wards. They discussed the risk mitigation and all agreed that a nurse special was required to minimize staff exposure to the patient.

Clinician S stated that they discussed the clinical guidelines in circulation, and other guidelines with other Department of Health services, and were aware that Cairns Hospital did not have any specific guidelines. The normal process was described as generally if there was a state-wide document then the local services would adapt the local guidelines, to local use, in this case the Infectious Diseases team determine the local process.

Clinician S stated that there was limited awareness of Cairns as a designated facility for receiving Ebola virus infection patients. However he stated that the Department was experienced with returned travellers, TB was a common presentation and Infectious Diseases familiarity generally
was good. Clinician S stated that they searched Qheps (Department of Health intranet) and noted the PA Hospital guidelines were on the intranet and were easy to search. They felt the PA Hospital guidelines were well written, practical, and had a good level of detail which they felt they could use. Clinician S and Clinician R searched independently on Qheps on the afternoon of the 9 October 2014 for relevant guidelines for dealing with a suspected Ebola case and came to the same conclusion that the PA Hospital guideline was the best in the absence of local guidelines.

77 Clinician S stated that he advised the Clinicians X, Y and Z in the ED of the decision to keep the patient in the Department. They were of the opinion that it would be better keeping ICU beds for sicker patients rather than well patients, and he felt that reinforced the decision.

78 Clinician S stated that he discussed the management with RN I re the nurse special and met the nurse special around 1800 to 1830 hours. He took a copy of the PA Hospital guideline and asked her to keep it outside the isolation room. They also discussed the sections on PPE and management of personnel log. He stated that the nurse special was OK, and commented that she volunteered to be a special for Patient A because she knew her and would be doing the bulk of the specialling over the weekend.

79 Clinician S stated that before he went home he sent an email to all senior ED medical and nursing staff providing a summary of events of the day, sent around 1830 hours to work and home email addresses. He stated that as a regular communication tool it was important to communicate about this particular case because of the attention drawn to it. In the email he had asked staff to contact him with any questions. He received four responses to his email but didn’t respond to any emails at the time as it was late after hours.

80 Clinician S stated that on 11 October 2014 in the afternoon he discussed the patient management with the ED Consultant on the floor and there were no issues reported, no specific management issues with the patient, she was well, and had no further fever or symptoms. Clinician S stated that he was aware that the laboratory testing process had been sped up a little.

81 Clinician S stated that as at time of Patient A’s presentation there was no specific training on Ebola virus infection as they were waiting for the Department of Health guidelines. He stated that the situation was changing quite rapidly, and it was difficult to formulate an interim plan.

82 Clinician S stated that in hindsight he wished CHHHS had had a procedure in place, with time and resources to train staff in using the procedure. He stated that in the situation they had to use the best clinical judgment, and that they had to do the best that they could do.
The CHHHS Executive A received a call from Department Executive A on 9 October 2014 to ask if she was aware of the potential Ebola virus infected patient, who was probably the first likely Ebola case. The CHHHS Executive A advised that she did not know about the patient.

CHHHS Executive A discussed the matter with the Department Executive A on 9 October 2014 and the plan was for CHHHS Executive A to discuss the matter with the CHHHS Executive D and Department Clinician A and for the patient to be seen by the Clinician R in the ED. CHHHS Executive A stated she was advised that Patient A had been in home quarantine and was taking her temperature twice daily. She had reported to the Department Clinician A that she had a low grade fever and she had been directed by him to attend Cairns Hospital ED. CHHHS Executive A was told by Department Executive A that the patient had stated to the Department Clinician A that she was confident that she was not exposed but had worked with Ebola patients in Sierra Leone.

CHHHS Executive A stated that Department Executive A advised her she was doing a media conference on the afternoon of Thursday 9 October 2014 about the suspected Ebola case.

CHHHS Executive A stated that the Department Executive A was also planning to do a media conference on Friday 10 October at 0600 hours to release information about the first Ebola PCR blood test result, and CHHHS Executive A stated that she wanted the patient to know about the media conference and she asked the CHHHS Executive D to go in at 0500 hours and advise the patient of the first negative test result, which he did attend and documented in the medical notes at 0545 hours.

On Friday 10 October 2014 CHHHS Executive A said that she went through the ED with Clinician S and she stated that no staff raised any issues or concerns with her directly. She stated that usually the ED staff had no problem raising issues with her.

CHHHS Executive A stated that on 10 October 2014 there was agreement with the Department Executive A, herself, Clinician S and Clinician T to offer the patient three options – to fly to Brisbane for the remainder of the 21 days quarantine, stay in Cairns Hospital for 3 days in quarantine for the 2nd test and if negative to go home for the remaining 21 day quarantine at home, or to stay in hospital in Cairns for the remainder of the 21 day quarantine. CHHHS Executive A stated that the patient chose to stay for the 3 days until the second test result was reported and then go home, and there was agreement that it was more sensible to stay in ED rather than go to the ward or ICU.

CHHHS Executive A stated that she was heavily involved in discussions about Patient A’s care, considering options of flying her to Brisbane, how, use of an isopod, waiting 3 days between tests etc.
On Saturday 11 October 2014 Department Executive B attended Cairns Hospital because of publicity surrounding Patient A’s care (discussed in more detail below). CHHHS Executive A accompanied Department Executive B and CHHHS Executive E to ED where a discussion with some of the clinicians took place.

Department Executive A advised the CHHHS Executive A on the Saturday that there were delays in taking the second test due to pathology and that it would not be taken until Monday. CHHHS Executive A spoke with Clinician T and Clinician W who undertook to come in personally on Sunday morning at 06:00 hours to ensure that the bloods were dealt with swiftly to minimise the time that Patient A was potentially in ED and to expedite her potential discharge.

Clinician T confirmed that the blood collected on Sunday 12 October was sent to Brisbane via Commercial flight as the usual courier flight was not scheduled until later in the day.

CHHHS Executive A spoke with Patient A by telephone on Sunday evening to thank her for her patience and professionalism. At that time the CHHHS Executive A told Patient A of the review into her care and asked her if she would consider participating, which she agreed to but at that time had considered her care to be good. CHHHS Executive A also discussed whether Patient A was happy to be discharged at night once the result was through, this was at the request of Clinician T who gave CHHHS Executive A the patients contact number. Patient A decided this was the best option for her at the time, recognising that there would be a high level of media interest the following morning. Patient A confirmed that the Red Cross had sourced alternative accommodation for her to maintain her privacy.

CHHHS Executive A stated that after that discussion she asked Clinician T if they could go into the isolation room to see Patient A, which he agreed. They applied full PPE, completed the log book and entered the room and spoke to Patient A.

**Interview with Clinician T**

Clinician T stated that on 8 and 9 October 2014 he was while there he heard from the Public Health Unit of a nurse coming to hospital with a temperature after having looked after Ebola virus infected patients in West Africa. Clinician T stated that he phoned the Public Health Unit to find out what was going on, and he was told that they had issues getting in touch with Patient A initially but had finally contacted her through Red Cross.

Clinician T heard on the news the media conference which the Department Executive A did about a Cairns patient with possible Ebola infection. There had been a lot of media that Patient A had done over the previous weeks, so it was obvious to him who it was.

Clinician T stated that he was flying back to Cairns on the evening of 9 October 2014 as the Clinician R had arranged leave and he was advised that Patient A had been admitted to the ED and all of the tests were
collected. Clinician T said that he was told that the on call microbiologist at RBWH would provide a result around 0400 hours on 10 October 2014 for malaria and Ebola. It was arranged that a Clinician at RBWH would let Department Executive A and himself know of the result.

Clinician T stated that he had a tentative plan to get the result and come in early to tell Patient A and give any relevant medications. Clinician T stated that he was phoned early with the negative Ebola virus PCR result around 0600 hours on 10 October 2014 when he heard Department Executive A doing a press conference announcing Patient A’s first negative result. Clinician T stated that he was concerned that he hadn’t told Patient A yet and he phoned the ED and spoke with the nursing staff who told him that CHHHS Executive D had come in to give her the results around 0530 hours. Clinician T stated that he felt relieved that Patient A had received the results before the media. Clinician T stated that he was subsequently told that Department Clinician B rang Department Executive A and CHHHS Executive A, who asked CHHHS Executive D to give Patient A the result.

Clinician T stated that the Clinician R had told him that it was unlikely that Patient A had Ebola virus infection, and that she was being managed as an outlier of the Infectious Diseases team (a patient from one clinical admitting unit location that is managed in another clinical unit location by the admitting unit clinicians) from the Infectious Diseases team in the ED.

Clinician T stated that he came into ED around 0800 hours on 10 October 2014 and saw Patient A and assessed her. He stated that he discussed the issues and plan with her and told her that he was unsure about the negative predictive value of the test, and they were planning to retest her on Friday.

Clinician T stated that there was a lot of media interest in the local press. He was asked to assist CHHHS Executive A in a 1000 hours media statement and MP Bob Katter appeared and took over the media conference with his own statement, and Clinician T stated that he left as he wasn’t required.

Clinician T stated that the ED isolation room was in a busy corner in the ED between resuscitation cubicles and that it has its own service corridor and they set up a Nurse at the junction of the corridor so that no-one could go in there if they were not involved in Patient A’s care.

Clinician T stated that he addressed nursing staff with Department Clinician A at handover to thank staff and answer any questions. They raised concerns about PPE as CDC had recommended wearing ‘space suits’, but Clinician T responded that he didn’t think that was necessary in this case.
Clinician T stated that there was an initial issue in ensuring all PPE was ready to use. Clinician T stated that RN G had told him that nurses went around the hospital and got face shields from OT and other locations on 9 October 2014.

Clinician T stated that the Clinician R had circulated the draft Qld Health Ebola guidelines that came out on 8 October 2014. However, the PA Hospital Ebola protocol was 4-5 pages long, more clinically focused and more clearly described what to do, so that protocol was used.

Clinician T stated that he was told on the morning of Friday 10 October 2014 by an ED Nurse that some staff overnight were not happy with the PPE and were suggesting extra PPE over and above what the protocol recommended.

Clinician T stated that the only persons who had been into Patient A’s room were Clinician R who assessed her on admission, the CHHHS Executive D to communicate the blood results, the Clinician’s X and Z, who took Patient A’s bloods and himself.

Clinician T stated when he did the Friday handover education session on 10 October 2014, the same questions about PPE came up again, and one or two ED doctors asked why Patient A wasn’t being nursed in the ward because it was inappropriate to care for admitted patients in the ED. Clinician T stated that he responded that he didn’t want to move Patient A through the hospital any further. They also added an extra yellow bin for waste that a contractor was arranged to move.

Clinician T stated that while he was in Grand Rounds around 1230 hours on 10 October 2014 he received a call from the RFDS flight nurse to ask him what equipment to take with Patient A to Brisbane. Clinician T stated that this was the first that he knew of any planned transfer, that the flight nurse said “we are taking the patient to Brisbane”. Clinician T rang Department Clinician a, Department Clinician B, CHHHS Executive D and CHHHS Executive A to ask what was going on, and to say that he felt that there was no reason to transfer her to Brisbane as she was clinically better with one negative result and was unlikely to have the disease. He said that he spoke with a Clinician at RBWH who also agreed it was unlikely that she had the disease.

Clinician T stated that after completing the nursing handover sessions on the afternoon of Friday 10 October 2014, CHHHS Executive D phoned him to discuss putting three options to the patient, and was told that it was a decision that had come from the Department Executive A. He stated that the CHHHS Executive D strongly advocated for the patient to make the choice, and when they put it to Patient A, she chose to stay in ED for 3 days until she got the second test result.

Clinician T said that Clinician W expressed concerns to him about the cost and logistics of re-testing on the weekend (Sunday) as this would involve
tying up two staff in the laboratory and chartering a jet to fly the sample to Brisbane. Clinician W recommended retesting on Monday 13 October 2014 when they had a regular pathology courier, and they would obtain the laboratory result first thing Tuesday morning. However, Clinician T and W have confirmed that ultimately the blood for the 2nd Ebola virus PCR test was collected from patient A on the morning of Sunday 12 October, and sent to Brisbane via Commercial flight as the usual courier flight was not scheduled until later in the day.

Clinician T stated that he went home Friday and saw the Courier Mail article around midnight Friday/Saturday on the internet but was not aware of the front page story about Ebola virus infection. When Clinician T arrived in ED Saturday morning, ED nurses asked him if he had seen the article about Patient A being treated in ED and putting her and other staff at risk.

Clinician T then discussed with the CHHHS Executive D, Patient A, and Clinician Z, a patient plan of Patient A remaining in the ED isolation room and re-testing on Monday. Clinician Z was in agreement with the plan.

Clinician T stated that the testing plan changed after the Saturday Courier Mail story. CHHHS Executive A phoned and asked him to be available to meet with the Department Executive A and Department Executive B for a media conference that afternoon. The Department Executive A phoned him and told him that the re-test was being brought forward despite the logistical and cost issues, with the aim of having Patient A tested by Sunday and discharged by the end of the weekend.

Clinician T stated he met Department Executive B and CHHHS Executive A in the ED around 1700 hours on 11 October 2014 and met with staff. The CHHHS Executive A then asked him if they could meet with Patient A and talk to her and he agreed. In hindsight he stated that it was bad infection control because you should minimise patient contact with unnecessary visitors. He stated that in the context he made a judgement that it was safe, however the ED staff could see them visiting Patient A which created concerns.

Clinician T stated that Clinician Y took Patient A’s bloods on Sunday 12 October 2014 and they chartered a plane to Brisbane with the bloods. The laboratory phoned him, the Department Executive A and CHHHS Executive A with the second Ebola negative PCR result around 2345 hours that night. He called the CHHHS Executive A and Patient A and having made a tentative plan with Patient A earlier in the day, she decided to discharge overnight and stay in temporary accommodation. She left the hospital just after midnight.

Arrangements for patient follow-up were made through the Public Health Unit to continue follow up for the remainder of the 21 days since leaving West Africa.

Clinician T stated that on 9 October 2014 he heard about the Ebola draft guidelines from Department of Health, then another version arrived the next
morning, and three further revisions have been made since then. He stated that the Communicable Disease Unit Brisbane sent guidelines to Public Health Units by email that he had seen prior to 9 October but he could not recall the specific date, for them to send to Infectious Diseases Units.

Clinician T stated that in terms of Public Health Communications there was no hard and fast protocol, rather an initial assessment made by Department Clinician A from the Public Health Unit and Clinicians T and R from the hospital. He stated that it was a potential issue as there are no sub-specialists on call after hours at CHHHS, so in theory if a patient presented at 2am and he and Clinician R have their phones turned off, the ED staff would have to deal with the patient presentation without specialist assistance. In those circumstances, ED staff would generally ring the Infectious Diseases Unit at RBWH and the patient would be admitted under the general physician of the day.

Clinician T stated that the Communicable Disease control guidelines mainly focus on public health aspects rather than local aspects.

In terms of how other hospital staff hear about potential infectious diseases problems or protocols, information is sent directly to ED or Executive Office to be distributed to all clinical staff, and in his opinion ‘it is a bit hit and miss getting guidelines or protocols out.’

Clinician T stated that his biggest concern is the public and staff misconceptions about the risks related to Ebola virus in this case. The biggest risk is incorrect use of PPE, but he felt happy about the overall clinical management of Patient A. However he felt that improved internal communications to all staff, such as town hall meetings for all staff, debriefings etc., would improve things for future cases.

**Interview with Clinician Q**

Clinician Q stated that on Friday 10 October 2014 he was on a day off. He was phoned by the Clinician D about a patient with suspected Ebola virus infection. He asked about her vitals and she seemed well, not a “wet” patient with Ebola virus infection. He asked why they were wanting to send her to ICU and was told that it was largely around an issue of isolating her for her hospital stay, and ICU was more of a closed environment and could stop staff walking in. Clinician D on duty felt that since the patient didn’t require ICU treatment that they should manage the patient in another isolation room with appropriate precautions.

Clinician Q stated that it was an evolving situation, the ICU nurses on duty were familiar with nurses in Dallas, Texas with Ebola virus infection and cognisant of the fact that nurses in Spain were infected and using PPE similar to our PPE. He was told by the Clinician D that the nurses felt our PPE was inadequate, and felt that we needed better guidelines.
He stated that the State infection control network had made no position statement on Ebola virus infection.

**Interview with RN E**

RN E stated that when ED was notified that Patient A was coming in, the Clinician S looked on QHEPS for an Ebola guideline, and the nursing staff were told by the Clinician S that the PA Hospital protocol was the most comprehensive and that was what they would use to guide their practice for managing the care of Patient A.

RN E stated that the ED Nursing staff used the policy to stock up on PPE but they had to get it from different areas in the hospital. The Clinician S had a meeting with ED staff, Clinician T and the Department Clinician A. From the perspective of nursing staff, the main purpose was to work out standardised PPE until ED received a plan from Brisbane. RN E stated that Department Clinician A and Clinician T didn’t give ED staff much information, nobody knew exactly what to use, and they stated that even the patient though it was highly unlikely that she had Ebola virus infection.

RN E stated that Department Clinician A and Clinician T played down the situation and said that it was very unlikely that Patient A has Ebola, they explained that she was self-monitoring, and a decision was made to keep her in isolation. They didn’t go into PPE very deeply but said to use the PPE currently available as there are risks in using new PPE.

RN E stated that in the sessions held at staff handover on the afternoon of 10 October 2014 by Department Clinician A and Clinician T with ED staff there were discussions about the decision-making process for Patient A to stay in the ED isolation room as it blocked 50% of the isolation capacity in ED. In the same meeting there was discussion and debate about whether it was feasible to transfer her to another isolation room or to Brisbane. Then we had another discussion that it would be a circus getting through the hospital particularly with the media and operational services.

RN E stated that the nursing staff did not like the decision to keep Patient A in ED. They were not so concerned about blocking the isolation room but more about if Patient A deteriorated in that room and not being able to resuscitate her, and if she was really unwell she could go to ICU.

RN E stated that ‘Grass roots’ staff were not involved in communications with any senior staff on over the weekend of 11 and 12 October 2014. RN E felt that the nursing staff would have benefitted from more presence of senior nursing staff and better communication.

RN E also stated that one of the outcomes of the experience in treating Patient A and through discussion over the weeks since Patient A’s admission is that the CHHHS management have agreed to organise a CHHHS central supply of PPE to provide to receiving hospitals, however staff also need more training in PPE.
Interview with RN F

RN F that that she attended a meeting on the afternoon of Friday 10 October 2014 arranged by Department Clinician A and Clinician T at handover with ED staff. At that meeting nurses discussed that they didn’t know what PPE to wear. RN F stated that some of the English nurses were unhappy but their visas are tied to their jobs and so they wouldn’t speak up but asked about it afterwards,

RN F said that RN G said not to worry, that Patient A would have her own nurse as a special, and ED nurses shouldn’t worry about it.

RN F stated that as Room 4 was tied up the whole time, there were a number of questions not answered about how ED would manage other patients coming in that might need isolation.

There were questions about why Patient A couldn’t be managed in an isolation room in the wards in the hospital. RN F stated that Clinician T told the meeting that he thought there would be too much hysteria about Ebola to move her, however RN F stated that she did not accept she did not accept this as other infectious patients are moved with a plan, usually after hours.

RN F stated that patient management had been planned at the higher level but people on the floor didn’t know anything because a special nurse had been allocated.

RN F also reported that there were a lot of practical issues in locating the required PPE.

RN F also stated that staff saw the CHHHS Executive A and Department Executive B go into Patient A’s room and weren’t sure if they should be going in there as there were five people and the ante room is not very big for that many people to put PPE on safely.

Interview with CHHHS Executive D

He stated that he wouldn’t usually get directly involved in clinical matters as his role is primarily professional governance and strategic not operational.

However he was included in an email trail from the Public Health Unit on 7 October 2014 notifying CHHHS of a patient in town self-monitoring following return from West Africa.

He stated that the protocol that they were using at the time was the CDC approach, and under those guidelines the patient was in voluntary home confinement with daily Public Health contact. The email from Public Health indicated that the patient was deemed low risk on home confinement. Infectious Diseases staff were asked to make themselves familiar with the guidelines.
He stated that he was asked by the CHHHS Executive A to see Patient A and advise her of the first negative blood result for Ebola virus infection which he did at around 0500 hours on 10 October 2014, taking a personal interest given the amount of anxiety involved in the matter. He stated that no issues were raised by ED staff with him about patient placement in ED.

He stated that staff raised with him their confusion about PPE and he raised it with the CHHHS Executive A on 10 October 2014. He stated that he followed procedures for PPE when he saw Patient A and didn’t feel at risk as she wasn’t ‘secreting’ or ‘wet’.

**Interview with Clinician R**

Clinician R described his role as 0.8FTE Infectious Diseases, with an Clinician T 0.5FTE for antimicrobial stewardship, and they also cover general medicine AMAT every 2 weeks, with one Registrar advanced trainee.

Clinician R stated that on 9 October 2014 he was doing a laboratory round and was handed a note from RN G from the Public Health Unit. He telephoned the Nurse and was told that a nurse returning from West Africa had reported a fever and had agreed to come into Cairns Hospital.

Clinician R stated that Department Clinician A told him on the around lunchtime on 9 October 2014 that he had already phoned the Clinician Y and advised that the patient was coming in at 1pm. Clinician R stated that he phoned ED and they did not have the draft Ebola guidelines, and he searched QHEPS and found the Department of Health draft guidelines and the PA Hospital protocol which was more practical. He then went to ED and discussed the procedure with ED and ICU and they were all happy to follow the PAH protocol.

Clinician R stated that Patient A arrived at the hospital at approximately 1300 hours on 9 October 2014. He was in ED with RN G met her with PPE and escorted her to the isolation room. Clinician R donned PPE and assessed her, and thought she had a viral respiratory tract infection but given her Ebola virus exposure had to exclude Ebola virus infection. He hadn’t collected blood for a long time and asked the Clinician X to collect blood and a nasophygeal swab.

Clinician R instructed the Clinician X about collecting tests and observed him donning PPE and observed him taking bloods and swab, then supervised removal of PPE. Clinician R took the specimens to the lab himself and discussed with the lab staff the procedures for processing.

A nurse special was stationed at Patient A’s room. The Clinician R stated that he then met with Clinician S, the CHHHS Executive D and the RN I to discuss patient placement and it was agreed that Patient A would remain in the ED Isolation Room until the results were available early the next day.
Clinician R phoned the Clinician T who was out of town and travelling back. He then had no further contact with the case.

Clinician R stated that he received a copy of the Department of Health Ebola guidelines via the Public Health Unit and by a memo from Department Executive A on or around 8 October 2014 as he recalled that it was only a day or so prior to Patient A presenting, and stated that he was not aware of a standard procedure of how to operationalize locally. He noted the document, discussed it with the RN G and other nurses in the team – especially the PPE, and considered what would be appropriate at that time for the patient’s context.

Evidence

**Relevant clinical and administrative policies and procedures**

The Clinical Reviewer identified the following national and international guidelines relating to Ebola Virus Disease (EVD) relevant to the management of a patient such as Patient A which were identified by the CHHHS clinicians as being available to them:

- **Ebola advice for clinicians – EVD outbreaks in West Africa, important information for clinicians in secondary and tertiary care (10/10/2014) – note this is sourced through Australian Government Department of Health website, with last update 7 November 2014**
- **Metro South Princess Alexandra Hospital Procedure Manual, management of patients with known or suspected Ebola virus, V1, September 2014**
- **Department of Health, Ebola virus disease: Interim guidelines for managing presentations of suspected cases, V1, 9 September 2014 – note this was last updated V2.0, 27 October 2014**
- **Ebola Virus Disease (EVD) CDNA National guidelines for Public Health Units, V1.2 (3/10/2014) - note this is sourced through Australian Government Department of Health website, with last updates 24 October 2014 and 6 November 2014**
- **Pathology Qld – suspected Ebola virus infection pathology management plan (October, 2014)**

In addition, the Clinical Reviewer identified the following national and international guidelines related to the management of contagious diseases and relevant to the management of a patient such as Patient A:

- **PHLN information for laboratories, laboratory procedures for samples collected from patients with suspected viral haemorrhagic fevers (sourced through the Australian Government Department of Health Website, with last update 13 November 2014)**
The Clinical Reviewer also identified the following Queensland and national policies, guidelines and protocols relating to the management of infectious diseases in emergency departments which are relevant to the management of Patient A:

- Qld Health (QHEPS) – Patients on transmission based precautions
- Qld Health (QHEPS) – General Signage
- CHHHS – Procedure aseptic technique V1, 8/10/2014
- CHHHS – Infection control poster, infection control precautions
- CHHHS – Procedure, rooms for airborne isolation, V1, September 2012

The interim EVD guidelines (dated 9th September 2014) were disseminated from Department of Health to the CHHHS Public Health Unit in the days prior to Patient A’s admission to Cairns Hospital.

Clinicians in the ED report that they first saw these interim guidelines disseminated from the Communicable Diseases Network through the Queensland Emergency Department Network on 7th October 2014. These interim guidelines, in unchanged form, were disseminated to all Cairns Hospital ED Consultants and Registrars on 8th October 2014. These guidelines specifically listed Cairns Hospital as a receiving hospital for suspected EVD cases from the international airport.

As at 9 October 2014, when Patient A presented to Cairns Hospital, there had been no specific hospital-wide planning in regards to the Cairns Hospital management of a patient with suspected Ebola virus infection, and as such no clear documented plan when Patient A did arrive in the Emergency Department. The Infectious Diseases and Infection Control staff
had reviewed these guidelines and had begun the relevant planning for their units.

159 The Department of Health Public Health Unit was aware that Patient A was in Cairns and returned from West Africa, and had emailed the Clinician R at approximately 1100 hours on 7 October 2014 to advise of her return to Cairns. However, the Public Health Unit were initially unable to make contact with her. Clinician R was working in the Medical Assessment Unit all day on 8th October 2014 and did not have any emails or phone calls. He first became aware of Patient A’s location when he was given a note on 9 October 2014 that informed him that she was febrile and would be coming into the ED at 1300 hours.

160 The consensus of Cairns Hospital clinicians interviewed was that the interim Department of Health guideline was of limited practical assistance in providing guidance as to the specific requirements for care presented with Patient A, and were not Cairns Hospital specific. The clinicians sourced the Metro South Princess Alexandra Hospital protocol for management of patients with known or suspected Ebola virus disease, and the consensus of clinical judgement from Emergency Department, Infectious Diseases and Intensive Care clinicians was that the PA Hospital protocol was practical and applicable to Patient A’s management. The PA Hospital protocol was emailed to all ED Consultants, Registrars, Emergency Nurse Practitioners and Nurse Unit Managers approximately 1800 hours on 9 October, approximately five hours after Patient A had presented to the hospital.

Staff awareness of relevant clinical and administrative policies and procedures

161 Key clinical staff (Infectious Diseases, Infection Control) were aware of the existence of the interim Department of Health Ebola virus disease guidelines, however only limited staff were aware that Cairns Hospital was a “designated” hospital for receiving Ebola virus infected patients. The key clinicians involved in managing Patient A’s care discussed the guidelines, and independently sourced the PA Hospital protocol and confirmed based on their clinical judgement that this protocol was the most appropriate to utilise in this circumstance.

162 On Thursday 9 October, 20014, when Patient A was admitted, a Clinician from Public Health Unit emailed the interim Department of Health Ebola virus disease guidelines to both Clinician T and R. Clinician T had seen an interim version of the guidelines through public health discussion prior to this, as he works half-time in the Public Health Unit. Clinician T stated that the Department of Health interim guidelines were in a state of change even then – the revised State guidelines were circulated on Friday 10 October, 2014, which he didn’t see during the course of Patient A’s management as he was busy in the ED all day managing her care and didn’t check his emails until after 4pm on Friday.
The requirements for wearing Personal Protective Equipment (PPE) as outlined in the PA Hospital protocol were followed, and “just in time” education provided to clinical staff working in the ED by Clinician T, Department Clinician A and Clinician S. However, ED nursing and medical staff raised concerns and stated that they were not entirely assuaged in their concerns following the education provided. This in part may have been impacted on by the extensive media coverage in Cairns, Australia and internationally in relation to clinical staff in US and Spanish hospitals contracting the Ebola virus from patients.

Prior to Patient A’s admission, there had been no prior education, training, exercises or communication beyond the circulation of the Department of Health interim guidelines to key senior clinicians in the hospital. In this respect, the staff were operating in a rapidly evolving scenario with education and information provided to the best of their ability for the treating clinicians on the ground. ED staff have provided positive feedback about the information and education provided to them by Clinician T during Patient A’s admission.

The Investigator has been advised that the PA Hospital had developed its protocol prior to the Department of Health interim guidelines being released, driven by their Infectious Diseases Unit, had provided formal education and training to staff in the ED and other key clinical departments, and had undertaken a desktop exercise to test the scenario and procedures. The protocol was developed with involvement of PA Hospital Division of Medicine Executive, PA Hospital and Metro South key clinicians, and management.

Staff within the Cairns Hospital ED were particularly concerned about reducing contact with Patient A by limiting interactions to those necessary for her care. A telephone was provided within the isolation room to assist in communication and further limit unnecessary personal interactions, in particular while awaiting the results of the first blood test. The staff providing care for Patient A were kept to a small number of consistent nurses. ED staff raised concerns about limiting staff interaction to comply with infection control precautions, however observed three senior Department of Health staff (Department Executive B, CHHHS Executive A, and CHHHS Executive E) enter the room with two clinicians to visit Patient A. Patient A herself acknowledged to the Investigator that she was “hyperaware” of not touching anyone or anything, and stated that she was surprised that the CHHHS Executive A and E, and Department Executive B visited her, although she acknowledged that it was after she had been informed of the first Ebola virus PCR negative blood result, and she was grateful for their care and consideration.

The PAH protocol provides for management of waste, linen and environmental cleaning. Clinician T and Department Clinician A provided education and information on this to CHHHS Environmental Services to assist in management of this aspect and assuage their concerns.
Compliance with identified policies and procedures

Management of Patient A complied with the procedures in the PAH protocol for management of a patient with suspected Ebola virus infection. The initial plan was for Patient A to be assessed in the ED negative pressure Isolation Room, and then stabilised, transferred to the Infectious Diseases Ward or ICU, as appropriate. The PAH protocol provides guidance for movement through the hospital. Clinician S and Clinician T discussed with D who argued it was not appropriate to transfer an otherwise well patient to ICU when the bed may be required for critical patients. Consideration was also made of transferring the patient to an isolation room in a ward setting, however there were concerns about appropriate management because of limited visual access into the room (solid walls in the ward versus glass walls in ICU and ED) and corridor design of the ward-based isolation rooms that made it difficult to restrict thoroughfares. Agreement was reached, and discussed with Patient A, to manage her in ED until the second negative test result was returned. This resulted in a four day stay in the ED isolation room, which also generated some issues raised by ED staff about ‘access block’ in an already busy department.

Senior staff were posted at Patient A’s door to ensure appropriate and consistent use of PPE and log maintained of all persons entering the room.

The PAH protocol states that visitors should be restricted to close family members only and then only if necessary. Accordingly, Clinician T’s approval, when requested of him, for the senior three members of Department of Health (including the Department Executive B) to visit Patient A did not comply with the protocol, and in hindsight he concedes that it would have been preferable for him to decline this request as the over-riding principle of clinical management should have been to limit all unnecessary visitors. A similar view was expressed by Patient A.

Findings

**Significant Decision Making Point - 1. Decision following discussion with Public Health Unit and Clinician R to bring patient into Cairns Hospital ED Isolation Room for assessment and admission.**

Patient A was accepted into the ED and assessed by a senior Infectious Diseases clinician. She had a low grade temperature, but was otherwise well. The Department of Health interim guidelines state “Emergency Department triage stations should be alert for people presenting with fever who have a history of travel to an EVD affected country in the previous three weeks.” The guidelines were written in relation to an ill patient entering the country.
The decision to arrange for Patient A to present to the ED was appropriate in the context of her known clinical state and travel history, and consistent with the Department of Health draft guidelines.

Response to Significant Decision Making Point - 2. Following initial assessment of Patient A in the ED Isolation Room, discussion and decision to continue to manage her in the ED Isolation Room rather than transfer her to an ICU Isolation Room or Ward Isolation Room.

Patient A was managed in the ED for four days, as a result of consideration of the options of keeping her in the ED isolation room, moving her to ICU or moving her to a ward isolation room. It was determined, following consultation (including with Patient A), that the ED was the best location to provide care for her in this situation. The Clinical Reviewer has considered this decision, and on the evidence provided has concluded that it was a reasonable decision that was widely discussed and discerned by the appropriate clinicians with the information available to them at the time.

Response to Significant Decision Making Point – 3. Following review of Department of Health draft Ebola virus guideline, discussion with the Clinician R, Clinician Q, Clinician S and other senior medical staff, decision was made to use the Princess Alexandra Hospital “Management of patients with known or suspected Ebola virus procedure” for management of Patient A in Cairns Hospital.

The senior clinicians in the hospital had knowledge of the Department of Health interim guidelines for management of a suspected Ebola case, however, there were limited knowledge or plans in place in relation to Cairns Hospital’s status as a designated hospital to receive suspected Ebola cases.

The senior clinicians sought a practical guide to manage a suspected Ebola virus infected case as they felt the interim guidelines issued by Qld Health did not meet their needs from a practical clinical management perspective. This was sourced through Department of Health web links (QHEPS), and the PAH protocol was determined as appropriate as it had been developed with expertise, education and local testing for practicality.

There does not appear to be an existing process in CHHHS as to how Department of Health guidelines, (e.g. Ebola virus guidelines in this case), are widely disseminated to clinicians, and then adopted or adapted for local implementation and scenario testing. A clear process for dissemination of Qld Health guidelines in the CHHHS is needed.

Significant Decision Making Point – 4. Following receipt of first negative Ebola virus PCR, options discussed with Department Executive A,
Department Clinician A, CHHHS Executive A, CHHHS Executive D, Clinician T and put to Patient A for decision which of 3 options she prefers, the patient chose option 1 which was to remain in ED Isolation room for 3 days until 2nd Ebola virus PCR test result returned.

The decision making around ongoing patient location and management was disseminated to senior medical and nursing staff in the ED for their information, however, there remained considerable disagreement from a wide range of stakeholders about the appropriateness of the decision. Clinician S and Clinician T were available to discuss the decision with a range of key parties, which they did. There was no escalation internally to the CHHHS Executive A and other senior staff of concerns by ED staff directly. Infection Control staff provided clear instructions, information and 24/7 contact details for any staff with concerns. Clinician T further encouraged direct contact to himself for any concerns.

Other Findings:

There was no disaster plan / strategy in place or tested for Ebola virus infection (confirmed or suspected) at Cairns Hospital. PAH had developed its procedure in consultation with Infectious Diseases, Emergency Department and Administration even prior to the Department of Health draft Ebola guidelines, and modified it to ensure practical application at the frontline. This was the protocol utilised in Patient A’s management as the Department of Health draft guideline has not been ‘localised’ and was not considered to be as clinically relevant as the PA Hospital guidelines.

There was no planned PPE training for staff as part of the guidelines and this caused considerable staff distress in the ED, which was expressed by nursing, medical and support staff. However Clinician T and Department Clinician A undertook one information session on PPE and other questions on 10 October 2014, with Infection Control staff available. Only one nurse special was allocated to Patient A and that nurse was trained in appropriate PPE and patient management.

There were strict visiting and isolation precautions in place with management of Patient A, well recorded in the medical record and policy by the special nurse allocated to Patient A’s room. However, on 11 October 2014 a number of senior staff from the CHHHS and the Department of Health visited Patient A in the isolation room. Although they had donned appropriate PPE (without formal training in use of PPE) and completed of the log book in accordance with the protocol guidelines for persons having contact with such a patient, the visit itself was not consistent with the requirements of the protocol to restrict access to the isolation room to close family members and medically necessary visitors. Clinician T agreed to this visit given Patient A had received the 1st Ebola virus negative result and he now considered Patient A was low risk. However with the benefit of hindsight he has acknowledged that it was inconsistent with the policy. It
would also be difficult for a Clinician T to refuse access to such senior members of Department of Health.

There was no planning for PPE stock availability, which required some coordination at short notice to access the appropriate PPE.

The clinical reviewer raised concerns that the limited size of the ED ante-room to adequately don and doff the PPE needed for management of patients with this type of infectious disease. In his view, consideration could be given to using the adjacent stock room to extend the size of the ante-room to make it more appropriate. This concern was also raised by ED clinicians.

There was no planned communication strategy in place during Patient A’s admission to ensure all relevant hospital stakeholders were adequately informed of relevant information. This may have contributed to the high level of dissatisfaction and confusion of ED staff about decision making in relation to patient placement and PPE. However, the key staff managing the events surrounding Patient A’s admission and management were reasonable in their local communication without a defined strategy in place. However, this still left many staff dissatisfied with the level and frequency of communication from senior clinical and administrative staff.

The Clinical Reviewer has identified concerns about Infectious Diseases team coverage to meet the 24/7 all year round requirements of the CHHHS service. The limited FTE covering this service creates some risks for the continuity of services in CHHHS. This did not affect the care provided to Patient A during her admission.

The CHHHS pathology laboratory did not provide 7 days/week services for referred pathology to Brisbane.

The CHHHS Executive D provided the first Ebola virus test result to the patient at 0645 hours on 10 October 2014. The treating consultant saw the Department Executive A media release on the television and contacted the hospital to inform the patient of the result. He was not aware that the CHHHS Executive D had already informed the patient of the test result outcome. This was undertaken by the CHHHS Executive D at the CHHHS Executive A’s request, as the CHHHS Executive D had previously known the patient and stated that he was concerned about the media impact and wanted to ensure that she was well supported. This would not be the normal process for provision of test results to a patient.
Conclusion

The evidence supports, on the balance of probabilities, that:

(a) The clinical management and treatment provided to Patient A was clinically appropriate, and generally complied with the relevant clinical and administrative policies and procedures.

(b) Department of Health guidelines, released on 9 September 2014 by the Communicable Diseases Unit, were circulated to some staff on 8 October 2014, but locally adapted guidelines on Ebola Virus Disease management did not exist. Not all staff interviewed were aware of these guidelines prior to arrival of Patient A, nor were they aware of the status of Cairns Hospital as a hospital designated to receive potential Ebola virus infected individuals.

(c) The treating clinicians utilised the PAH protocol for Ebola management as the basis for their decision making and clinical judgement in regard to her care and management of potential risk to other persons because these were assessed to be the most detailed and practically applicable protocol available to them. The decision to use the PAH protocol was reasonable in the circumstances.

(d) There were some local staff concerns raised about ongoing patient placement in the ED, however this was a decision which was the subject of proper consideration by the relevant stakeholder clinicians, was clinically supportable, was not contrary to the patient protocols available to the clinicians, and was the most appropriate option in Patient A’s particular clinical circumstances.

(e) Allowing non-family non-essential visitors into Patient A’s isolation room was a non-compliance with acceptable protocols. It ought not to have been permitted, however it did not affect Patient A’s clinical care.

Accordingly, the evidence supports, on the balance of probabilities that the standard and quality of clinical management and treatment of Patient A was of an acceptable standard for the information available at the time.

Recommendations

The investigator was asked to consider and make recommendations, insofar as they arise out of the investigation, in relation to:

(a) Ways in which patient safety can be maintained and improved.

(b) Ways in which the public safety of the community can be maintained or improved.

(c) Ways in which the management, administration or delivery of public sector health services can be otherwise maintained and improved.
Any other matter identified during the course of the investigation.

The CHHHS has undertaken ongoing consultation within the Cairns Hospital, Senior Medical Staff Association, Department of Health Public Health Unit and the office of the Chief Health Officer since Patient A’s hospitalisation. CHHHS has now developed its own guidelines and management flowcharts, in line with the most recent Department of Health guidelines for management of suspected Ebola virus infected patients. In conjunction with that, the investigator makes the following recommendations.

**Further recommendations should be considered in relation to:**

1. Disaster plans need to be in place early for areas of identified risk to the organisation, and regularly exercised to identify strengths and weaknesses.

2. Disaster plans should include a Communication plan in addition to clinical guidelines. This is to allow the contribution of site-specific adjustments of such guidelines by all relevant stakeholders.

   a. In the case of the “Department of Health, Ebola virus disease: Interim guidelines for managing presentations of suspected cases, V1, 9 September 2014”, provided to the Public Health Unit, and reviewed by Infectious Diseases and Infection Control teams, distribution to other parts of the hospital was suboptimal. A strategy for clear distribution of such guidelines needs to be implemented by the CHHHS administration. This will help co-ordinate detailed and regular staff updates, the listening to and answering of staff concerns, provide respect and support for staff with concerns about care, and allow local discipline-specific leadership that is accessible for medical and nursing staff, and provide Divisional and Facility leadership. The communication pathways within the ED, a complex part of the hospital, should also be reviewed to ensure that medical, nursing and other staff are able to receive the same clinical and management advice. This is the responsibility of the Medical and Nursing Directors of the ED, with the assistance of the CHHHS administration.

3. The case definition for EVD must be standardised along with clear locally relevant protocols for clinical management. This includes situations where patients fall outside the high risk or no risk categories.

4. PPE advice and training should be standardised throughout the hospital, in keeping with relevant Queensland and Australian advice.

5. An appropriately resourced plan for ongoing PPE training and credentialing is essential for clinical and support staff, including environmental and food services.

6. PPE stock or pre-prepared kit availability needs to be addressed at a facility-wide level. There must be adequate stock of required equipment, with stock rotation to ensure it remains fit for purpose.
7. An agreed plan must be developed for potential Ebola virus infected patient assessment and triage, clinical examination and sample collection, then if admission required, placement within the hospital. This is needed to ensure that the patient (and other patients in the hospital) receives the best care in the most appropriate location. As a minimum, this plan needs defined leadership to ensure agreement between the ED, ICU, Infectious Diseases and Infection Control, relevant wards, and hospital administration. The method of circulation and ongoing review of this plan needs to be delineated.

8. CHHHS should undertake analysis of the ward-based isolation rooms to improve visual access (e.g. changing patient-only operated louvres in doors) and to restrict movement in corridors, if necessary. The isolation room in the ED is compromised by a too small ante-room, and strong consideration should be given to expanding the size of this ante-room. The correct donning and doffing of PPE in a fit-for-purpose anteroom is crucial in preventing healthcare worker-acquired infection.

9. Visitors to patients in isolation rooms should be actively managed to minimise unnecessary contact with potential or confirmed highly infectious patients, and all relevant signage and policies should reflect this requirement. It needs to be emphasised that in the context of Ebola virus infection (and other highly infectious diseases), limiting of entry to staff directly involved in patient care, and close family members, and always on the advice of the treating doctor, is a crucial part of such management.

10. Management of waste, linen and environmental cleaning should be specifically addressed in local policies relating to management of potential and confirmed infectious patients.

11. The CHHHS Media Management plan needs to be reviewed, agreed by administration and senior medical and other staff, and distributed to all staff. The Senior Medical Staff Association needs to develop their own Media Management plan in conjunction with the CHHHS administration, and consistent with Staff Specialist contracts. It is reasonable to expect that staff understand and adhere to such plans, and accept their responsibilities in this area as outlined in the public service codes of conduct and relevant work contracts. This is needed to minimise potential distress to the patient, loss of confidence in the local health care system and irresponsible media activity.

12. Liaison with the patient about clinical plans, movement to other wards, and provision of test results, treatment, discharge and follow-up remains the sole responsibility of the admitting consultant. The public health, administrative and media responses to admission of individuals to CHHHS should be made with the input of the admitting consultant.

13. As Cairns Hospital has designated responsibilities for infectious diseases (related to the international airport and international shipping, proximity to PNG, high tourism numbers and known local infectious diseases issues e.g. TB, melioidosis, dengue etc.), strong consideration
needs to be given to employing enough infectious diseases specialists to provide a year-round 24/7 service. This is needed to provide clinical and assist with laboratory (microbiology) services.

14. The laboratory needs to consider providing a 7 day a week courier service to Brisbane for testing in major clinical problems e.g. Ebola virus infection.

15. Senior staff and the hospital need to provide an appropriate safe, quiet and private environment for discussions with employees relating to criticisms of patient care or its complications.
Part B
7. External Communications – Patient A

Background

On 11 October 2014 the Courier Mail published an article under the headline “Doctors outraged that suspected Ebola patient (Patient A - name removed) was treated in busy emergency department of Cairns Hospital”.

The Courier Mail article named the patient, and included personal and medical information about her, including her symptom history, presentation to Cairns Hospital, test results, location in the hospital and plans for further investigations.

The Courier Mail article also cited purported staff concerns about Patient A being treated in ED, about plans for her to remain in ED during her isolation period, and the possible effects for her treatment and for staff and other patients.

Comments are presented in the form of quotes, but not attributed to any staff member.

On the day the Courier Mail article was published, two clinicians were identified as potentially having provided information to the journalist which formed the basis of, or contributed to, the information presented in the article.

Issues for investigation

The issues for investigation are whether external communications made by health service employees or contractors located at CHHHS:

(a) Were made without approval
(b) Led to confidential information being in the public domain
(c) Were at all times appropriate and in compliance with Department of Health policy, Code of Conduct and legislation impacting the Health portfolio.

Evidence

The external communications

Investigations indicated that the following external communications were made in relation to or regarding Patient A:
A Courier Mail article published on 11 October 2014 by journalist titled “Doctors outraged that suspected Ebola patient was treated in busy emergency department of Cairns Hospital”.

Media articles had already appeared on 9 and 10 October 2014 concerning Patient A, which disclosed her name, occupation, nursing service in Sierra Leone, symptoms on presentation to Cairns Base Hospital, the fact of her having been admitted to Cairns Base Hospital, that tests had been undertaken, that initial tests were negative, and that she was in an isolation room at the hospital. The reports quoted extensively from Department Executive A and Department Clinician A.

The Courier Mail article which appeared on 11 October 2014 contained no additional personal information about Patient A but did include further details regarding future testing/observations to be undertaken and that the isolation room in which Patient A was located, and where it was planned that she continue to be monitored, was in the hospital ED.

The article also reported purported criticisms of Patient A’s management which the article attributed to “doctors”, “senior doctors”, “a senior clinician speaking on behalf of a group of concerned doctors” and “the clinician” (refer Annexure D). In particular, the article reported:

Doctors are outraged a suspected Ebola patient was tested for the deadly virus in the busy emergency department rather than in isolation in the highly infectious diseases unit at Cairns Hospital.

Doctors branded as “bizarre” the decision by Department of Health to test her in the busiest part of the hospital which handles some of the “most vulnerable” patients.

Senior doctors told the Courier Mail of an internal outcry after plans emerged to keep Patient A for six days in a negative pressure room in the hospital’s emergency department where up to 200 patients a day are treated.

“It’s appalling. What the hell is going on?” said a senior clinician, speaking on behalf of a group of concerned doctors.

“Why’s she is still in ED (sic)? It's the wrong place.”

“Lights are on 24 hours a day, medical staff are incredibly busy, and we’ve got a possible Ebola case in a bed in the midst of where we treat our most sick, ill and injured patients”.

The clinician said it reflected “the hospital is unable to deal with the situation”.

The article did not attribute these sentiments or the quoted comments to any individual CHHHS staff member by name.
Communications by Clinician A

Communication with media

Clinician A stated that had one contact with a journalist in relation to an Ebola related matter. Advised the circumstances and content of that contact were as follows:
Relevant Department of Health policies, Code of Conduct and legislation

Department of Health (Queensland Government) Policy E1 Workplace Conduct and Ethics (Policy E1)

Department of Health (Queensland Government) Policy E1 Workplace Conduct and Ethics, last update January 2014, provided in SMO Contract of Employment kit in May 2014 to Clinicians A and B outlines the obligations of management and employees to comply with the code of conduct for the Queensland Public Service (the Code of Conduct) and contribute to the achievement of a professional and productive work culture within Department of Health, characterised by the absence of any form of unlawful or inappropriate behaviour.

In particular, Item 2, paragraph 2 of the policy states that:

“Employees have a responsibility to always conduct and present themselves in a professional manner and to ensure personal conduct displays integrity and maintains public confidence in the Queensland Public Sector”.

Clause 6 1f of the SMO Contract of Employment requires compliance with the Code of Conduct and Clause 22 requires compliance with Policies and Procedures.

The Code of Conduct in particular refers to a commitment to:

(a) the highest ethical standards (1.1);

(b) contributing to public discussion in an appropriate manner (1.3);
(c) demonstrating a high standard of workplace behaviour and personal conduct (1.5); and

(d) ensuring appropriate use and disclosure of personal information (4.4).

**Good Medical Practice: A Code of Conduct for Doctors in Australia**

Clause 6.1g of the SMO Contract of Employment requires compliance with all applicable professional obligations and standards of conduct, including the “Good Medical Practice: A Code of Conduct for Doctors in Australia” (Good Medical Practice Code).

The Good Medical Practice Code describes what is expected of all doctors registered to practise medicine in Australia. It sets out the principles that characterise good medical practice and makes explicit the standards of ethical and professional conduct expected of doctors by their professional peers and the community. In particular, the Good Medical Practice Code provides that:

3.4 Confidentiality and privacy - Patients have a right to expect that doctors and their staff will hold information about them in confidence, unless release of information is required by law or public interest considerations –

4.2 Respect for medical colleagues and other health care professionals. Good patient care is enhanced when there is mutual respect and clear communication between all health care professionals involved in the care of the patient –

6.2.6 Taking all reasonable steps to address the issue if you have reason to think that patient safety may be compromised –

8 Professional behaviour, 8.1 - In professional life, doctors must display a standard of behaviour that warrants the trust and respect of the community. This includes observing and practising the principles of ethical conduct –
SMO Contract of Employment

Clause 23 of the SMO Contract of Employment refers to privacy obligations.

Clause 24 of the SMO Contract of Employment refers to Confidential Information.

Hospital and Health Boards Act 2011 (HHB Act)

Section 139 of the HHB Act 2011 provides the following definition:

Confidential information means information, acquired by a person in the person’s capacity as a designated person, from which a person who is receiving or has received a public sector health service could be identified.

Section 142 of the HHB Act provides that:

Confidential information must not be disclosed (1) A designated person must not disclose, directly or indirectly, confidential information to another person unless the disclosure is required or permitted under this Act.

Other Legislation

Public Health Act 2005 - Confidentiality of information and use of information supplied for Notifiable Conditions Register, S77 Confidentiality of information requires that a: (1) A relevant person must not, whether directly or indirectly, disclose confidential information.

Crime and Corruption Act 2001 - This matter does not fit the requirements under Section 15 in relation to corrupt conduct.

Criminal Code Act 1899 - Ch12 unlawfully obtaining and disclosing information – this matter does not fit the requirements for Sections under this Chapter of the Act. Ch20 Miscellaneous offences against public authority – this matter does not fit the requirements for Sections under this Chapter of the Act.
Recommendations

The investigator was asked to consider and make recommendations, insofar as they arise out of the investigation, in relation to:

Ways in which the management, administration or delivery of public sector health services can be otherwise maintained and improved.

CHHHS has provided an update on information to staff in relation to media release of information (refer to annexure E), and CHHHS Executive A is currently working with the SMSA on a CHHHS Media Policy.

A State-wide formal media policy would be desirable, given the frequent movement of staff between HHSs, to be reflected in a formal media policy within the HHS making any necessary allowances for local matters.

Such a Media Policy should include information to assist clinicians and other staff to understand their responsibilities and restrictions regarding media contact, and how this relates to their professional ethical responsibilities. The policy should be explicit as to what a staff member should do if contacted by a media representative without prior notice, i.e. handling of ‘cold calls’.

Education and training should be provided to senior clinicians as to the Policy and how to comply with it.

The management of Patient A involved issues broader than the management of a single patient. It was a matter likely to generate not only media scrutiny but intense interest by staff not directly involved in Patient A’s treatment. Consistent feedback to the investigator was that staff did not feel sufficiently involved or informed, by either line management in ED or CHHHS, and many felt they obtained information through the media rather than being informed as staff members.

Clearly, it would not be appropriate to engage in broad ranging information dissemination as a matter of course in relation to individual patient issues. However, the events that unfolded at CHHHS in relation to management of Patient A highlighted a shortcoming in communication to grass roots staff. It would be worthwhile for the CHHHS Executive to:

Consider developing a communication strategy to be used in matters likely to receive media scrutiny, to ensure that staff feel supported and informed; and

Review necessary steps to improve leadership and multidisciplinary communication within the ED. The investigator understands that steps in this regard have been commenced by the CHHHS Executive E. These should be continued, and the matter should be one for ongoing monitoring and review by the CHHHS Executive.
Annexure A

Copy of the Instruments of appointment together with the Terms of Reference for:

(a) The investigator

INSTRUMENT OF APPOINTMENT
HEALTH SERVICE INVESTIGATOR

I, DR. MICHAEL CLEARY, Chief Operations Officer, Queensland Health, appoint, pursuant to Part 9 of the Hospital and Health Boards Act 2011, Ms Chris Foley, Regional Safety and Quality Manager, St Vincent's Health and Aged Care ("the appointee"), as a health service investigator to investigate and report on matters relating to the management, administration or delivery of public sector health services in Cairns and Hinterland Hospital and Health Service and provide a written report to me by 13 November 2014 or such other date as agreed by me.

Conditions of appointment

1. The appointment commences on the date of this Instrument and will end on delivery of the required report.

2. The appointee is to work co-operatively during the investigation as appropriate with the appointed Clinical Reviewers, Professor Dominic Dwyer, Fellow of the Royal Australasian College of Physicians and a yet to be appointed reviewer, under Part 6 Division 3 of the Hospital and Health Boards Act 2011, and is to prepare a report to me under section 199 of the Hospital and Health Boards Act 2011. The appointee must have regard to any report provided by the Clinical Reviewers under section 136 of the Hospital and Health Boards Act 2011 and must attach the Clinical Reviewers' reports to the investigation report.

3. The appointee will be indemnified against any claims made against the appointee arising out of the performance by the appointee of her functions under this instrument, on the terms contained in her Instrument of Indemnity.

DR. MICHAEL CLEARY
CHIEF OPERATIONS OFFICER
QUEENSLAND HEALTH

13/11/2014
CAIRNS AND HINTERLAND HOSPITAL AND HEALTH SERVICE

INVESTIGATION INTO CLINICAL AND OTHER MATTERS AT CAIRNS HOSPITAL

TERMS OF REFERENCE

1. Purpose

The purpose of this Health Service Investigation is to:

Clinical Management of Ebola

- Assess the standard and quality of clinical management and treatment provided to [insert names of individuals] and [insert names of individuals] (and other matters) at the Cairns Hospital, Cairns and Hinterland Hospital and Health Service (CHHHS) as outlined under ‘3. Scope of the investigation’ below.

External communications matters

- Assess whether the external communications relating to the treatment of [insert names of individuals] and [insert names of individuals] at the Cairns Hospital were at all times appropriate as outlined under ‘3. Scope of the investigation’ below.

2. Appointment

Pursuant to section 190(1) of the Hospital and Health Boards Act 2011 (HHBA), following my assessment that she has the necessary expertise and experience, I have appointed Ms Chris Foley, Regional Safety and Quality Manager, St Vincent’s Health and Aged Care, as a health service investigator to conduct the investigation.

Ms Foley is to investigate the matters outlined under ‘3. Scope of the investigation’ below and prepare a Health Service Investigation report to me under section 199 of the HHBA. In the preparation of this report, Ms Foley must have regard to the Clinical Review reports prepared by the appointed Clinical Reviewers (Professor Dominic Dwyer, Fellow of the Royal Australasian College of Physicians) and provided to Ms Foley under section 138 of the HHBA. Professor Dwyer will clinically review matters relating to Ebola.

Ms Foley must attach the respective Clinical Reviewers’ reports to the investigation report.

The Terms and Conditions of the indemnity provided to Ms Foley are detailed in Attachment 1 Instrument of Indemnity.

3. Scope of the investigation

The functions of the health service investigator are to:

3.1. investigate the following matters relating to the management, administration and delivery of public sector health services:

Clinical Management of Ebola

The standard and quality of clinical management and treatment provided to [insert names of individuals] by the Cairns Hospital and the compliance with relevant clinical and administrative
policies and procedures in place at the Cairns Hospital relating to the treatment of the patient and management of potential risk to other persons, including:

(a) Reviewing the patient records for

(b) Developing a sequence of key events and significant clinical decision-making points relevant to the clinical management of

(c) Reviewing the admission, examination, assessment, diagnosis, treatment and overall management of [redacted] when she presented at Cairns Hospital with a low grade fever, 9 October 2014, including the appropriateness of placing [redacted] in an isolation room in the emergency department.

(d) Reviewing relevant clinical and administrative policies and procedures, specifically including those relating to infectious diseases and public health and considering whether appropriate policies and procedures were in place and the compliance with existing policies, had any impact on:

   i. the standard and quality of care provided to [redacted];
   ii. hospital staff safety and well-being attending to the care of [redacted];
   iii. other hospital staff, patient’s and visitor’s safety and well-being who were at Cairns Hospital during [redacted] stay;
   iv. the community’s safety and well-being during [redacted] stay at Cairns Hospital; and
   v. the community’s safety and well-being upon release of [redacted] from Cairns Hospital.

In undertaking this aspect of the investigation, the Health Service Investigator is to consider and take into account:

- national and international guidelines relating to Ebola Virus Disease (EVD) and other guidelines and protocols relevant to the management of contagious diseases;
- State and national policies, guidelines and protocols relating to the management of infectious diseases in emergency departments.
External communication matters

In addition to the clinical management issues outlined above, the Health Service Investigator
is to investigate the following further matters relating to the management, administration and
delivery of public sector health services:

An assessment of the external communications made by health service employees or
contractors located at CHHHs without prior approval by the Health Service Chief Executive,
and the appropriateness of the external communications, leading to confidential information
being in the public domain and if those communications were at all times appropriate and in
compliance with Queensland Health policy, Code of Conduct and legislation impacting the
Health portfolio with respect to [REDACTED] not limited to the
following:

Code of Conduct
Public Health Act 2005
Hospital and Health Boards Act 2012
Crime and Corruption Commission Act 2011
Criminal Code Act 1899
Contractual employment obligations

3.2. Make findings and recommendations in a report in respect of matters outlined above,
under section 199 of the HHA in relation to

(a) the ways in which patient safety can be maintained and improved;
(b) the ways in which the public safety of the community can be maintained and
improved;
(c) the ways on which the management, administration or delivery of public sector
health services can be otherwise maintained and improved; and
(d) any other matter identified during the course of the investigation.

4. Powers of the Health Service Investigator

The health service investigator has authority pursuant to section 194 of the HHA to access
any documentation under the control of the Cairns Hospital and CHHH relevant to this
investigation which may assist the investigation including ‘confidential information’ as defined
in the HHA, noting and complying with the confidentiality obligations as a health service
investigator pursuant to the HHA.

The investigator should make every reasonable effort to obtain any other material or
documentation that is relevant to these terms of reference.

5. Conduct of the Investigation

5.1 The Health Service Investigator is to make clear to any person who provides
information to the Health Service Investigator that they have been appointed as an
independent Health Service Investigator, having no conflict or perceived conflict in
respect of the matters under review.
5.2 The Health Service Investigator is to be aware of and comply at all times with the provisions of Part 9 of the HHBA which governs the undertaking of this Health Service Investigation, including (but not limited to) the duty of confidentiality.

5.3 With the prior notification to and facilitation by the CHNE’s Chief Executive, the investigator has the authority to:

(a) interview any person who may be able to provide information which directly assists in the investigation. The investigator may seek to interview persons who are not employees of Queensland Health who may be able to directly assist in their investigation. The investigator need only interview persons who can provide information that they believe is credible, relevant and significant to the matters under investigation, and

(b) give any appropriate lawful directions which may be required during the review. For example, to provide a lawful direction to an employee to maintain confidentiality to attend an interview, or to provide copies of documents maintained by the Cairns Hospital or QHHS. The investigator will inform me of any failure to comply with a direction, and I will advise regarding the approach that will be taken.

6.4 The Health Service Investigator may co-opt specialist clinical, clinical governance, or human resource management expertise or opinion where they deem it appropriate. The investigator must obtain my prior approval, before incurring any expenses in this regard.

6.5 The Health Service Investigator must provide persons who may be able to provide information which directly assists in the matters set out in under ‘Scope of the Investigation’, and they to be credible, relevant and significant to the matters under investigation, with the opportunity to respond verbally and/or in writing to the specific matters under investigation. This will not include a formal skills assessment at this stage.

6.6 A summary of evidence relied upon by the Health Service Investigator in order to make a recommendation is to be referred to in the report.

6.7 The names of persons providing information to the investigator must be kept confidential and referred to in a de-identified form in the body of the report, unless the identification of the person is essential to ensure that natural justice is afforded to any particular person.

6.8 Legal advice is able to be obtained by the Health Service Investigator at the arrangement and cost of Queensland Health in accordance with section 187(3)(a) of the Hospital and Health Boards Act 2011.

6.9 The Health Service Investigator is to provide within 7 days (or as otherwise agreed) of receiving the appointment and these terms of reference:

- an investigation plan; and
- confirmation in writing of an ability to meet the timeframes for the conduct of the investigation, including the due date for the report;
ATTACHMENT 1
INSTRUMENT OF INDEMNITY

Grant of Indemnity

Queensland Health agrees to indemnify Ms Chris Foley, Regional Safety and Quality Manager, St Vincent's Health and Aged Care (“the indemnified”) in respect of this Health Service Investigation, in accordance with the terms and conditions of the Queensland Government Indemnity Guideline as at the date of this Instrument.

Signed this 21st day of November 2014.

[Signature]

DR MICHAEL CLEARY
CHIEF OPERATIONS OFFICER
QUEENSLAND HEALTH

5.10 The Health Service Investigator is to notify me about the progress of the investigation at regular intervals, as will be agreed following the submission of the investigation plan.

5.11 Any request for an extension of the due date for the report is to be in writing at least 7 days before the due date with supporting reasons.

5.12 The Health Service Investigator is to submit to me a draft investigation report no later than 7 days prior to the due date for the report.

5.13 Your professional rate for this investigation will be [Redacted].

5.14 Out of pocket expenses incurred in the undertaking of the investigation will be reimbursed by Queensland Health in accordance with Public Service Directive 9/11 Domestic Travelling and Relieving Expenses (or any replacement Directive as in force from time to time). You will be required to forward a copy of all tax invoices in this regard to the attention of [Redacted] Business Co-ordinator, Legal and Governance Branch, at legal.business.support@health.qld.gov.au. Please retain original invoices in the event that they are required to be submitted.

5.15 All other travel arrangements will be arranged through Business Support Services, Legal and Governance Branch. Your contact will be [Redacted] at the above email or on (07) [Redacted].

5.16 If necessary, the investigator should report back to me (or other person nominated by me) for further instructions during the course of the investigation.
INSTRUMENT OF APPOINTMENT
CLINICAL REVIEWER

I, DR MICHAEL CLEARY, Chief Operations Officer, Queensland Health, appoint, pursuant to Part 8, Division 3 of the Hospital and Health Boards Act 2011, Professor Dominic Dwyer, Fellow of the Royal Australasian College of Physicians ("the appointee"), as a Clinical Reviewer to undertake a clinical review in the Cairns and Hinterland Hospital and Health Service and provide expert clinical advice set out in the Terms of Reference in the form of a written report to the appointed health service investigator outlined below by 7 November 2014, to enable the health service investigator to provide a report to me by 13 November 2014 or such other date as agreed by me.

Conditions of appointment

1. The appointment is made in accordance with sections 124(o) and 126(1) of the Hospital and Health Boards Act 2011 to conduct a Clinical Review in the Cairns and Hinterland Hospital and Health Service and to prepare and provide expert clinical advice to the appointed health service investigator.

2. The appointee is to prepare a report containing expert clinical advice in accordance with section 138(2) of the Hospital and Health Boards Act 2011 to the health service investigator (Ms Chris Foley, Regional Safety and Quality Manager, St Vincent’s Health and Aged Care) appointed by me under Part 9 of the Hospital and Health Boards Act 2011 the appointee is to work co-operatively with Ms Foley as appropriate during the Clinical Review.

3. The appointment commences on the date of this Instrument and will end on delivery of the required report.

4. The appointee will be indemnified by Queensland Health against any claims made against the appointee arising out of the performance by the appointee of his functions under this Instrument, on the terms contained in their Instrument of Indemnity.

Dr Michael Cleary
Chief Operations Officer
Queensland Health
3/11/2014
CAIRNS AND HINTERLAND HOSPITAL AND HEALTH SERVICE

REVIEW OF CLINICAL MATTERS AT CAIRNS HOSPITAL

TERMS OF REFERENCE

1. Purpose

Clinical Management – Ebola

The purpose of this Clinical Review is to assess the standard and quality of clinical management and treatment provided to [condition redacted] at the Cairns Hospital, Cairns and Hinterland Hospital and Health Service (CHHHS) and the compliance with relevant clinical and administrative policies and procedures in place at the Cairns Hospital relating to the treatment of the patient and management of potential risk to other persons.

2. Appointment

Pursuant to sections 124(c) and 125(1) of the Hospital and Health Boards Act 2011 (HHBA), following my assessment that he has the necessary expertise and experience, I have appointed Professor Dominic Dwyer, Fellow of the Royal Australasian College of Physicians, as a Clinical Reviewer to conduct this Clinical Review.

Professor Dwyer is to prepare a report containing expert clinical advice in accordance with section 126(2) of the HHBA to the Health Service Investigator (Ms Chris Foley, Regional Safety and Quality Manager, St Vincent’s Health and Aged Care) appointed by me under Part 9 of the HHBA.

The Terms and Conditions of the indemnity provided to Professor Dwyer are detailed in Attachment 1 Instrument of Indemnity.

3. Scope of the Clinical Review

Professor Dwyer is to undertake a clinical review in respect of the following matters:

Clinical Management – Ebola

The standard and quality of clinical management and treatment provided to [condition redacted] by the Cairns Hospital and the compliance with relevant clinical and administrative policies and procedures in place at the Cairns Hospital relating to the treatment of the patient and management of potential risk to other persons, including:

(a) Reviewing the patient records for [condition redacted];

(b) Developing a sequence of key events and significant clinical decision-making points relevant to the clinical management of [condition redacted];

(c) Reviewing the admission, examination, assessment, diagnosis, treatment and overall management of [condition redacted] when she presented at Cairns Hospital with a low grade fever, 9 October 2014, including the appropriateness of placing [condition redacted] in an isolation room in the emergency department;

(d) Reviewing relevant clinical and administrative policies and procedures, specifically including those relating to infectious diseases and public health and considering whether appropriate policies and procedures were in place and the compliance with existing policies, had any impact on.
i. the standard and quality of care provided to
ii. hospital staff safety and well-being attending to the care of
iii. other hospital staff, patient’s and visitor’s safety and well-being who were at
Cairns Hospital during stay;
iv. the community’s safety and well-being during stay at Cairns
Hospital; and
v. the community’s safety and well-being upon release of from
Cairns Hospital.

In undertaking this aspect of the Clinical Review, Professor Dwyer is to consider and
take into account:

• national and international guidelines relating to Ebola Virus Disease (EVD) and
  other guidelines and protocols relevant to the management of contagious
diseases; and
• State and national policies, guidelines and protocols relating to the management
  of infectious diseases in emergency departments.

3.1. Make findings and recommendations (as appropriate to the clinical review undertaken)
in relation to:

(a) the ways on which the safety and quality of public sector health services can be
    maintained and improved;
(b) the ways in which the public safety of the community can be maintained and
    improved; and
(c) any other matter identified during the course of the clinical review.

4. Powers of the Clinical Reviewer

The Clinical Reviewer has the authority under section 129 of the HHBA to enter a public
sector health service and to access, copy or take extracts from any document (including
documents that contain confidential information) that is relevant to the Clinical Reviewer’s
functions and is in the possession or control of the public sector health services.

The Clinical Reviewer should make every reasonable effort to obtain any other material or
documentation that is relevant to these terms of reference.

5. Conduct of the Clinical Review

5.1. The Clinical Reviewer is to make clear to any person who provides information to the
Clinical Reviewer that they have been appointed as an independent Clinical
Reviewer, having no conflict or perceived conflict in respect of the matters under
review. The Clinical Reviewer must also make clear to any person who provides
information to the Clinical Reviewer that their report is to be provided to a Health
Service Investigator and accordingly, will not be protected from disclosure under the
HHBA.

5.2. The Clinical Reviewer is to be aware of and comply at all times with the provisions of
Part 6 Division 3 of the HHBA which govern the undertaking of this Clinical Review,
including (but not limited to) the duty of confidentiality, requirements regarding
stopping of a Clinical Review and the protection for Clinical Review reports.
5.2 With the prior notification to and facilitation by the CHHS Chief Executive, the Clinical Reviewer has the authority to:

(a) interview any person who may be able to provide information which directly assists in the Clinical Review. The Clinical Reviewer may seek to interview persons who are not employees of Queensland Health who may be able to directly assist in the Clinical Review. The Clinical Reviewer needs only interview persons who can provide information that they believe is credible, relevant and significant to the matters under review; and

(b) give any appropriate lawful directions which may be required during the review. For example, to provide a lawful direction to an employee to maintain confidentiality, to attend an interview, or to provide copies of documents maintained by the Cairns Hospital or CHHHS. The Clinical Reviewer will inform me of any failure to comply with a direction and I will advise regarding the approach that will be taken.

5.3 The Clinical Reviewer may co-opt specialist clinical, clinical governance, or human resource management expertise or opinion where it is deemed appropriate. The Clinical Reviewer must obtain my prior approval, before incurring any expenses in this regard.

5.4 The Clinical Reviewer must provide persons who may be able to provide information which directly assists in the matters set out in '3 Scope of the Clinical Review', and likely to be credible, relevant and significant to the matters under review, with the opportunity to respond verbally and/or in writing to the specific matters under review. This will not include a formal skills assessment at this stage.

5.5 The report prepared in accordance with section 132(2) of the HHBA should specifically address the matters outlined above. The Clinical Reviewer is to provide in the body of their report their assessment and reasons for these conclusions. Any inferences, which are derived from hearsay, should also be clearly identified.

5.6 A summary of evidence relied upon by the Clinical Reviewer in order to make a recommendation is to be referred to in the report.

5.7 The names of persons providing information to the Clinical Reviewer must be kept confidential and referred to in a de-identified form in the body of the report, unless the identification of the person is essential to ensure that natural justice is afforded to any particular person.

5.8 Legal advice is able to be obtained by the Clinical Reviewer at the arrangement and cost of Queensland Health in accordance with section 132(3)(a) of the HHBA.

5.9 The Clinical Reviewer is to provide within 7 days (or as otherwise agreed) of receiving the appointment and these terms of reference:

- a Clinical Review plan; and
- confirmation in writing of an ability to meet the timeframes for the conduct of the Clinical Review, including the due date for the report;
5.10 The Health Service Investigator is to notify me about the progress of the investigation at regular intervals, as will be agreed following the submission of the investigation plan.

5.11 Any request for an extension of the due date for the report is to be in writing at least 7 days before the due date, with supporting reasons.

5.12 The Health Service Investigator is to submit to me a draft investigation report no later than 7 days prior to the due date for the report.

5.13 Your professional rate for this investigation will be ____________________________.

5.14 Out of pocket expenses incurred in the undertaking of the investigation will be reimbursed by Queensland Health in accordance with Public Service Directive 9/11 Domestic Travelling and Relieving Expenses (or any replacement Directive as in force from time to time). You will be required to forward a copy of all tax invoices in this regard to the attention of [here should be the name of a Business Co-ordinator, Legal and Governance Branch, at legal.business.support@health.qld.gov.au. Please retain original invoices in the event that they are required to be submitted.

5.15 All other travel arrangements will be arranged through Business Support Services, Legal and Governance Branch. Your contact will be [here] at the above email or [here] _________.

5.16 If necessary, the investigator should report back to me (or other person nominated by me) for further instructions during the course of the investigation.
Pages 109 through 121 redacted for the following reasons:
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1 Executive Summary

Introduction

This is a report of clinical review conducted pursuant to section 136 (2) of the Hospital and Health Boards Act 2011 in relation to:

(a) The standard and quality of clinical management and treatment provided to Patient A (and other matters) at the Cairns Hospital.

Key Findings

In summary, on the evidence available to the Clinical Reviewer on the balance of probabilities:

Broadly, the clinical management and treatment provided to Patient A was clinically appropriate and reasoned, and generally complied with the relevant clinical and administrative policies and procedures.

It should be noted that the treating clinicians utilised the Metro South Ebola guidelines as the basis for their decision making and clinical judgement in regard to her care and management of potential risk to other persons. Queensland Department of Health guidelines, released on 9th September 2014 by the Communicable Diseases Unit, were circulated to some staff a month later on 8th October 2014, but locally adapted guidelines on Ebola Virus Disease management were not available. Not all staff interviewed were aware of these guidelines prior to arrival of the patient, nor aware of the status of Cairns Hospital as a hospital designated to receive potential Ebola virus infected individuals.

Treatment and other options were appropriately discussed with the patient by the Infectious Diseases, Emergency Department and other staff. However, there were some local staff concerns raised about ongoing patient placement in the Emergency Department, and that suboptimal communication and leadership had led to considerable local Emergency Department staff dissatisfaction: this may be improved through the adoption of recommended strategies to improve communication and leadership through lessons learned from this event.

In seeking feedback from the patient, Patient A, a Registered Nurse experienced in managing patients with Ebola virus infection, she supports the assessment that the clinical care and management was appropriate and to an acceptable standard. In particular, she described herself as being “hyperaware” of PPE precautions and undertook self-care while in isolation in the Emergency Department where possible, including taking her own observations. This assisted in limiting staff contact with her should she have returned a positive Ebola PCR result.

Accordingly, the evidence supports, on the balance of probabilities, that the standard and quality of clinical management and treatment of Patient A was of an acceptable standard for the information available at the time.
Appointment
Background

The offices of the Director General Department of Health and the CHHHS Executive raised concerns about:

- The standard and quality of clinical management and treatment provided to the patient, and the compliance with relevant clinical and administrative policies and procedures in place at the CHHHS in relation to the treatment of the patient and management of potential risk to other persons.

Authority

Pursuant to an instrument of appointment dated 21 October 2014, Professor Dominic Dwyer, Fellow of the Royal Australasian College of Physicians, was appointed as a Clinical Reviewer to undertake a review in relation to those aspects of the investigation relevant to the management and treatment of Patient A at the Cairns Hospital. Professor Dwyer was also requested to assess compliance with relevant clinical and administrative policies and procedures in place at Cairns Hospital relating to the treatment of Patient A and management of potential risk to other persons.
Limitations

The Clinical Review has applied his investigative knowledge to determine the facts relevant to the matters within the scope of the instrument of appointment. The findings reached reflect his analysis of the facts available to him, ascertained as a result of his investigations and from the information.

The Clinical Reviewer is not a lawyer and the report should not be relied upon as legal advice. The report does not contain legal conclusions, only findings of fact and statements from interviewed personnel.

The Clinical Reviewer reserves the right to alter the findings reached in this report should information that is relevant to the findings subsequently become available after the date of this report. However, the Clinical Reviewer assumes no responsibility for updating this report for events and circumstances occurring after the date of this report.

This report should not be distributed, used or relied on for any other purpose or without the written consent of the clinical reviewer. If it is, the investigator does not accept any liability or responsibility for loss suffered by any party.
3 Methodology

Interviews

700 The Clinical Reviewer sought interviews from clinicians involved in the treatment of Patient A, as well as members of the Department of Health Corporate Office, CHHHS Executive, the Senior Medical Staff Association and the Hospital Divisional Executive. Patient A was also invited and accepted interview in relation to her care.

701 Interviews were conducted as set out in Annexure B to the report. Interviews were conducted in person at the Cairns Hospital for clinicians currently working in the hospital to minimise disruption to service delivery and the GHD Building for the Medical Practitioners under suspension from employment, Patient A and CHHHS Executive members who ordinarily work in the GHD building. One interview was conducted via telephone with the SMO and Dr Douglas as the staff member was not working on site at the hospital.

702 The interviews were not formally recorded.

703 The Clinical Reviewers would like to acknowledge and thank the CHHHS Executive and all staff that participated in this investigation. The high level of cooperation and openness provide to the Clinical Reviews from all levels of staff has been commendable and greatly assisted in completing the investigation as quickly and diligently as possible.

Documents

704 Pursuant to the powers conferred on the clinical reviewer by the HHB Act, the clinical reviewer sought documentation for the purposes of his clinical review from CHHHS and various CHHHS employees.

705 Documents were sought and produced as set out in Annexure C to the report. This included documents not specifically requested by the investigators.

706 Where the evidence relied upon for findings in this report is contained in a document, the source of that evidence is specifically referenced in the report and a copy of the document is available on request.

Individual officers

707 In accordance with the principles of natural justice, where the conduct of individual officers was considered by the clinical reviewer to potentially be the subject of an adverse finding, each officer was afforded the opportunity to respond to the allegations against each allegation.
Assessment of evidence

708 This report sets out the evidence that is credible, relevant and significant to the matters under clinical review in relation to each matter. For each matter under clinical review, the Clinical Reviewer assessed the available evidence. Where conflicting evidence existed, considered whether the evidence supported or does not support particular findings on the balance of probabilities, that is whether the Clinical Reviewer could be satisfied that a matter is more probable than not, but not beyond a reasonable doubt, based on the strength of the available evidence.

709 All evidence provided to the Clinical Reviewer has been taken into consideration, although the report may not specifically refer to all of the material provided.

Confidentiality of individuals

710 The terms of reference of the Clinical Reviewer’s appointment states that the names of person providing information to the investigator must be kept confidential and referred to in a de-identified form in the body of the report unless the identification of the person is essential to ensure that natural justice is afforded to any particular person. In this regard, the names of the patients have been retained as they are referenced in the terms of reference of the investigation. All other parties are referred to by positional title or role function.
4 Clinical Management of Ebola

4.1 Management of Patient A

Background

Patient A presented to the hospital as directed at approximately 1300 hours on Thursday 9 October 2014 where a strategy was in place to greet her and escort her with personal protective equipment (PPE) to the isolation room within the Emergency Department for assessment of suspected Ebola virus infection. Patient A was assessed and remained in airborne isolation protection in the Emergency Department while blood tests were taken (sent
to Brisbane) and awaiting a result, and was confirmed as having a negative Ebola virus PCR result in the early hours of Friday 10 October 2014. These results were provided directly to the patient by the Director of Medical Services, not the admitting consultant. Patient A remained in the Emergency Department isolation room until a second confirmed negative result was returned (blood collected on Saturday 11 October, and sent to Brisbane) and she was discharged home just after midnight on Sunday 12 October 2014. She was to continue to have ongoing daily monitoring with the local Public Health Unit.

Issues for Investigation

The issues for investigation are:

a. The standard and quality of clinical management and treatment provided to Patient A by the Cairns Hospital.

b. Whether the clinical management and treatment provided to Patient A complied with relevant clinical and administrative policies and procedures in place at Cairns Hospital relating to the treatment of Patient A and management of potential risk to other persons.

Standard and quality of clinical management and treatment provided to Patient A by the Cairns Hospital

Evidence

Relevant clinical and administrative policies and procedures

The Clinical Reviewer identified the following national and international guidelines relating to Ebola Virus Disease (EVD) relevant to the management of a patient such as Patient A that the CHHHS clinicians had identified:

- Ebola advice for clinicians – EVD outbreaks in West Africa , important information for clinicians in secondary and tertiary care (10/10/2014) – note this is sourced through Australian Government Department of Health website, with last update 7 November 2014
- Metro South Princess Alexandra Hospital Procedure Manual, management of patients with known or suspected Ebola virus, V1, September 2014
- Qld Health, Ebola virus disease: Interim guidelines for managing presentations of suspected cases, V1, 9 September 2014 – note this was last updated V2.0, 27 October 2014
- Ebola Virus Disease (EVD) CDNA National guidelines for Public Health Units, V1.2 (3/10/2014) note this is sourced through Australian
Government Department of Health website, with last updates 24 October 2014 and 6 November 2014

- Pathology Qld – suspected Ebola virus infection pathology management plan (October, 2014)

In addition, the Clinical Reviewer identified the following national and international guidelines related to the management of contagious diseases and relevant to the management of a patient such as Patient A:

- PHLN information for laboratories, laboratory procedures for samples collected from patients with suspected viral haemorrhagic fevers (sourced through the Australian Government Department of Health Website, with last update 13 November 2014)


- WHO Statement, 8 August 2014, Statement on the 1st meeting of the IHR Emergency Committee on the 2014 Ebola outbreak in West Africa


The Clinical Reviewer also identified the following Queensland and national policies, guidelines and protocols relating to the management of infectious diseases in emergency departments which are relevant to the management of Patient A:

- Qld Health (qheps) – Patients on transmission based precautions
- Qld Health (qheps) – General Signage
- CHHHS – Procedure aseptic technique V1, 8/10/2014
- CHHHS – Infection control poster, infection control precautions
- CHHHS – Procedure, rooms for airborne isolation, V1, September 2012

The interim Ebola virus disease guidelines (dated 9 September 2014) were disseminated from Qld Health down to the CHH public health unit in the
days prior to Patient A’s admission to Cairns Hospital. Clinicians in the Emergency Department report that they first saw these interim guidelines disseminated from the Communicable Diseases Network through the Qld Emergency Department Network on 7 October 2014. These interim guidelines, in unchanged form, were disseminated to all Cairns Hospital Emergency Department Consultants and Registrars on 8 October 2014. These guidelines specifically listed Cairns Hospital as a receiving hospital for suspected EVD cases from the international airport. By 9 October 2014, when Patient A presented to Cairns Hospital, there had been no specific hospital-wide planning in regards to the Cairns Hospital management of a patient with suspected Ebola virus infection, and as such no clear documented plan when a patient did arrive in the Emergency Department. The Infectious Diseases and Infection Control staff had reviewed these guidelines and had begun the relevant planning for their units.

The Qld Health Public Health Unit was aware that Patient A was in Cairns and returned from West Africa, and had emailed the Clinician R on 7 October 2014 at approximately 1100 hours of her return to Cairns. However, the Public Health Unit were initially unable to make contact with her. The Clinician R was working in the Medical Assessment Unit all day on 8 October 2014 and did not have any emails or phone calls, and first knew of Patient A’s location when he was given a note on 9 October 2014 that informed him that she was febrile and would be coming into the Emergency Department at 1300 hours.

The consensus of clinicians was that the interim Qld Health guidelines were of limited practical assistance in providing guidance to the specific requirements for care presented with Patient A, and were not Cairns Hospital specific. They sourced the Metro South Princess Alexandra Hospital procedure for management of patients with known or suspected Ebola virus disease, with consensus of clinical judgement from Emergency Department, Infectious Diseases and Intensive Care Clinicians that they were practical and applicable to this patient’s management. The Metro South procedure was emailed to all Emergency Department Consultants, Registrars, Emergency Nurse Practitioners and Nurse Unit Manager approximately 1800 hours on 9 October, approximately five hours after the patient had presented to the department.

Staff awareness of relevant clinical and administrative policies and procedures

Key clinical staff (Infectious Diseases, Infection Control) were aware of the existence of the interim Qld Health Ebola virus disease guidelines, however only limited staff were aware that Cairns Hospital was a “designated” hospital for receiving Ebola virus infected patients. The key clinicians involved in managing Patient A’s care discussed the guidelines, and independently sourced the Metro South guidelines and confirmed based on
their clinical judgement they were the most appropriate to utilise in this circumstance.

On Thursday 9 October, 20014, when Patient A was admitted, a Clinician from Public Health Unit emailed the interim Qld Health Ebola virus disease guidelines to both Clinician T and R. One consultant had seen an interim version of the state management guidelines through public health discussion prior to this, as he works half-time in the Public Health unit. The clinician stated that the QLD Health interim guidelines were in a state of change even then – the revised state guidelines were circulated on Friday 10 October, 2014, which he didn’t see during the course of Patient A’s management, as he was busy in the Emergency Department all day managing her care and didn’t check his emails until after 4pm on Friday.

The requirements for wearing Personal Protective Equipment (PPE) were provided in the Metro South guideline which were followed, and “just in time” education provided to clinical staff working in the Emergency Department by Clinician T, Public Health Unit Clinician and Clinician S Department. However, Emergency Department Nursing and Medical staff raised concerns and stated that they were not entirely assuaged in their concerns following the education provided. This is part may have been impacted on by the extensive media coverage in Cairns, Australia and internationally with clinical staff contracting the Ebola virus in US and Spanish hospitals.

Prior to Patient A’s admission to hospital, there had been no prior education, training, exercises or communication beyond the circulation of the Qld Health interim guidelines to key senior clinicians in the hospital. In this respect, the staff were operating in a rapidly evolving scenario with education and information provided to the best of their ability for the treating clinicians on the ground. The Emergency Department have provided positive feedback about the information and education provided to them by Clinician T during Patient A’s admission.

The clinical reviewer has been advised that the Princess Alexandra Hospital had developed their procedures prior to the Qld Health interim guidelines being released, driven by the Director of the Infectious Diseases Unit, and that they had provided formal education and training to staff in the emergency department and other key clinical departments, and also had undertaken a desktop exercise to test the scenario and procedures. The procedures were developed with involvement of Princess Alexandra Hospital Division of Medicine Executive support, hospital and Metro South key clinicians, and management support and involvement.

Staff within the Emergency Department were particularly concerned about reducing contact with the patient by limiting interactions to those necessary for her care. A telephone was provided within the isolation room to assist in communication and further limit unnecessary personal interactions, in particular while awaiting the results of the first blood test. The staff providing care for Patient A were kept to a small number of consistent
nurses. Emergency staff raised concerns about limiting staff interaction to comply with infection control precautions, however observed three senior Qld health staff (the Department Executive B, CHHHS Executive A, and CHHHS Executive E) enter the room with two clinicians to visit Patient A. Patient A herself acknowledged to the investigator that she was “hyperaware” of not touching anyone or anything, and stated that she was surprised with the CHHHS Executive A, CHHHS Executive E and Department Executive B visited her wearing PPE in her room. She acknowledged that it was after she had been informed of the first Ebola virus PCR negative blood result, and she was grateful for their care and consideration.

Direction in the Metro South policy provides for management of waste, linen and environmental cleaning. Clinician T and Department Clinician A provided education and information on this to Environmental Services to assist in management of this aspect and assure their concerns.

Compliance with identified policies and procedures

The policies and procedures were complied with in so far as they were following the Metro South procedures for management of a patient with suspected Ebola virus infection. The patient was to be assessed in the Emergency Department negative pressure Isolation Room, and then once stabilised, transferred to the Infectious Diseases Ward (Ward 5A) or ICU, as appropriate. The guidelines provide guidance for movement through the hospital. The Clinician S and Clinician T discussed with Clinician D who argued it was not appropriate to transfer an otherwise well patient to ICU when the bed may be required for critical patients. Consideration was also made of transferring the patient to an Isolation Room in a ward setting, however concerns about appropriate management with limited visual access into the room (solid walls in the ward versus glass walls in ICU and ED) and corridor design of the ward based isolation rooms that made it difficult to restrict thoroughfares. Agreement was reached, and discussed with the patient, to manage the patient in ED until the second negative test result was returned. This resulted in a four day staff in the ED Isolation room, which also generated some issues raised by ED staff about ‘access block’ in an already busy department.

Senior staff were posted at the patient’s door to ensure appropriate and consistent use of PPE and log maintained of all persons entering the room.

The Metro South procedure states that visitors should be restricted to close family members only and then only if necessary. So, while Clinician T did provide approval, when requested of him, for the senior three members of the Executive to visit the patient, in hindsight he concedes that it would have been preferable for him to decline this request as the over-riding principle of clinical management should have been to limit all unnecessary visitors. A similar view was expressed by the patient.
Findings

The patient was accepted into the Emergency Department and assessed by a senior Infectious Diseases clinician. She had a low grade temperature, but was otherwise well. The Qld Health interim guidelines state “Emergency department triage stations should be alert for people presenting with fever who have a history of travel to an EVD affected country in the previous three weeks.” The guidelines were written in relation to an ill patient entering the country.

The senior clinicians in the hospital had knowledge of the Qld Health interim guidelines for management of a suspected Ebola case, however, there were limited knowledge or plans in place in relation to Cairns Hospital status as a designated hospital to receive suspected Ebola cases.

The senior clinicians sought a practical guide to manage a suspected Ebola virus infected case as they felt the interim guidelines issued by Qld Health did not meet their needs from a practical clinical management perspective. This was sourced through Qld Health web links (qheps), and the Metro South guideline was determined as appropriate as it had been developed with expertise, education and local testing for practicality.

The patient was managed in the Emergency Department for four days, as a result of consideration of options not to move her to ICU or a ward isolation room. It was determined, following consultation (including with the patient), that the Emergency Department was the best location to provide care for her in this situation.

The decision making around patient location and management was disseminated to senior medical and nursing staff in the Emergency Department for their information, however, there remained considerable disagreement from a wide range of stakeholders about the appropriateness of the decision. Clinician S and Clinician T were available to discuss the decision with a range of key parties, which they did.

There does not appear to be an existing process in CHHHS as to how Qld Health guidelines, e.g. Ebola virus guidelines in this case, are widely disseminated to clinicians, and then adopted or adapted for local implementation and scenario testing. A clear process for dissemination of Qld Health guidelines in the CHHHS is needed.

Conclusion

Broadly, the clinical management and treatment provided to Patient A was clinically appropriate, and generally complied with the relevant clinical and administrative policies and procedures. It should be noted that the treating
clinicians utilised the Metro South Ebola guidelines as the basis for their decision making and clinical judgement in regard to her care and management of potential risk to other persons. Queensland Department of Health guidelines, released on 9 September 2014 by the Communicable Diseases Unit, were circulated to some staff on 8 October 2014, but locally adapted guidelines on Ebola Virus Disease management were not available. Not all staff interviewed were aware of these guidelines prior to arrival of the patient, nor aware of the status of Cairns Hospital as a hospital designated to receive potential Ebola virus infected individuals. However, there were some local staff concerns raised about ongoing patient placement in the Emergency Department, and that suboptimal communication and leadership had led to considerable local Emergency Department staff dissatisfaction: this may be improved through the adoption of recommended strategies to improve communication and leadership through lessons learned from this event.

In seeking feedback from Patient A, [redacted], she supports the assessment that the clinical care and management was appropriate and to an acceptable standard. In particular, she described herself as being “hyperaware” of PPE precautions and undertook self-care while in isolation in the Emergency Department where possible, including taking her own observations. This assisted in limiting staff contact with her should she have returned a positive Ebola PCR result.

Accordingly, the evidence supports, on the balance of probabilities, that the standard and quality of clinical management and treatment of Patient A was of an acceptable standard for the information available at the time.

Recommendations

The Clinical Reviewer was asked to consider and make recommendations, insofar as they arise out of the investigation, in relation to:

(a) Ways in which patient safety can be maintained and improved.
(b) Ways in which the public safety of the community can be maintained or improved.
(c) Ways in which the management, administration or delivery of public sector health services can be otherwise maintained and improved.
(d) Any other matter identified during the course of the investigation.

The CHHHS has undertaken ongoing consultation within the Cairns Hospital, Senior Medical Staff Association, Qld Health Public Health Unit and the office of the Chief Health Officer since Patient A’s hospitalisation. They have developed their own guidelines and management flowcharts, in line with the most recent Qld Health guidelines for management of suspected Ebola virus infected patients.
Further recommendations should be considered in relation to:

1. Disaster plans need to be in place early for areas of identified risk to the organisation, and regularly exercised to identify strengths and weaknesses.

2. A Communication plan needs to be included with all relevant Disaster plans and clinical guidelines. This is to allow the contribution to site-specific adjustments of such guidelines by all relevant stakeholders. In the case of the “Qld Health, Ebola virus disease: Interim guidelines for managing presentations of suspected cases, V1, 9 September 2014”, provided to the Public Health unit, and reviewed by Infectious Diseases and Infection Control teams, distribution to other parts of the hospital was suboptimal. A strategy for clear distribution of such guidelines needs to be implemented by the CHHHS administration. This will help co-ordinate detailed and regular staff updates, the listening to and answering of staff concerns, provide respect and support for staff with concerns about care, and allow local discipline-specific leadership that is accessible for medical and nursing staff, and provide Divisional and Facility leadership. The communication pathways within the ED, a complex part of the hospital, should also be reviewed to ensure that medical, nursing and other staff are able to receive the same clinical and management advice. This is the responsibility of the Medical and Nursing Directors of the ED, with the assistance of the CHHHS administration.

3. The case definition for EVD must be standardised along with clear locally relevant protocols for clinical management. This includes situations where patients fall outside the high risk or no risk categories.

4. PPE advice and training should be standardised throughout the hospital, in keeping with relevant Queensland and Australian advice.

5. A plan for ongoing PPE training and credentialing is essential for clinical and support staff, including environmental and food services.

6. PPE stock or pre-prepared kit availability needs to be addressed at a facility-wide level. There must be adequate stock of required equipment, with stock rotation to ensure it remains appropriate to use.

7. An agreed plan must be developed for potential Ebola virus infected patient assessment and triage, clinical examination and sample collection, then if admission required, placement within the hospital. This is needed to ensure that the patient (and other patients in the service) receives the best care in the most appropriate location. As a minimum, this plan needs defined leadership to ensure agreement with the ED, ICU, infectious diseases and infection control, relevant wards, and hospital administration. The method of circulation and ongoing review of this plan needs to be delineated.

8. The hospital should undertake analysis of the ward-based isolation rooms to improve visual access (e.g. changing patient-only operated
louvers in doors) and to restrict movement in corridors, if necessary. The isolation room in the ED is compromised by a too small anteroom, and consideration should be given to expanding the size of this anteroom. The correct donning and doffing of PPE in a fit-for-purpose anteroom is crucial in preventing healthcare worker-acquired infection.

9. Visitors to patients in isolation rooms should be actively managed to minimise unnecessary contact with potential or confirmed highly infectious patients, and all relevant signage and policies should reflect this requirement. It needs to be emphasised that in the context of Ebola virus infection (and other highly infectious diseases), limiting of entry to staff directly involved in patient care, and close family members, and always on the advice of the treating doctor, is a crucial part of such management.

10. Management of waste, linen and environmental cleaning should be specifically addressed in local policies relating to management of potential and confirmed infectious patients.

11. Liaison with the patient about clinical plans, movement to other wards, provision of test results, treatment, discharge and follow-up remains the sole responsibility of the admitting consultant. The public health, administrative responses to admission of individuals to CHHHS should be made with the input of the admitting consultant.

12. As Cairns Hospital has designated responsibilities for infectious diseases (related to the international airport and international shipping, proximity to PNG, high tourism numbers and known local infectious diseases issues e.g. TB, melioidosis, dengue etc), strong consideration needs to be given to employing enough infectious diseases specialists to provide a year-round 24/7 service. This is needed to provide both clinical and laboratory services.

13. The laboratory needs to consider providing a 7 day a week courier service to Brisbane for testing in major clinical problems e.g. Ebola virus infection.

14. Senior staff and the hospital need to provide an appropriate safe, quiet and private environment for discussions with employees relating to criticisms of patient care or its complications.
Pages 137 through 159 redacted for the following reasons:

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Annexure E - Courier Mail Article

Doctors outraged that suspected Ebola patient Sue Ellen Kovack was treated in busy emergency department of Cairns Hospital

by: Peter Michael From: The Courier-Mail October 11, 2014 12:00AM

Queensland nurse Sue-Ellen Kovack, who recently returned from Sierra Leone, has tested negative for the deadly virus Ebola while federal health authorities report 21 people have been tested so far.

DOCTORS are outraged a suspected Ebola patient was tested for the deadly virus in the busy emergency department rather than in isolation in the highly infectious diseases unit at Cairns Hospital.

International Red Cross volunteer nurse Sue Ellen Kovack was last night due to be transferred out of emergency to an isolation unit in a medical ward after internal pressure by senior clinicians in the north Queensland hospital.

Doctors branded as “bizarre” the decision by Queensland Health to test her in the busiest part of the hospital which handles some of the “most vulnerable” patients.

The 57-year-old tested negative to Ebola yesterday but faces a three-day stay in Cairns Hospital ahead of new blood test results on Monday.

Health officials told how the nurse was an “extremely low risk” of Ebola, which is not airborne or highly contagious.

Queensland Health has placed an order for an Isopod - a hi-tech isolation chamber - to transport infectious patients.

Queensland’s chief health officer, Jeannette Young, said the negative test result reinforced how Ms Kovack’s condition posed no danger to the public.

Dr Young said the nurse was into day 30 of the 21-day incubation period for the hemorrhagic fever.

Queensland health authorities are taking an “extremely cautious” approach towards a nurse’s Ebola scare.

She was still feeling “a bit unwell” but the “fever has resolved” and she was being watched closely in isolation, Dr Young said.

Ms Kovack returned home to Cairns on Tuesday from treating Ebola-infected patients in Sierra Leone. She had been in home quarantine and presented to hospital with mild fever after a temperature spike on Thursday. Her flatmate who drove her to hospital has been cleared of any risk, Dr Stephen Doherty said.

International Red Cross volunteer nurse Sue Ellen Kovack has tested negative for Ebola but will undergo another round of testing in Cairns Hospital on Monday.
Senior doctors told The Courier-Mail of an internal outcry after plans emerged to keep Ms Kovack for six days in a negative pressure room in the hospital's emergency department where up to 200 patients a day are treated.

"It's appalling. What the hell is going on?" said a senior clinician, speaking on behalf of a group of concerned doctors.

"Why's she is still in ED? It's the wrong place.

"Lights are on 24 hours a day, medical staff are incredibly busy and we've got a possible Ebola case in a bed in the midst of where we treat our most sick, ill and injured patients."

MP Bob Katter has called for official compulsory isolation of all Australians who come into direct contact with Ebola overseas.

The clinician said it reflected "the hospital is unable to deal with the situation."

Dr Young said: "The major learnings so far is that the case would be easier to manage if the patient was in Brisbane."

Tourists in Cairns (left) wore protective masks in the streets and on flights amid heightened fear about Ebola.

Federal Health Minister Peter Dutton yesterday warned against "panic" as he confirmed 11 Australians had been tested for Ebola and all had returned a negative result.

He dismissed calls by federal MP Bob Katter for all Australians who come into direct contact with Ebola overseas to be compulsorily kept in official isolation clinics for three weeks.

Dr Young said creating a register of Queenslanders that are overseas helping to fight Ebola was being considered.

Queensland Health also revealed it has inspected and ordered an Isopod—a hi-tech isolation chamber—to transport infectious patients.
Annexure F – Health up North Extract October 2014 issue

Responsibility Refresher...

October’s ‘Responsibility Refresher’ looks at the requirements for staff when contacted by members of the media. Each month the Communications Team will include an article outlining staff responsibilities across a series of topics (we take requests).

Health Services attract a high level of public interest and as a result are frequently the subject of enquiries from media outlets at a local, state, national and sometimes international level. The following overview identifies the rights and responsibilities of CHHHS staff who come in contact with the media.

The CHHHS Communications Team is the primary conduit between media outlets and the Health Service. All media enquiries should be referred to a Public Affairs Officer within the Communications Team, this position is an on-call role and the officer is available for out of hours enquiries.

The Public Affairs Officer will discuss the media inquiry with relevant members of staff before deciding on the best way to respond, be it through a written statement or by putting up an expert in that field as a spokesperson for the service.

There will be cases when a journalist will attempt to contact members of staff directly. A member of the press has an ethical obligation to identify themselves as a journalist from a particular outlet at the beginning of the discussion. Use fair, responsible and honest means to obtain material. Identify yourself and your employer before obtaining any interview for publication or broadcast. Never exploit a person’s vulnerability or ignorance of media practice.” Journalism’s Code of Ethics

In a case where someone doesn’t adequately identify themselves or is unknown to you, refer them to the Communications Team. Staff should not comment on behalf of the Health Service unless they are approved to do so by the Chief Executive or Public Affairs Officer and must at all times be aware of the importance of maintaining the confidentiality of patients.

All employees must also adhere to the Queensland Public Service Code of Conduct and their obligations under the Hospital and Health Boards Act, 2011, the Health Services Act 1991 and Information Privacy Act.

The Communications Team can be contacted on CHHHS-Comms@health.qld.gov.au or on 4226 3228. The after hours number for the Public Affairs Officer is 0405 108 512.

Health up North is the newsletter of the Cairns and Hinterland Hospital and Health Service.

We hope you found this issue enjoyable and informative. If you have any articles you would like to contribute for the next month’s edition, please contact the Communications Team on CHHHS-Comms@health.qld.gov.au or on 4226 3228. Copy for the November edition is due on Friday, November 21.