Submission

No 46

INQUIRY INTO THE ROYAL NORTH SHORE HOSPITAL

Name: Mr and Mrs Warren and Michelle Anderson

Date Received: 12/11/2007

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The Rev. Hon Fred Nile MLC
Chairman
Joint Select Committee on the Royal North Shore Hospital
Parliament House
Macquarie Street
SYDNEY NSW 2000

By facsimile: 9230 2981

FAXED
12 NOV 2007

Dear Sir

RE: SUBMISSION TO PARLIAMENTARY INQUIRY

We refer to your letter dated 29 October 2007.

We **enclose** for you attention Submissions addressing the Terms of Reference, on behalf of Mr and Mrs Anderson.

We confirm that Mr and Mrs Anderson are happy for these Submissions to be made public.

Furthermore, Mr and Mrs Anderson are happy to give further information, documentation and/or oral evidence if the Committee so desires.

Yours faithfully,
McLaughlin & Riordan

Per:

Melanie Palmer

Encls.
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Submission of Warren and Michelle Anderson to the Joint Select Committee on the Royal North Shore Hospital

Vanessa Anne Anderson died at Royal North Shore Hospital ('RNSH') on 8 November 2005. Her death is the subject of a Coronial Inquest and an HCCC investigation.

During the course of these investigations and inquiries Vanessa's parents, Warren and Michelle Anderson, have become aware of numerous systemic failures at RNSH that they believe caused their daughters death.

Warren and Michelle Anderson respectfully request that the final report of Joint Select Committee on the Royal North Shore Hospital ('the Committee') RNSH be delayed until after Deputy State Coroner Carl Milovanovich has delivered his findings and recommendations, if any, regarding the death of Vanessa. It is believed that such findings are likely to be given in early 2008.

Nevertheless, Warren and Michelle Anderson welcome the opportunity to provide information to the Committee as follows:

(a) clinical management systems at the hospital

Protocols/Policies

There was a lack of knowledge among the staff in relation to the following protocols/policies:

a) Admissions policy regarding minor children;
b) Provision of opiates to a head injured patient, particularly in the absence of supplemental oxygen;
c) Completing medication charts, in particular, recording of maximum dosage of certain medication;
d) Making entries in the medical records, in particular, plan of management and orders.

This lack of knowledge was not confined to the neurosurgery department of RNSH. It includes the Emergency Department and Anaesthetic Department.

In addition, the protocols and policies, in particular, on the neurosurgery ward were not readily available. For instance, the medical officers handbook was locked in a cupboard in a room on the ward. New members of staff on the neurosurgery ward were not provided with the appropriate orientation handbook. It has been disclosed that the orientation handbook had not been updated for a considerable period of time.

(b) the clinical staffing and organisation structures at the hospital

i) Nursing staff

On the evening Vanessa died, there were three (3) nurses in a Step Down Neurosurgical Ward, that is Ward 7B which was virtually full.

Warren and Michelle have been told that Ward 7B was adequately staffed with nurses, however they believe it was woefully inadequate, particularly when the following is taken into account:

a) Neurosurgical patients, by virtue of their injuries and conditions can deteriorate at any time. An emergency may require multiple nurses to attend to the patient, leaving other seriously ill patient without nursing cover.

b) At the time of Vanessa's admission, there were two (2) High Dependency Unit beds vacant as there was not enough nursing staff to enable those beds to be filled.

ii) Medical Staff

Those in control of the neurosurgery ward were inexperienced, with a cumulative length of about 2 weeks experience on the neurosurgery ward.

There was little support available from senior medical staff for these junior medical officers. Two (2) RMOs were in Melbourne on a regular training exercise, and the other Registrar was in the operating theatre all day.

In addition, due to this shortage the Registrar on duty had been working for a number of days and was too tired to respond to questions from junior medical staff. This resulted in Vanessa not being given anti-convulsant medication.

Medical officers that were overseas trained and who may not have had the requisite knowledge were not provided with appropriate senior support. Warren and Michelle believe this resulted in Vanessa being given opiates, in conjunction with Panadeine Forte when she had suffered a closed head injury.

c) the efficiency, effectiveness and appropriateness of resource allocation and utilisation within the hospital, and in particular the operation of the Emergency Department.

No submission is made.

d) the effectiveness of complaints handling and incident management at the hospital.

Following Vanessa's death the family were treated with little empathy or consideration by senior management.

Meetings with Warren and Michelle, which were requested by RNSH management, were held on the grounds of RNSH, even though they had requested the meetings be held off site.

Verbal disputes between medical staff and management occurred in front of Vanessa's parents. Some RNSH staff members were disinterested in the process; to the extent one senior staff member appeared to be asleep during the meeting.

In addition incorrect and/or incomplete information was provided to Vanessa's parents about what occurred the night she passed away. For example, it was not until the Autopsy Report was provided to Warren and Michelle that they were made aware that at 0100 am on the day of her death she was found unable to move for a period of minutes, following which she had no recollection of the event.

All of these factors have added to and prolonged the suffering of the Anderson family.

e) operational management of Royal North Shore Hospital in general but in particular, the interaction between area and hospital management as it relates to hospital efficiency.

No submission is made.

In response to all of the terms of reference, Warren and Michelle Anderson also wish to bring to the attention of the Committee that the problems or difficulties at RNSH are not unknown to the government.

Six (6) months prior to the death of Vanessa Anderson, Professor Lali Skehon wrote to the then NSW Health Minister, Honourable Member John Hatzistergos about the problems that were beleaguering RNSH. It was these problems that caused Professor Skehon to resign his position and to practice overseas.

It was not until Vanessa passed away that Professor Skehon's letter was responded to by the Honourable Member John Hatziergos.

The issues at RNSH need to be addressed to ensure that patient's are cared for in an appropriate manner, and to ensure that competent staff are not lost from the NSW, and Australian Health system.

Melanie Palmer
Of McLaughlin & Riordan Solicitors
Solicitor for Warren and Michelle Anderson