STATEMENT OF MARTIN JOHN BRENNAN of address known to the Queensland Nurses' Union of Employees

Qualifications and experience

1. I am a Registered Nurse licensed to practise in the State of Queensland. I have been registered since 1982.

Patient names

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

Background

3. I am employed by Queensland Health and have worked as a clinical nurse in the Intensive Care Unit ("ICU") of the Bundaberg Base Hospital since 1991, approximately 14 years. Prior to this I worked in the UK as a registered nurse.

Patient P26

4. On 23 December 2004, P26 returned from theatre following surgery received for a groin injury sustained in a motor bike accident. On return we could not find a pulse in his left leg. We contacted medical staff including Dr Anthony Athanasiouv who was the Surgical Registrar, as we were concerned for this patient and felt the patient couldn't be managed in Bundaberg and needed to be transferred. After he examined the leg he said the patient needed to go to Brisbane, for specialised vascular management.

5. I believe Dr Anthanasiouv was in the process of contacting Brisbane when Dr Patel gave him the instructions to keep the patient in Bundaberg and he would take him back into theatre himself. Dr Anthanasiouv reversed his position and the patient was not transferred. Shannon Mobbs returned to theatre for two further operations that night. I had gone off duty when the patient returned from theatre the third time.

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6. Vascular surgery is highly specialised and we had no vascular surgeon available in Bundaberg. I feel that the patient's management was compromised by this decision. I spoke to Dr Carter about this, and he said something to the effect that another surgeon could not have done anything more. I also spoke about this with other unit staff including Nurse Unit Manager Toni Hoffman.

Death of the patient P21

7. On Sunday 19 December 2004, I was the nurse in charge of the ICU on a 12 hour night shift starting at 1900 hours finishing 0730 hours. One of the patients was a Mrs P44. This lady had a cerebral bleed and was critically ill on ventilatory life support. At handover we were told that some family members would be arriving around 2200 hours and that Dr Patel wanted the ventilator switched off after they had seen her. No brain death tests had been performed. The unit was full and very busy. There were no other patients able to be moved out to provide a bed for any other admission.

8. The nursing staff and Principal House Officer on duty for the ICU were unhappy about switching the ventilator off without formal brain death tests and the Consultant on call for ICU, Dr Jon Joiner, was contacted at home. He said he was not prepared to have the ventilator switched off.

9. The next morning, Monday 20 December, at about 0700 Dr Patel came into the unit. When he saw P44 was still there he became agitated and angry and demanded to know why she had not been turned off as he had instructed. I was aware that he had a patient booked to come to ICU that day after he had performed an oesophagogastrectomy on that patient. I told him we could not switch patients off without the proper tests and that he might have to postpone his planned operation. He said something to the effect that he had to do the operation that day as he was due to go on holidays in a few days and walked off angrily into theatre.

10. When I returned to duty that evening I found that P44's ventilator had been turned off and she had died at 0900hrs. I later spoke to Dr Martin Carter, the Director of ICU, about this patient. I told him I was unhappy that no brain death tests etc had

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been performed and the staff felt the ventilator had been turned off 'with indecent haste to clear a bed for Dr Patel's patient'. He told me he did not see any problem with what had occurred.

11. That same night, Monday 20 December, when we came on duty at 1900, the patient Dr Patel had performed an oesophagogastrectomy on, P21 had just returned to theatre for a second operation to try and control extensive haemorrhaging following his first op. After about an hour I received a call from theatre to get P21's family to the hospital and to bring them to theatre for Dr Patel to talk to. I brought them into theatre and was with them when Dr Patel spoke to them. He told them he had opened the patient up again and that he had checked his original surgery and it was 'perfect, no problems'. He repeated this numerous times while talking to them. He told them he could not stop the bleeding and could not find where he was bleeding from. He said perhaps he might have had an undiagnosed aortic aneurysm and bled from that. He repeated he did not know why he was bleeding. P21 returned to ICU. He continued to bleed heavily during the night and died the next morning at 9:30, after I had finished on duty.

12. That morning, 21 December, Dr Patel came into the unit around 0700 hours. He told us that when P21 died, there would be no need for a coroner's case as he knew what he had died from and would be prepared to write a death certificate. I was unhappy with this and spoke to Dr Dieter Berens, consultant anaesthetist, and Dr Martin Carter, ICU Director. Dieter was adamant it should be a coroner's case, Martin was unsure and when I went off duty they were looking through the Coroner's Act.

13. Around the beginning of April, I felt I needed to refresh my memory in relation to P44's management as I felt I may have to make a statement or give evidence about her case. I located her UR (Unit Record) number and went to locate the chart in the hospital computer system, HBCIS, and found the file tracked to the Executive and listed as unavailable.

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Dr Patel - Behaviours

14. One of the junior doctors in ICU – I don't remember his name – told us in early 2004 that Dr Patel's junior doctors had been instructed by him not to record complications on patients' discharge summaries, for example wound infections and wound breakdowns. This has the effect of problems with Dr Patel's surgery going unnoticed. This was reported to Gail Aylmer in the infection control department.

15. In my dealings with Dr Patel, I had a perception that he was indispensible to the hospital and as such could do what he wanted. On one occasion I heard him say "I can get what I want from Darren as I've just made this hospital $500,000". He would often talk of his extensive experience in different surgical specialties, for example, saying that he had 20 years trauma experience and I have done countless pancreatic operations. I felt this couldn't be true as usually general surgeons do not have extensive experience in one area, or in this case many areas. I could never understand why a US surgeon would come to work in Bundaberg if he was competent as he would have a vastly higher earning capacity in the States.

Patients from Theatre

16. Over a period of time I noticed that many patients that came to us from theatre would have had complications intraoperatively (for example, where a bowel or bladder was nicked during the operation) which were reported verbally to us by theatre nursing staff, but which complications had not been recorded on the patients' operating theatre notes. Dr Patel would either write these notes up himself, or instruct one of his assistant surgeons what to write.

Complaint Culture at the BBH

17. Retrospectively, I feel I should have been more persistent in following up my concerns, but I felt that any complaint would not be acted on due to the way previous incidents had been handled and ignored. I spoke to Dr Carter (ICU Director) and Toni Hoffman about problems and incidents but did not formally document my issues.

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18. I have observed that those more willing to raise these issues are among the newer members of staff and I feel that staff who have been there a long time have become used to not being able change things or have issues addressed.

Dr Patel undertaking complicated procedures

19. Not long after Dr Patel's arrival I became aware that he was undertaking procedures and operations that we did not normally do, for examples Whipple's procedures, and oesophago-gastrectomies. These are normally done at tertiary hospitals that have resources and specialised staff to deal with these cases.

20. I have noticed in the two years that Dr Patel was Director of Surgery that there was a large increase in the number of patients being ventilated and the hours of ventilation recorded. The hours of ventilation increased from an average of less than 100 hours per month to between ~~600~~ 200 – ~~800~~ 300 hours per month. The majority of these patients were patients of Dr Patel's who were either admitted due to the complexity of the operation, that required post-operative management in intensive care, or patients who had developed serious complications following surgery. Since the beginning of April 2005, I have already noticed a drop in this figure.

21. Attached and marked MB1 is a printout of a table of statistics kept by me in the course of my employment in an excel spreadsheet from details in the ICU admission book. These statistics are printed out for the ICU Nurse Unit Manager and attached to cost centre reports submitted by her to the executive each month. The table includes data for the number of ventilated patients each month since July 2004 to April 2005, as well as the number of Ventilated/tubed hours each month. The figures in the row labeled "Ventilated" refers to patient numbers; the figures in the row labeled "Vent/tubed hrs" refers to number of ventilated/tubed hours. The figures show that there was a dramatic decrease in the number of ventilated hours in November 2004, when Dr Patal took a period of leave, and in

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April 2005, which reflects Dr Patal's resignation. It is my recollection that prior to Dr Patal's arrival, the number of ventilated hours per month would rarely exceed 100.

.....Martin Brennan.....
Signed:Martin John Brennan

Date: 18/05/05

I Martin John Brennan do solemnly and sincerely declare that the content of this my statement for the Bundaberg Hospital Commission of Inquiry (this declaration being at the foot of the last page of the statement comprising 6 pages) and I make this solemn declaration conscientiously believing the same to be true and by virtue of the provisions of the *Oaths Act 1867*.

.....Martin Brennan.....
Martin John Brennan

Declaration Taken By:

.....
Lawyer

Date: 18/5/05

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2004/5

	jul	aug	sep	oct	nov	dec	jan	feb	mar	apr	may	jun	total
Total patients	79	56	45	55	54	44	51	52	52	57			545
ICU	35	25	23	26	26	24	32	33	30	35			289
CCU	43	31	22	28	27	20	19	19	20	22			251
Paeds	1	0	0	1	1	2	0	2	2	0			9
Died	4	3	1	4	3	5	3	3	3	2			31
Ventilated	15	12	10	11	3	7	12	10	10	7			97
Vent/tubed hrs	735	812	280	601	85	192	840	331	418	73			4367
Retrieved ICU	3	6	5	5	2	2	6	7	6	4			46
Retrieved CCU	8	8	3	3	2	6	1	5	3	5			44
CVC inserted													0
Inability to admit													0
Unplanned readmission													0
Snake bite	0	0	0	0	1	0	0	2	1	0			4
Overdose	4	0	4	3	3	1	5		5	4			29
CPAP/BIPAP	4	3	2	2	1	5	5	4	7	3			36
													0
MI	14	16	4	10	10	13	6	2	12	11			98
Thrombolysis	2	3	0	3	4	2	1	1	1	5			22
Organ Donation								1					

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