Health Care Complaints Commission

STATEMENT OF DECISION

Respondent:	**Ms Dianne Reader**

1. Background

1.1. On 8 October 2020, the Health Care Complaints Commission (**Commission**) received a complaint from NSW Health Pathology (**NSWHP**) advising that Ms Dianne Reader, a Senior Technical Officer in the Anatomical Pathology Laboratory at Royal North Shore Hospital (**RNSH**), was subject to an internal investigation due to concerns that she had tampered with patient samples (by swapping tissue samples from different patients) already processed by another staff member.

1.2. NSWHP was concerned that by her conduct, Ms Reader intended to discredit the other staff member by creating the impression of errors in her work. NSWHP Pathology identified the matter as a Reportable Incident because the sample swapping could have had serious implications for patient safety where diagnostic findings could be attributed to incorrect patients.

2. The Respondent

2.1. Ms Reader is 61 years old. Ms Reader has worked in pathology for over forty-one (41) years at Royal North Shore Hospital in the Anatomical Pathology Department. Ms Reader commenced as a trainee Technical Officer on 2 April 1979 and was later classified as a Senior Technical Officer.

2.2. According to Ms Reader's resume:

- As a Technical Officer, Ms Reader's responsibilities included maintaining laboratory manuals and laboratory equipment, training of all staff, co-supervising the Quality Assurance program, testing of new laboratory techniques, evaluation of new equipment, problem solving AUSLAB specimens (processing, staining and equipment), supervising the mortuary (when the Team Leader was unavailable), and reviewing and modifying all staining techniques for optimum performance.

- She attained a Pathology Technician Certificate in 1981, a Pathology Technician Higher Certificate in 1983 and a Certificate IV in Business (Frontline Management) in 2003. In addition to working at RNSH, Ms Reader has held teaching positions at the University of Technology Sydney and TAFE.

- She holds membership with the Histopathology Group of NSW and the ANZESS – Forensic Society.

2.3. NSWHP reported that Ms Reader trained many staff during her employment, many of which are now more senior to her due to their qualifications and positions held in the organisation.

2.4. Ms Reader's employment with NSWHP was suspended on 26 June 2020.

2.5. At the conclusion of its investigation, NSWHP terminated Ms Reader's employment on 9 June 2022.

2.6. As a non-registered health practitioner providing pathology services, Ms Reader is subject to the Code of Conduct set out in Schedule 3 of the *Public Health Regulation*

2012 (**Code of Conduct**) (as published at the time of the incidents and up to 31 August 2022).

2.7. Ms Reader has been subject to an interim protection order issued by the Commission pursuant to s41AA of the *Health Care Complaints Act 1993* (**the Act**) since 6 November 2020. The terms of the interim protection order are:

Ms Dianne Reader must not under any circumstances provide, or cause to be provided, health services, either in paid employment or voluntarily, to any member of the public.

3. Issues

3.1. The Commission's investigation focused on whether Ms Reader has breached the Code of the Conduct (as published at the time of the incidents and up to 31 August 2022) and whether she poses a risk to the health or safety of members of the public.

3.2. The relevant clause of the Code of Conduct (as published at the time of the incidents and up to 31 August 2022) is:

- 3(1): *A health practitioner must provide health services in a safe and ethical manner.*

4. Investigation

4.1. The Commission relies on the extensive evidence accumulated by NSWHP during the course of its investigation.

5. Summary of Evidence

Background

5.1. After tissue samples from organs (gall bladders, appendix and uterus) are extracted, or after whole organs have been removed from patients, they are processed by the Anatomical Pathology Department Laboratory (**the Laboratory**) as follows:

- Tissue samples are removed from patients and placed in formalin fixative in a sample pot.
- Samples are accessioned into the laboratory system and given a unique number (P number)
- Cassettes are printed and placed with the pot.
- Samples are macroscopically examined by cut up staff who describe the sample into a dictation system, dissect the sample and place the tissue into the cassette ready for processing.
- Cassettes are placed in racks and loaded onto the tissue processor (Peloris). Tissue processing is the procedure of removing water from cells and replacing it with paraffin wax. This happens overnight with the processors ready to access by 6am.

- Tissue is then embedded in appropriately sized moulds in a paraffin wax medium and allowed to solidify.

- Tissue is then thinly sliced on a microtome, floated on a water bath and placed on a glass slide.

- The slide is stained and is able to be viewed under a microscope for diagnosis by a pathologist.

5.2. All patient information and the pathology results are entered onto the Australian Laboratory Information Management System (**AUSLAB**). AUSLAB can only be accessed via password/log on.

5.3. Ms Reader was required to access the AUSLAB system as part of her role as a Senior Technical Officer.

5.4. Staff at the Laboratory identified that tissue samples had been swapped on 19 March 2020, 25 May 2020, 23 June and 25 June 2020, when a scientific staff member, Employee A, was on specimen cut up duty. Following the second incident on 25 May, Employee A was devastated that she appeared to have made another mistake (specimen interchange), and she requested that she take a break from cut up duties. Employee A was removed from cut up for a period of approximately three (3) weeks.

5.5. When Employee A returned to cut up duties on 23 June 2020, Senior Register E supervised the cut-up. Employee A took photographs of her work prior to submission. Another Supervisor also photographed the samples prior to them being placed in the processor.

5.6. On 23 June 2020, when the samples were removed from the processor, it was identified that there had been a swap of the tissue samples between the cassettes prepared by Employee A. Those cassettes did not match the photographs of the samples prepared by Employee A when the samples were submitted.

5.7. On 23 June 2020, this process was repeated, with Employee A preparing and photographing her work and a Supervisor photographing the samples prior to them being placed in the processor. The following day, when the samples were removed from the processor, it was again identified that the tissue samples had been swapped between cassettes.

5.8. In every instance where tissue interchange had occurred, Ms Reader was the staff member who had unpacked the tissue processor. It was also apparent that Ms Reader accessed the patient cases associated with the mixed-up specimens on the AUSLAB record system before her shift started on the days when the incidents of tissue interchange occurred, and, that Ms Reader's access to the patient records was unrelated to the course of her duties at that time.

NSWHP's investigation

5.9. The investigators identified a pattern of conduct whereby Ms Reader accessed cases on the AUSLAB system (prior to her 6.00am shift start time and for no reason associated with

her own work) to identify tissue samples including appendices, gallbladder, products of conception (**POCs**) and curettings (usually low risk / non-urgent specimens), that had been cut up by Employee A. The audit confirmed that there were no instances of early morning access to the AUSLAB system on days when Employee A was not rostered on cut up. In each case of specimen interchange, Ms Reader had accessed Employee A's case on AUSLAB beforehand.

5.10. On 26 June 2020 allegations of unsatisfactory behavior in relation to the processing of tissue samples and accessing the AUSLAB record system were put to Ms Reader. Ms Reader participated in recorded interviews on 3 and 29 July 2020 during which she said that she liked to start early before her shift start but that she was never alone because staff were always coming in and out. In summary, Ms Reader said:

- she only accessed AUSLAB on 23 June 2020 because she had noticed a few blocks/cassettes were out of order and she wanted to see what number of cassettes /blocks there were and put them in the appropriate basket.
- she only accessed AUSLAB on 25 June 2020 because she had knocked over the baskets of cassettes and needed to check that she had picked up all the cassettes.
- she only accessed AUSLAB on 28 February 2020 to make sure the cassettes were on the right list.
- in respect of accessing cases on AUSLAB on 25 May 2020, anyone could have used her computer whilst she was logged into AUSLAB.
- she accessed AUSLAB to check the cassettes and to see if they had been placed in the right basket, or may have been asked by the 'embedders' to check the cases whilst they were embedding.
- she only accessed AUSLAB on 16 April 2020 to make sure the cassettes were in the right basket.
- she only accessed AUSLAB on 6 May 2020 to check the 8am basket.
- she only accessed AUSLAB on 13 May 2020 to check the cassettes were on the 8am list.
- denied that she had ever interchanged specimens and could not explain how it may have happened.

5.11. Investigators completed an audit /review of Ms Reader's access to the AUSLAB system (for cases involving gallbladder, appendix, POC, curettings and placentas, during the period 1 January 2020 to 30 June 2020 between the hours of 5:30am until 6.30am.

5.12. On 3 July 2020 NSWHP conducted recorded interviews with the following staff members:

Employee B, Laboratory Manager

- Employee B said that there was no reason for Ms Reader to access the patient records on AUSLAB.
- On 22 June 2020 Senior Registrar E observed Employee A at her first shift back on cut up (after her three week break), to ensure that no mistakes were being made.
- Employee B's recollection of Employee A's cutting was identical to photos taken by Employee A of the Patient A specimen at 1.19pm and Patient B specimen at 1.57pm showing the form, jar and tissue of each specimen immediately after she had cut them up, leading Employee B to conclude that interchange of the samples took place after the photos were taken.
- On 24 June 2020 Employee B took photos of Employee A's cut up at 6pm due to the multiple incidents of tissue exchange. Employee B lay down the cassettes and opened them in order to take the photo, laying them in the same order as they had been in the specimen basket. The next day Employee B took a further

photo at 10am before the specimens were embedded. Employee B determined that the specimens in the cassettes presented differently to the way they had the previous evening. Employee B said “I can’t see any reason how it happened except someone purposely moved it into the wrong cassette”.

Employee C, Hospital Scientist

- Employee C said there was no reason for Ms Reader to access the patient records on AUSLAB.
- Employee C said the working relationship between Ms Reader and Employee A “can be frosty”.
- Employee C said that they became suspicious when Ms Reader was only looking up gall bladders and appendices on AUSLAB on the mornings after Employee A had been cutting up.
- Employee C took a photo of Employee A’s cut up on 22 June 2020 at 7.08pm, and then a further photo of the stained slide and corresponding embedded tissue at 4.33pm on 23 June 2020. The cases presented differently to how they had been prepared at cut up.

Employee A, Scientific Technical Officer

- It was not until 22 June 2020 (after multiple incidents of tissue interchange) that Employee A started taking photos of her work immediately following cut up.
- Following the specimen interchange on 25 May 2020, Employee A started to gather all the time stamps from when she dictated the records for each specimen and she began looking at who had accessed the relevant patient accounts. Employee A said that this is when she noticed that Ms Reader had been accessing the patient accounts on the AUSLAB system before each tissue interchange had occurred. Employee A then reported her concerns to Employee C.
- Employee A took a 3 week break from cut up. Employee A returned to cut up on 22 June 2020 and was supervised by Senior Registrar E during cut up.
- Employee A took photos of her cut up work on 22 June 2020 and 24 June 2020.
- On 3 July 2020 the photos taken by Employee B on the evenings of 24 June 2020 and 25 June 2020 showing a mix up of two patient’s specimens, was shown to Employee A. In response Employee A was able to show the photos she had taken of each specimen immediately after she had cut them up and before any specimen interchange had occurred.

Employee D, Technical Officer

- Employee D said that looking into AUSLAB records is not part of a technician’s morning routine. It is not usual practice to check the specimens as it is assumed that everything is in the correct place.
- Employee A was suspicious that she was being framed. There had been several ‘mix ups’ from her before.

Senior Registrar E

- Senior Registrar E watched Employee A cut up the specimens on 22 June 2020 and said that she had no concerns with Employee A’s process, with Exhibit 6 showing Employee A’s work as she saw it being done. Senior Registrar E did not have any concerns with Employee A’s work.
- Senior Registrar E suggested that any mix-up of the specimens may have taken place after the photos were taken, possibly when they were being removed from the tissue processor.

5.13. Additional incidents of tissue exchange on 19 March 2020, 16 April 2020 and 6 May 2020 were identified during the audit and the further allegations were put to Ms Reader on 23 September 2020. Ms Reader provided a written response of 2 October 2020 in which she stated that:

- She did not tamper with the specimens in the cassettes and there would have been no need for her to open the cassettes
- She did not open any cassettes or interchange the contents in them

NSWHP's findings

	Allegation	***Finding***
1.	On 23 June 2020 Ms Reader accessed AUSLAB for five (5) patient records between 5:47am and 5:49am.	Substantiated. Ms Reader admitted to accessing the records on 23 June 2020. There is no evidence to support that cassettes were out of order as claimed by Ms Reader or that she was required to access to access AUSLAB to look at the patient records. The investigators found Ms Reader to be an unreliable witness.
2.	On 23 June 2020 Ms Reader accessed two (2) cassettes and interchanged tissue specimens (gallbladder and appendix) initially processed by Employee A.	Substantiated. Employee A had just had two weeks off because she was distressed about previous mistakes made on the cutting table on 25 March 2020. This further incident occurred on her first day back at the cutting table (22 June) and whilst Senior Registrar E observed her. Senior Registrar E specifically recalled P11249 (appendix) and that cut up was completed with no mistake because there were three (3) blocks stacked A1, A2 and A3 and their recollection of the case was identical to the photo taken by Employee B prior to loading onto the tissue processor on the evening of 22 June 2020. Evidence confirms the tissue processor was uninterrupted until drained the next morning at 5.41 am and 5.43 am. Ms Reader was the staff member who had unpacked the tissue processor. Based on the evidence the error did not occur at cut up or prior to loading the specimens on the tissue processor.
3.	On 25 June 2020 Ms Reader accessed the AUSLAB system for ten (10) patients unrelated to the course of her duties.	Substantiated. The AUSLAB audit confirms that Ms Reader accessed results management for 10 patient records between 5.44am and 5.49 on 25 June 2020.

		Ms Reader admitted to accessing the records and maintained that she accessed the records in the course of her duties. The investigators accepted evidence from Employee B and Employee C that there was no reason for Ms Reader to access AUSLAB to look at the patient records.
4.	On 25 June 2020 Ms Reader accessed two (2) cassettes, initially processed by Employee A, and placed one piece of appendix in with a gallbladder case.	Substantiated. Ms Reader was the staff member who had unpacked the tissue processor. The photos taken by both Employee A and Employee B demonstrate that the specimens for Patient C and Patient D were interchanged after being unloaded from the tissue processor on the overnight run and prior to being embedded. The investigator noted that Ms Reader denied the allegation but found no reason for the interchange without someone purposely moving the section into the wrong cassette. The error was not detected by the embedder and Ms Reader reported the error to Employee B bringing the slides with her to raise the error. Based on the evidence the investigators found it more likely than not that Ms Reader interchanged the specimens.
5.	On 25 June 2020 Ms Reader reported that she found an error to her supervisor Employee B.	Substantiated. Ms Reader admitted that she reported the error to Employee B but said she did not know that Employee A had been responsible for the cut up. Investigators found that because Ms Reader accessed the patient records for two patients on 25 June 2020 she would have been aware that Employee A had attended to the cut up of each specimen. Further the roster and allocated tasks is always accessible to all staff.
6.	On 28 February 2020 Ms Reader accessed the AUSLAB laboratory information system for three (3) patient records unrelated to the course of her duties at that time.	Substantiated. The AUSLAB audit confirms that Ms Reader accessed results management for three (3) patient records between 5:49 and 5:55 on 28 February 2020 cut up by Employee A - all gallbladder.

		Ms Reader admitted to accessing the records and maintained that she accessed the records in the course of her duties. Employee B and Employee C provided evidence that that they could see no reason for Ms Reader to access AUSLAB to look at the patient records.
7.	On 28 February 2020 Ms Reader accessed two (2) cassettes and interchanged tissue specimens (gallbladder and lymph node) initially processed by a work colleague.	Not substantiated due to insufficient or inconclusive information. Ms Reader was the staff member who had unpacked the tissue processor. Employee A had not taken photos of the specimens immediately after cut up. In this instance, despite finding Ms Reader to be an unreliable witness, the investigators were not able to conclusively determine that interchange of the patient samples occurred as a result of human intervention rather than by human error.
8.	On 13 March 2020 Ms Reader accessed the AUSLAB laboratory information system on five (5) patient records unrelated to the course of her duties at that time.	Substantiated. The AUSLAB audit confirms that Ms Reader accessed results for five (5) gallbladder and appendix cases on the AUSLAB system between 5:58am and 10:40am. Ms Reader admitted to accessing the records and maintained that she accessed the records in the course of her duties. Employee C and Employee B could see no reason for Ms Reader to access AUSLAB to look at the patient records.
9.	On 13 March 2020 Ms Reader accessed two (2) cassettes and interchanged tissue specimens (gallbladder and appendix) initially processed by Employee A.	Not substantiated due to insufficient or inconclusive information. Ms Reader denied the allegation. Ms Reader was the staff member who had unpacked the tissue processor. Employee A had not taken photos of the specimens immediately after cut up. In this instance, despite finding Ms Reader to be an unreliable witness, the investigators were not able to conclusively determine that interchange of the

		patient samples occurred as a result of human intervention rather than by human error.
10.	On 25 May 2020 Ms Reader accessed the AUSLAB laboratory information system on four (4) patient records unrelated to the course of her duties at that time.	Substantiated. The AUSLAB audit confirms that Ms Reader accessed results management for four (4) patients on 25 May 2020 between 5:52 and 6.38am as part of this allegation. Ms Reader admitted to accessing the records and maintained that she accessed the records in the course of her duties. Employee C and Employee B could see no reason for Ms Reader to access AUSLAB to look at the patient records.
11.	On 25 May 2020 Ms Reader accessed two (2) cassettes, initially processed by Employee A and placed one piece of appendix in with another piece of appendix.	Substantiated. Ms Reader denied the allegation. Ms Reader was the staff member who had unpacked the tissue processor. Employee A's evidence was that by this point, she was devastated and confused by her apparent mistakes. She had sought advice from Senior Registrar E and was being diligent throughout the cut up process. Employee A provided detailed evidence about her process and how she would always wait for the cassette/block to be printed and place the tissue in it before moving on and would never have two (2) cases on the bench at once. Senior Registrar E gave evidence that it was unlikely that the error would have occurred at cut up because it would be very difficult to mix up the A1 and A3 cassettes. Based on available evidence, noting the usual circumstance of the specimen interchange into from cassette A1 to A3, the advice given by Employee A that she never has two (2) cases on the bench at once and Ms Reader's pattern of behavior, the investigators found it more likely that not, that Ms Reader interchanged the specimen. .
12.	On 19 March 2020 Ms Reader accessed AUSLAB laboratory information system for four (4) patient	Substantiated.

	records unrelated to the course of her duties at that time.	The AUSLAB audit confirms that Ms Reader accessed results management for four (4) patient records between 5.55am and 7.42 on 19 March 2020. Ms Reader advised that she would have checked the 8am list to ensure all the blocks were there. The AUSLAB audit confirms that the 8.00am list was not printed until 5.59am, which does not explain why Ms Reader accessed 3 patient cases at 5.55am.
13.	On 19 March 2020 Ms Reader accessed two (2) cassettes and interchanged tissue specimens (both POC) initially processed by Employee A.	Not substantiated due to insufficient or inconclusive information. Ms Reader denied the allegation. Ms Reader was the staff member who had unpacked the tissue processor. The investigators were not able to conclusively determine that interchange of the patient samples occurred as a result of human intervention rather than by human error.
14.	On 16 April 2020 Ms Reader accessed AUSLAB laboratory information system for seven (7) patient records unrelated to the course of her duties at that time.	Substantiated. The AUSLAB audit confirms that Ms Reader accessed results management for eight (8) cases on 16 April 2020 between 5.45am and 5.47am. Ms Reader admitted to accessing the records and maintained that she accessed the records in the course of her duties. Employee C and Employee B could see no reason for Ms Reader to access AUSLAB to look at the patient records.
15.	On 16 April 2020 Ms Reader accessed two (2) cassettes and interchanged tissue specimens (gallbladder and appendix) initially processed by Employee A.	Not substantiated due to insufficient or inconclusive information. Ms Reader denied the allegation. Ms Reader was the staff member who had unpacked the tissue processor. The investigators were not able to conclusively determine that interchange of the patient samples occurred as a result of human intervention rather than by human error.
16.	On 6 May 2020 Ms Reader accessed AUSLAB laboratory information	Substantiated.

	system for five (5) patient records unrelated to the course of her duties at that time [one of patients was accessed by Ms Reader on the following day on 7 May 2020].	The AUSLAB audit confirms that Ms Reader accessed results management for 5 patients on 6 May 2020 between 5.46am and 5.47am. Ms Reader admitted to accessing the records and maintained that she accessed the records in the course of her duties. Employee C and Employee B could see no reason for Ms Reader to access AUSLAB to look at the patient records.
17.	On 6 May 2020 Ms Reader accessed two (2) cassettes and interchanged tissue specimens (2 x appendix) initially processed by a work colleague.	Not substantiated due to insufficient or inconclusive information. Ms Reader denied the allegation. Ms Reader was the staff member who had unpacked the tissue processor. In this instance, despite finding Ms Reader to be an unreliable witness, the investigators were not able to conclusively determine that interchange of the patient samples occurred as a result of human intervention rather than by human error.
18.	On 13 May 2020 Ms Reader accessed AUSLAB laboratory information system for two (2) patient records unrelated to the course of her duties at that time.	Substantiated. The AUSLAB audit confirms that Ms Reader accessed results management for 2 patients on 13 May 2020 at 5:42am and a second time at 8:52am both being appendix cases. Employee C and Employee B could see no reason for Ms Reader to access AUSLAB to look at the patient records.
19.	On 13 May 2020 Ms Reader accessed two (2) cassettes and interchanged tissue specimens (both appendix) initially processed by a work colleague.	Not substantiated due to insufficient or inconclusive information. Ms Reader denied the allegation. Ms Reader was the staff member who had unpacked the tissue processor. The investigators were not able to conclusively determine that interchange of the patient samples occurred as a result of human intervention rather than by human error.
20.	On 25 May 2020 Ms Reader accessed two (2) cassettes and interchanged tissue specimens (both	Not substantiated due to insufficient or inconclusive information.

	curetting) initially processed by a work colleague.	Ms Reader denied the allegation. The investigators were not able to conclusively determine that interchange of the patient samples occurred as a result of human intervention rather than by human error.

5.14. Of the 20 allegations against Ms Reader, NSWHP found 13 of allegations proven.

5.15. In summary NSWHP found that Ms Reader initiated early morning searches of [perceived low risk specimens] gallbladder and appendix samples on days after Employee A had been rostered to cut up specimens. The cases included appendices, gallbladder, POCs and curettings. On each occasion that Ms Reader searched AUSLAB she accessed cases that had been cut up by Employee A the day before and there was no legitimate work-related reason for her to access the cases.

5.16. The audit of the AUSLAB system confirmed that there was no early morning access by Ms Reader (or any other staff) when Employee A had not been rostered on to cut up the day before. The audit confirmed that 43 patient records were accessed and 20 specimens interchanged.

5.17. In each instance that specimen interchange occurred, Ms Reader had accessed the relevant case on the AUSLAB system and she was the staff member who had unpacked the tissue processor. The investigators found that it was likely that Ms Reader accessed the cases on AUSLAB in order to plan which specimens to interchange.

5.18. Ms Reader was found to have interchanged tissue specimens on 3 occasions: 25 May 2020, 23 June 2020, 25 June 2020.

- In the case of the specimen interchange on 23 June 2020, Senior Registrar E supervised Employee A attending to the cut up and reported no errors; Employee took photos of the specimens after she had completed the cut up and compared these with photos she took of the specimens the following day before they were embedded; and Employee C also took before and after photos of these specimens without Employee A knowing. Both sets of photos showed that the cases presented differently to how they had been prepared at cut up.

- In the case of the specimen interchange on 25 June 2020, again Employee had taken photos of the specimens immediately after cut-up and again the following day before they were imbedded. Before and after photos had also been taken by Employee B. Again, both sets of photos showed that the cases presented differently to how they had been prepared at cut up.

5.19. There was insufficient evidence to establish that Ms Reader had interchanged tissue specimens on 28 February 2020, 19 March 2020, 16 April 2020, 13 May 2020, 6 May 2020 and 25 May 2020, despite the fact that she accessed the relevant patient records on the AUSLAB system early in the morning on each of these days. The investigators in part attributed the difficulty in establishing who interchanged the tissue samples on these days to the lack of time stamps recorded for each case dictate at cut up.

5.20. Ms Reader had been relied upon to present for work early and this provided an opportune time for her to access systems unrelated to the course of her duty.

5.21. Following the discovery of the incidents of tissue exchange, the Laboratory made four (4) formal disclosures to patients where the potential for clinical harm could be identified. The patients were informed that a misdiagnosis occurred during the pathology medical examination and a multidisciplinary team met to discuss whether or not the patients' treatment plans would need to be changed. In the case of Patient X, based on the incorrect sample (uterine curettings) she was diagnosed with endometrium associated with a glandular polyp, while the correct specimen showed she was suffering from endometrial hyperplasia. At the disclosure meeting with her treating clinicians the patient's scheduled hysteroscopy was changed to a hysterectomy. Fortunately, following the hysterectomy there was no evidence of malignancy.

5.22. NSWHP found that Ms Reader had breached the following policies and procedures:

- Clauses 4.1, 4.2 and 4.3 of the NSW Health Policy Directive PD2015_049 - Code of Conduct which requires staff to promote a positive work environment which require staff to, respectively, promote a positive work environment, demonstrate honesty and integrity, and to act professionally and ethically.

- NSW Health PD 2009_076, Communications- Use and Management of Misuse of NSW Health Communications Systems, because Ms Reader did not use AUSLAB as intended.

- Fraud and Corruption Control NSWHP PD_024 in that Ms Reader misused her position at NSWHP to make it appear that Employee A had been making multiple mistakes.

- Prevention and Management of Workplace Bullying in NSW Health Policy Directive PD2018_016 because Ms Reader systematically targeted Employee A and was intended to be humiliating and threatening.

6. Submissions

6.1. The Commission wrote to Ms Reader on 10 January 2023 proposing to take action under section 41A and section 41B of the Act and inviting submissions under section 40 of the Act. Ms Reader was provided with a draft copy of the Commission's Statement of Decision.

6.2. On 2 February 2023 a representative from the Health Services Union wrote to the Commission seeking a three month extension for Ms Reader to make submissions because she was undertaking medical treatment. The Commission allowed Ms Reader until 7 April 2023 to lodge any submissions.

6.3. The Commission received submissions from Ms Reader on 5 April 2023. Ms Reader denied the allegations in their entirety and argued that she looked up samples on the AUSLAB system to check for errors, and that the reason she attended the lab early each morning was because she had to take her husband to medical appointments. Ms Reader also inferred that the mistakes could have been made with the tissue samples because "staff would open more than one cassette at a time which is a dangerous habit".

6.4. Ms Reader's submissions have been considered in determining the outcome of the investigation.

7. Findings

7.1. The Commission considered the evidence obtained by NSWHP and concurs with its findings that Ms Reader, on multiple occasions, accessed patient records on the AUSLAB system to identify tissue samples that had been cut up by her colleague Employee A, and then took steps to swap the specimens.

7.2. The Commission considers that Ms Reader has not offered any plausible alternate explanation for why she accessed the AUSLAB system on each of the identified dates, and nor has she provided any feasible explanation for how the tissue specimens came to be interchanged.

7.3. The Commission accepts the evidence of Employee C and Employee B that Ms Reader had no reason to access and check the AUSLAB patient records in the course of her usual duties at the relevant times. The Commission is of the view that it was unlikely that the tissue samples were interchanged due to staff error, preferring the evidence of Employee A who said that she never had two (2) cases on the bench at once. Furthermore, Senior Registrar E gave evidence that it was unlikely that the error would have occurred at cut up because it would be very difficult to mix up the A1 and A3 cassettes.

7.4. The Commission is of the view that Ms Reader's conduct was motivated by a desire to target and discredit her colleague, Employee A.

7.5. Ms Reader repeatedly engaged in conduct that demonstrated a flagrant disregard for patient health and safety. Ms Reader's improper access to patient records amounted to a breach of patient privacy and the misuse of patient information. Furthermore, by interchanging patient tissue samples Ms Reader may have prevented the correct diagnosis of a patient, potentially leading to serious adverse consequences for the patients involved.

7.6. Accordingly, the Commission considers that Ms Reader has breached clause 3(1) of the Code of Conduct (as published at the time of the incidents and up to 31 August 2022) by failing to provide a health service in a safe and ethical manner.

7.7. The Commission considers that Ms Reader poses a risk to the health or safety of members of the public because she was prepared to risk patient safety in order to discredit her colleague.

8. Decision

8.1. In the absence of any admissions, remorse or insight into her conduct despite the overwhelming evidence, the Commission is of the opinion that the only way at present to manage the risk posed by Ms Reader is by making a permanent prohibition order against her in the following terms:

Ms Dianne Reader is permanently prohibited from providing, or causing to be provided, any health services, either in paid employment or voluntarily, to any member of the public.

For the purposes of this order 'a health service' carries the same meaning as defined under section 4 of the Act.

8.2. The Commission also issues the following public statement, under section 41A(2)(b) of the Act:

*The Health Care Complaints Commission (**the Commission**) conducted an investigation into the conduct of Ms Dianne Reader, a Senior Technical Officer in the Anatomical Pathology Laboratory at Royal North Shore Hospital.*

The investigation found that Ms Reader repeatedly engaged in conduct that demonstrated a flagrant disregard for patient health and safety. On multiple occasions Ms Reader accessed patient records in order to identify patient tissue samples that had been cut up by her colleague Employee A, and then took steps to swap the specimens. Ms Reader did this to undermine, discredit and to cause harm to the mental health and wellbeing, and employment, of Employee A.

In her role as a Senior Technical Officer working in Pathology, Ms Reader was afforded significant trust by patients and the wider community. Her actions had the potential to result in significant adverse outcomes for patients. The Commission considers that Ms Reader has breached clause 3(1) of the Code of Conduct made under Schedule 3 of the Public Health Regulation 2012 (as published at the time of the incidents and up to 31 August 2022) by failing to provide a health service in a safe and ethical manner.

The Commission also considers that Ms Reader poses a risk to the health and safety of members of the public.

Accordingly, the Commission has permanently prohibited Ms Reader from providing any health services in any capacity.

8.3. The Commission has decided to make this Statement of Decision publicly available, under section 41B(3)(c) of the Act.

8.4. Under section 41D of the Act, the Commission will provide a copy of this Statement of Decision to:

- The Australian Health Practitioners Regulation Agency (**AHPRA**); and
- Each Professional Council in NSW.

Tony Kofkin
Executive Director, Complaint Operations

4 May 2023