Bundaberg Hospital *Commission of Inquiry*

STATEMENT OF DR DAVID CHARLES RISSON

David Charles Risson, c/- the Dalby Hospital makes oath and states:

Background

1. I graduated from the University of Queensland in 2001 with a bachelor of medicine and bachelor of surgery ("MBBS"). I have received a rural scholarship from Queensland Health. In 2002 and as part of my scholarship, I did my intern year at the Toowoomba Base Hospital. I was then transferred to the Bundaberg Base Hospital ("the Hospital"). In 2003, I was employed at the Hospital as a Junior House Officer ("JHO") and, in 2004, I worked there as a Principal House Officer ("PHO").

2. Since the beginning of 2005, I have been employed as a Senior Medical Officer at Dalby Hospital. I am currently completing the final year of my rural scholarship training.

Time at the Bundaberg Base Hospital

3. In 2003, I was on a basic surgical training program. That program involved me working three months in Accident and Emergency, three months in Anaesthetics and then six months in General Surgery.

4. During my rotation in General Surgery, I worked with Dr Patel. I also worked (for a period of about three months) with Dr Nadine Lowe and Dr Kate Gray, who were Principal House Officers from Brisbane.

5. In 2004, I worked for six months (up until June/July), in the paediatric unit where I was supervised by Dr Chris Ryan and Dr Judy Williams. For the

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second half of the year, I worked as a Principal House Officer in orthopaedics and I was supervised by Dr Robinson.

Dr Patel

6. I first worked with Dr Patel when I was doing my anaesthetics training. I observed that he was a hard worker who put in a lot of hours at the Hospital. Most of the time, he was also supportive of the junior medical staff. I recall that, if you felt out of your depth and had concerns about a patient, you could call him after hours and he would often come to the Hospital and provide advice.

7. I also recall that there were times when Dr Patel could be abrupt. I recall one specific example concerning a patient who had a laparoscopic procedure. Some days after the operation she developed a bile leak. At the time I was the JHO in General Surgery and Dr Lowe was the PHO. Dr Patel requested that the patient be transferred to Brisbane so that staff down there could perform an Endoscopic Retrograde Cholangio Pancreatography (ERCP), to find the source of the leak.

8. I had thought that Dr Patel wanted the patient transferred for definitive treatment, and made the arrangements on that basis. Several days later, I was in theatre with Dr Patel and Dr Lowe. Dr Patel asked me the outcome of the diagnostic test for the patient, and I said that she had been transferred as a surgical patient for definitive treatment. Dr Patel became quite angry. He made clear that he had expected that the patient would return to Bundaberg for surgery. He said he would not work with me ever again, and he said that I should go and see Darren Keating immediately after surgery to work out alternative arrangements.

9. After surgery I went straight to Dr Keating's office and waited to be seen. Dr Patel arrived shortly afterwards and proceeded into Dr Keating's office. I do not know the nature of their conversation. After Dr Patel left, I was called in to see Dr Keating. I can't recall the exact words Dr Keating used but they were

to the effect that the incident would blow over and I would continue to work for Dr Patel. Afterwards, Dr Patel was pleasant to me and there was no animosity.

10. I recall that there was a general view that Dr Patel was reluctant to transfer patients to Brisbane. I recall a few occasions when I dealt with patients whom I thought would be better treated in Brisbane. I cannot now recall the names of the patients.

Clinical Audit

11. When I first started at the Hospital, the surgical teams used the OTAGO surgical audit system to record post-operative complications. When Dr Patel arrived he specifically told me that there was no need to continue using the OTAGO system. He directed that in future we would keep our own written records of any complications that occurred.

12. I had some concerns about the transparency of the audit process that Dr Patel instituted. In my opinion the OTAGO system functioned well and was used in other hospitals for recording, and tracking, post operative complications. On 2 November 2004, I attended a meeting with Dr Keating and Mr Leck about the issues that I had with the transparency of the audit process. Annexed to my statement and marked with the letters "DCR-1" is a copy of ~~Mr Leck's~~ Dr Keating's notes of that meeting.

13. Dr Patel instituted a morbidity and mortality meeting with the surgical staff. At those meeting we would discuss particular cases where there were surgical complications, or deaths resulting from surgery or the patients' pre-existing condition. I recall an instance where I was presenting some statistics for the orthopaedic unit. Dr Patel told me not to worry about the specific figures as they would be held in the corporate office anyway. He said that the time was to be used for case discussions.

Wound Dehiscence

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14. Dr Patel used to have meetings with the surgical staff. I recall that at one of the morbidity and mortality meetings, I discussed a case of wound dehiscence that I had observed involving an orthopaedic patient. The skin sutures had split apart and his wound had reopened. This patient also had an oedema in his leg which contributed to the dehiscence. The precise cause of the dehiscence was never identified but the matter resolved itself.

15. I presented this case at an M&M meeting and at that meeting Dr Patel said to the meeting words to the effect of "we should be careful what we call wound dehiscence and what we class as wound dehiscence". I was concerned at this remark and felt there was an attempt not to record the true incidence of wound dehiscence.

16. I recall that, during my time in General Surgery at the Hospital, there seemed to be considerable concern among the surgical nursing staff about the number of dehiscences, wound infections, and post-operative complications that were occurring. Although it would need an independent audit to show whether the rate was unusually high, it did seem as though wound dehiscence was common. It also seemed as though there was always a patient on the surgical ward with a post-operative complication.

17. I also recall an instance where Dr Patel made a comment to Dr Sanjeev Kariyawasam that he (Dr Sanjeev) might be causing all of the infections. As I recall, Dr Patel made this comment as a joke - but to me it shows that Dr Patel acknowledged that there were a large number of infections at the time.

Mr Kemps

18. I assisted Dr Patel with oesophagectomies whilst I was in Bundaberg. At the time I recall there was a general feeling that it would be better if those operations were carried out in Brisbane, from the point of view that these operations were out of Bundaberg's scope of practice.

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19. I recall assisting in an operation on Gerry Kemps in December 2004. He had had a post operative bleed and I was called in to assist during the second operation. When I arrived Dr Athanasiov and Dr Kariyawasam were also present during that operation. At the time I was working in orthopaedics and I was called in urgently to assist so I went to theatre and when I arrived Mr Kemps was anaesthetised and they were already operating to try and find the source of the bleeding.

20. I was informed that the patient was bleeding post operatively, and his bellovac drain was filling repeatedly during this second operation. During the operation they were unable to control his bleeding and they could not locate the source of the bleeding.

21. I recall that during this operation Dr Patel said words to the effect "maybe I should start thinking about not doing these types of procedures anymore". He seemed quite concerned that he was unable to locate the source of the bleeding. I recall Dr Kariyawasam was making suggestions about where the source of the bleeding was. Everyone present was trying to find out what was going wrong with Mr Kemps.

22. It was a bit of a concern to me that a more junior doctor was making suggestions to the Director of Surgery about where Mr Kemps was bleeding.. That is certainly not a criticism of Dr Kariyawasam. It appeared to me that Dr Patel was out of his depth on this occasion. I can't recall what happened with this patient immediately after surgery, but I don't believe that Dr Patel ever located the source of the bleeding.

23. After the operation I recall that I had a brief discussion with Dr Dieter Berens about whether or not a post-mortem should be carried out on Mr Kemps. Dr Berens indicated to me that he had discussed it with other senior staff and they had decided not to notify the coroner because the funeral had already been arranged and a post-mortem would cause the family unnecessary grief.

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24. Aside from taking to Dr Berens, I did not raise my concerns with any other senior staff as I assumed that the matter had been discussed at a more senior level to me.

25. Although I am not qualified to comment on the exact cause of death for Mr Kemps, I feel certain his death resulted from complications of the procedure performed by Dr Patel, and not as a result of a pre-existing condition.

26. As I recall Dr Patel had not had a good success rate with oesophagectomies (i.e a high mortality rate)

27. In my experience as far as oesophagectomies are concerned Dr Patel would take the lead during the operation, and the junior medical staff were there to assist.

28. At the end of the operation Dr Patel would ordinarily make the notes. Sometimes, however, the PHO might make the chart entry on the actual procedure.

Procedure for signing death certificates

29. Usually the junior medical staff does most of the paper work for the consultants, including filling out death certificates. If the junior staff had concerns about the cause of death they would ask the consultant.

30. It is necessary to be quite specific about the cause of death. I recall that if the were any issues with the cause of death listed on a certificate - for example if it were not specific enough - I would sometimes receive a phone call from Dr Kees Nydham who would question me about the cause of death and make suggestions about the proper entry.

Permacaths inserted by Dr Patel

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31. I recall that there were some issues about complications from Dr Patel's surgery to insert catheters for dialysis patients. A particular patient that I recall was P30. I recall that I took this gentleman through the consent procedure prior to the operation. I remember saying to him that, as with all operations, there is always the possibility of complications that lead to death. I recall this gentleman saying to me that hopefully that would not happen because he had plans to do some things with his son in the days following the operation.

32. I was not present during the operation, but I was working in ICU when he came in after surgery. He was brought in following an arrest, and then became very tachycardic and as I recall he also had a cardiac tamponade (blood around his heart).

33. When he arrived in ICU he was in a very bad way, and I found out from other people what had happened in theatre. Apparently there was also some difficulty gaining access during the procedure and several doctors had attempts at putting the catheter in.

34. When these types of catheters are introduced into the main blood vessel it is usually passed in with a "J" tip protecting the end so that if you poke it into the vessel wall it won't perforate. I believe that I was told that what happened in this case was that they turned it around for whatever reason and passed the straight tip in and presumably this went through the superior vena cava portion that was intracardiac in the pericardial sac.

35. I recall that this gentleman passed away shortly after the procedure.

36. I recall that sometime after this incident, it was common knowledge around the hospital that Dr Miach did not want Dr Patel to operate on any of his patients. I found this out from Dr Toby Gardner who was Dr Miach's PHO at the time. I also recall Dr Miach telling my brother, who works at the Hospital, that Dr Patel was not on friendly terms with him (Dr Miach).

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Patient P26

37. I was involved in P26's treatment during his initial operation and then just prior to his transfer to Brisbane. This patient was a young boy who was involved in a motor cycle accident and he was airlifted to the Hospital on 23 December 2004. At the time I was a PHO in the orthopaedic ward and, as such, I was not directly involved in P26's acute care.

38. I saw P26 being wheeled into a lift with a lot of people around him. The paramedic was compressing a large bleeding vessel in this boy's left inguinal region, and the boy looked very pale. Dr Patel was there, and I asked Dr Patel if he needed me in theatre. He said that it would be a good idea and I quickly went in as an extra pair of hands.

39. The bleeding appeared to be coming from the femoral vein laceration that was tied off. I thought that the laceration to the femoral vein had been repaired but, in hindsight, I think what happened was the femoral vein was ligated. He then had massive venous hypertension in the leg afterwards. I later heard from the vascular surgery registrar at the RBH that, in consequence of the ligation, P26 had no venous outflow from the leg.

40. The first procedure was to control the bleeding, repair the laceration to the femoral vein, debride the wound and do a compound scrub. The wound was closed at the time with a view to going back in later to do further wound washouts as the wound was fairly contaminated.

41. I remember at the end of this operation there were some concerns about the circulation of blood in P26's foot. I recall that, immediately after the procedure had been completed and P26 was ready to be taken out of the theatre, one of the nurses, Katrina Zwolak, commented that P26's foot was slightly mottled. I think there was no pulse in the foot at that time. Dr Patel

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had left the theatre and there were no investigations as to why there was poor circulation in that foot.

42. The anaesthetist also had concerns about P26's tachycardia. After I spoke with Dr Berens, I asked if it might be worthwhile having the sonographer perform an abdominal ultrasound to see if there was any internal bleeding inside the abdomen. I called the sonographer and he performed an ultrasound. I don't believe that there was any evidence of internal bleeding. Dr Patel then came in and saw the ultrasound being performed and he became quite angry. He asked me who had organised it. I mentioned that Dr Berens and I thought it was appropriate, as it wasn't something that delayed a more definitive CT scan investigation and it was very quick. Dr Patel said that ultrasounds are of no value because they are operator dependent and he was very critical of the sonographer.

43. P26 went back to theatre later that afternoon, although I was not assisting during the second operation. I did go back to Intensive Care to check his progress, and found out that he was not there and he had been returned to theatre. I went back to theatre to check on him and, when I arrived, Dr Patel was performing some fasciotomies for compartment syndrome.

44. I then rang Dr Neil Robinson the orthopaedic consultant who had been present at the first operation for a very short time. I think he was there at the initial operation, at Dr Patel's request to see if there was any orthopaedic issues which needed urgent attention. I told Dr Robinson that Dr Patel was performing fasciotomies. Dr Robinson told me that Dr Patel would know what he was doing so there was no real need for him to come to theatre. (By mentioning Dr Robinson's name I am in no way suggesting any improper judgement on his behalf, I have always respected his clinical judgement and sound advice)

45. As I was working in orthopaedics during that term, I had no further involvement in P26's care until about a week later when I was on call for

Surgery and Orthopaedics. The only other involvement was an opinion about a pelvic fracture which Dr Robinson provided.

46. I was not involved in the third operation, although I have read the notes of that operation and understand that there was a prosthetic bypass of the femoral artery performed. I also believe that a vascular ultrasound was performed to review the circulation in P26's leg.

47. About a week later I was due to start doing weekend calls, at about 5pm on the Friday afternoon. Very soon after I started on that afternoon, I was getting a handover of the surgical patients from other teams. I noticed at that time that P26's blood test showed that his white cell count had been progressively increasing over the previous day or two. I then spoke to the intern who was working in Dr Gaffield's team. I asked if there had been any investigations done into the cause of the increasing white blood cell count.

48. I believe that on either Friday evening or Saturday morning, I spoke to Dr Gaffield and raised my concerns about P26. At that point, Dr Gaffield asked me to contact the vascular team in Brisbane and see if they would accept this patient.

49. On Saturday 1 January or Friday 31 December 2005 I spoke to Dr Mark Ray at the RBH about transferring P26 to Brisbane. I gave Dr Ray a summary on the course of treatment that P26 had undergone and explained the nature of the three operations that had been performed. Dr Ray sounded surprised and shocked when I told him that Dr Patel had performed a synthetic by-pass of the femoral artery. He was horrified that an operation like that had been done in Bundaberg.

50. Dr Ray was understandably upset about the length of time P26 had remained in Bundaberg. Dr Ray advised that we would have to talk to the clinical co-ordinator about the transfer to Brisbane. Dr Ray was upset about the situation and I recall he said words to the effect of "another Bundaberg

Special coming down". It suggested that the Bundaberg Hospital had already quite a notorious reputation with the vascular unit at the RBH.

51. Dr Ray also discussed the possibility of some form of amputation and said I should raise this possibility with P26 and his Mum before he arrived in Brisbane. This was difficult for me because I had the impression that Dr Patel had reassured P26's mother that P26 would regain function in his legs.

52. I do not understand why P26 was not transferred to Brisbane earlier for definitive vascular treatment. I also have concerns about the fact that soon after the first operation there was no obvious concern from Dr Patel about P26's circulation and why nothing was done to investigate why there were problems with circulation. It was one of the most upsetting and distressing cases I have witnessed while at Bundaberg.

53. Just before I left Bundaberg I remember Dr Patel spoke to me about how he was being called up to see Peter Leck (about an email sent by the Clinical Co-ordinator in regards to P26.)

54. Dr Patel asked me if I knew what the meeting with Mr Leck was all about. I told him that I thought that it was about some concerns that Brisbane had about the treatment of P26. I recall that Dr Patel said to me words to the effect of "if these non-clinical people start getting involved and telling me what to do I am going to resign."

55. I attended a meeting with Peter Leck and Dr Darren Keating sometime before late 2004. I am not sure exactly when it occurred. At that meeting they asked me if I had any concerns about Dr Patel. I spoke to them about a patient whose a name I can no longer recall. I informed Dr Keating and Mr Leck that Dr Patel had performed some vascular surgery on this lady's arm and there were complications and a return to theatre. I recall that she developed a thrombosis. Afterwards I organised her transfer to the vascular ward at the RBH.

Dr Tariq Qureshi

56. Dr Qureshi worked in different units at the Bundaberg Hospital, however I recall that at some time during 2003 he was transferred into the surgical unit. I had heard rumours that he was transferred as a result of some complaints against him involving transgressions of a sexual nature.

57. Because of these allegations Dr Patel had said that the surgical unit might be suitable as Dr Qureshi would be better supervised and there would always be someone else around to supervise him if he was on a surgical team.

58. I had some concerns with his surgical skills. I recall that we went to theatre one day and I had to teach him how to do a surgical scrub and it was obvious to me that he had not done many scrubs at all and I felt that I had to watch him very closely to make sure that he did a surgical scrub properly.

All the facts and circumstances above deposed to are within my own knowledge and belief, save such as are deposed to from information only and my means of knowledge and sources of information appear on the fact of this my Statement.

Dated this 25th day of July 2005

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Dr David Charles Risson

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Witness

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EXECUTIVE SERVICES

CONFIDENTIAL

Notes of Meeting – 2 Nov 04

Present :

Dr David Risson - PHO (PGY3) - BBH
Mr Peter Leck – DM BHSD
Dr Darren Keating – DMS BHSD

Context :

Ms Tom Hoffman NUM ICU/CCU has made a number of allegations against Dr Jayant Patel, Director of Surgery BBH, including some allegations about his clinical competence. Dr Risson was asked to provide any comment in relation to these allegations because Ms Hoffman had named him as one doctor who shared similar concerns

Response :

Dr Risson's concerns related to transparency of the current surgical audit process conducted in the Surgical Department, where he believed there was lack of structure. He was concerned that upon cessation of use of the Otago database, there weren't reasons provided about the change nor an adequate replacement put in place. He had concern (which was shared by nursing staff) about the apparent number of post-operative complications including infection.

Ms Hoffman had spoken to Dr Risson about the care of Mr Bramich but he wasn't involved in the care of this patient and couldn't comment. He did remember hearing about one case where insertion of a CVP line by Dr Patel had possibly pierced the SVC, leading to pericardial tamponade and patient death. Dr Risson was involved in getting consent for the procedure from the patients, but hadn't observed the procedure.

Dr Risson described his relationship with Dr Patel as amicable noting that he could be flighty and occasionally unpredictable. The resident staff believed that he was very severe in reprimands, particularly for minor issues.

Dr Risson had never been told to not write anything on a discharge summary and had attended a Surgical Department meeting where wound dehiscience and superficial infection had been discussed.

Dr Darren Keating
DMS