BUNDABERG HOSPITAL *COMMISSION OF INQUIRY*

I, **DR SANJEEVA KARIYAWASAM**, c/- Nambour Hospital, Nambour in the State of Queensland, state:

Qualifications and Experience

1 I graduated from the University of Queensland with the degrees of Bachelor of Medicine and Bachelor of Surgery (MBBS) in 1998.

2 I thereafter accepted a position as a resident medical officer at the Royal Brisbane Hospital. I was an intern in 1999, a junior house officer (JHO) in 2000, and a senior house officer (SHO) in 2001 and 2002. As a resident medical officer I undertook rotations across numerous practice areas within the Royal Brisbane and Royal Children's Hospitals.

3 During the period November 2002 to April 2003 I traveled and worked in the United Kingdom. Specifically, I worked at the Royal Sussex Hospital, Brighton Hospital, Basildon Hospital and Orsett Hospital.

4 I returned to Australia in April 2003 where I again worked at the Royal Brisbane Hospital as a senior house officer.

5 In January 2004 I accepted a position as a principal house officer (PHO) in surgery at the Royal Brisbane Hospital. During the period January 2004 to July 2004 I worked as the night reliever. As the night PHO my role was to cover the surgical in-patients and surgical admissions, after hours, and to alert the responsible surgical consultant of any concerns as required. I therefore had very little exposure to general surgical procedures, routine or otherwise.

6 In July 2004 I was seconded to the Bundaberg Base Hospital as a surgical PHO, where I worked until January 2005. The Director of Surgery, and surgical consultant to whom I was directly responsible, was Dr Jayant Patel. The other surgical PHO was Dr James Boyd. Doctors Ben Waterson, Anthony Athonasiov, Ashish Gupter, and Hazel Dobinson were the resident medical

officers working for Dr Patel during this period. The consultant urologist was Dr Peitre Anderson and the consultant general surgeons at the hospital were Dr Jim Gaffield and Dr Kingston.

7 On 17 January 2005 I commenced work at the Gold Coast Hospital as a PHO in plastic surgery. I remained in this position until 15 July 2005. On 18 July 2005 I commenced work at Nambour Hospital as a PHO in Urology surgery.

Bundaberg Base Hospital

8 I commenced work as a surgical PHO at Bundaberg Hospital on 17 July 2004. The role of a PHO is to coordinate patient care under the supervision and direction of the consultant surgeon. During my time at Bundaberg 80%-85% of my time was spent working directly with Dr Patel. During the other 15%-20% of my time I worked with the other consultant surgeons and the consultant urologist.

9 A typical day at the hospital would involve doing a ward round with Dr Patel for an hour or so each morning. During this time we would organize various investigations and tests, arrange patient discharges, and attend to general patient management. After the ward round I would assist Dr Patel with either his outpatient clinics or his theatre lists, depending on what had been scheduled for that day.

10 My role in theatre was to act as an assistant for Dr Patel during surgical procedures. I would typically assist by holding retractors, tying off structures and suturing, as directed. I assisted Dr Patel with numerous procedures including general abdominal surgery, appendectomies, gall bladder surgery, bowel surgery, hernia repairs, and breast and thyroid surgery. As a basic surgical trainee, I would, in some of the simpler operations, undertake the actual surgical procedures at the direction of Dr Patel. In those procedures, he would give specifically direction to me as to what I was to do and I would follow his direction completely. Prior to commencing work at Bundaberg Hospital I had very little general, and in particular abdominal, surgical experience. Of the operations undertaken by Dr Patel during my period at Bundaberg Hospital, there were a large number of which I had not seen

before. For example I had no prior experience with oesophagectomies, anterior resection, or total colectomies.

11 When assisting Dr Patel with clinics, my role was to review existing and post-operative patients. Dr Patel would examine all new patients and make the decisions with respect to the appropriate management of patients, be it surgical or otherwise. I had no real input into this decision-making process. Neither however, did I have any doubt that Dr Patel, as the Director of Surgery, was other than competent to make all decisions with respect to appropriate patient management.

Dr Patel

Working Relationships

12 I had a good working relationship with Dr Patel. I found that Dr Patel was helpful and supportive of the surgical and medical staff when he was on call. Whilst he was pleasant to the surgical staff working within the unit he was occasionally aggressive in his manner towards nursing and other staff. For example, Dr Patel was most critical of nursing or clinical staff if they talked or made comments during his review of patients. I can recall him reprimanding a member of nursing staff on one occasion and a member of the clinical staff on another, when that occurred. It is my view that Dr Patel was tolerated by other hospital staff.

13 Dr Patel did work very hard. I recall Dr Patel talking about the importance of having a good work ethic. The surgical department at Bundaberg was a very busy department due to the sheer volume of patients who would present to the hospital or who were referred to the outpatient department. My time at Bundaberg was probably the busiest time of my surgical experience.

Theatre Lists and Theatre Targets

14 Dr Patel would occasionally boast to me that he had managed to significantly reduce waiting lists. I believe that Dr Patel was pleased that he was reducing the waiting lists. I recall Dr Patel advising myself and others that the elective

surgery targets were being met. I also recall Dr Patel stating that he got on well with Dr Keating.

15 Dr Patel was active in securing theatre time, by liaising with theatre staff and other surgical consultants, to ensure that general surgical patients who required operations received treatment as quickly as possible.

16 When there were a lot of patients waiting for a certain procedure Dr Patel would have what he called a "blitz". I recall that he had a colonoscopy blitz where Dr Patel did a whole week of colonoscopies. I also recall that he had a blitz on gall bladder surgery. I think that Dr Patel did around 15 gall bladder operations in one week to try to reduce the waiting list.

17 It was Dr Patel's practice to book around five patients per day for surgery. Time was allocated for the surgery depending on the type and nature of the surgery. For example, an hour was allocated for a gall bladder surgery and two or three hours for a colon resection. If an operation took longer than expected, patients were not cancelled but rather the team would work overtime in order to complete the list.

18 I have been asked whether Dr Patel rushed operations. In my limited experience I do not consider that Dr Patel rushed operations. It appeared to me that Dr Patel operated at his own pace. Any rush or pressure to work quickly was associated with organizing lists and completing other tasks out of hours, rather than with the operations themselves. Dr Patel discussed with me the fact that he was able to do an operation in 3 hours when it would normally take a surgeon 5 hours to do the same procedure. For example, Dr Patel undertook a proctocolectomy, in which I assisted him. Some time after the operation, he told me that it would normally take a surgeon 5 hours to do the operation but he had done it in 3 hours.

Operative Technique/Ability

19 Dr Patel appeared to me to be a competent surgeon. I concede that my level of experience is such that it is difficult for me to offer any really authoritive opinion about his technical ability.

20 Dr Patel was a very confident person who regularly advised staff that he was an experienced surgeon, having performed various procedures on numerous occasions in the past. For example, I can recall that he once said that he had many years experience in paediatric surgery. I have some recollection of him saying that he had had twenty years experience but I cannot be certain. Dr Patel appeared very knowledgeable and as a junior staff member I had no reason to think that he was anything other than competent.

21 The surgical department at Bundaberg was a very busy department and consequently the junior staff within the department, myself included, were kept continuously busy with routine patient management. As a relatively inexperienced doctor undertaking a six-month rotation through Bundaberg Hospital, I was not in a position to evaluate the performance of any surgeon. In my view, any concerns with respect to performance and/or patient outcomes would have been more readily obvious to other staff and management within the hospital who had had the benefit of working with Dr Patel since his arrival at Bundaberg and who were in possession of all the data with respect to patient outcomes.

22 With hindsight, knowing what I now know about Dr Patel's history and medical limitations in the United States, Dr Patel did perform some surgery that he should not have. One example is the pancreatic surgery performed for P152.

Patient Transfers

23 All decisions with respect to the appropriateness or otherwise of patient transfers were made by the consultant. In a trauma situation a patient would be stabilized before any consideration was given to a transfer. I would always speak with the consultant about transfer to Brisbane, the ultimate decision was that of the consultant.

24 There were only 2 or 3 ventilated intensive care beds in Bundaberg. I recall a few occasions on which there was a push from the intensive care unit to transfer patients in circumstances where it had reached its patient limit and

there was concern about further patients being admitted. I cannot be any more specific about the details of those occasions.

Surgical Audit Meetings

25 The surgical department held a monthly morbidity and mortality meeting attended by Dr Patel, Dr Gaffield, Dr Kingston, the two PHOs and, the resident medical staff. I would present patient complications with respect to those seen by Dr Patel's team and Dr Boyd, the other PHO, would present patients seen by Dr Gaffield's team.

26 All patient deaths and all patients suffering significant complications (that is, complications requiring further intervention, surgical or otherwise) were presented at these surgical audit meetings. Dr Patel did not attempt to influence the selection of patients for discussion. I recall only one occasion where Dr Patel suggested, due to time constraints, that a patient, who had suffered a minor infection treated by oral antibiotics, need not be discussed.

27 The usual procedure, during the meetings, was for the PHO to present a patient's case after which the responsible consultant would take over and discuss the case. There was little general, or round-table, discussion during the meetings. Similarly there was little critical analysis of why any adverse consequence had occurred. In general terms, surgical facts were presented without any explanation of what had occurred so that problems might be avoided in the future.

Catheter Group

28 Dr Patel told me that he and Dr Miach did not 'get on' and that he was not involved in any of Dr Miach's catheter insertions. I was aware that Dr Miach's patients who needed catheters were referred to Dr Gaffield.

Letter of Support

29 In early 2005 it came to the attention of the medical officers within the surgical department, myself included, that the medical administration had

raised some concerns with Dr Patel with respect to the surgical management of P26.

30 The medical officers within the surgical department wished to ensure that the medical administration were aware of the support Dr Patel provided to junior staff. Dr Athanasiov wrote a letter, which I signed, in which he referred to the support Dr Patel provided to junior staff, especially when on-call. We wished medical administration to be aware that there was never a time when we felt we could not call Dr Patel, even if was the middle of the night. Dr Patel would make himself available to come in to the hospital out of hours and on weekends to see his patients. In the letter we did not purport to make any comment with respect to Dr Patel's surgical skill, expertise or complications.

Wound Infection and Wound Dehiscence

31 It is my understanding that wound dehiscence occurs where a wound incision which has been sutures, comes apart. That is, in an abdominal incision, it is the separation of the tissues of the abdominal wall. It can be superficial (skin) or deep (fascia). Wound dehiscence may be caused by infection, poor technique or increased intra-abdominal pressure after surgery. Wound dehiscence is relatively uncommon.

32 Wound infection is different. Wound infection is caused by organisms infecting the wound site. Wound infection is much more common than wound dehiscence.

33 When I first arrived at Bundaberg I was told by Di Jenkins, the clinical nurse consultant of the surgical ward, did mention to me that in the past Dr Patel had complications of wound dehiscence. She also told me that there was a higher infection rate with Dr Patel's surgical procedures. I asked her whether anyone was aware why that was happening. I can not recall now what her response was. I have a vague recollection of a member of staff telling me that Dr Patel had told him that the incidence of dehiscence was due to poor suture material.

34 Towards the latter part of 2004 I can recall being present for part of a conversation between Dr Patel and Di Jenkins, where the definition of wound

dehiscence was discussed. I recall that nursing staff were describing instances of minor superficial/skin parting as wound dehiscence whereas it is my understanding that wound dehiscence refers to a situation where the deep tissue of the wound separates.

35 I can only recall one instance of wound dehiscence during my time in Bundaberg, which occurred after an abdominal hernia repair. I cannot recall patient's name but I seem to recollect that Dr Patel repaired the wound. The dehiscence occurred as a result of a wound infection post-operatively.

36 There did seem to be a higher incidence of wound infection concerning Dr Patel compared to other hospitals I had worked in. I was unable to attribute this increased incidence of wound infection to any one specific thing. I did observe Dr Patel's hand scrubbing technique and his operative technique but was unable to identify any particular concerns in this regard.

37 There was a change in infection control practice that occurred whilst I was at Bundaberg Hospital. Theatre staff, including nurses, ward persons and doctors, would commonly go the cafeteria wearing theatre attire. On returning to the theatre, staff would don new gowns. This is a not uncommon practice amongst theatre staff and is a practice that I have observed in all hospitals in which I have worked. However, infection control staff were concerned about the practice and staff were consequently directed not to wear theatre attire outside the operating theatres. This direction was complied with.

P11

38 I have had the opportunity to review the clinical record for P11.

39 I recall that P11, was a 55-year-old man, who was airlifted to Bundaberg Base Hospital on 25 July 2004, following an accident where he was pinned under a caravan for 10 minutes.

40 I examined P11 on his arrival at Bundaberg Hospital. I formed the impression that P11 was suffering with multiple fractured ribs and that his clinical condition was consistent with pneumothorax (air in the pleural cavity) and

haemothorax (bleeding into the pleural cavity). On consultation with Dr Patel it was determined that a right intercostal catheter should be inserted to drain any blood. A CT scan of the chest and abdomen was performed to confirm the clinical diagnosis of haemothorax and/or pneumothorax, and to exclude abdominal injuries.

41 I inserted a chest tube under local anaesthetic with Dr Patel in attendance. The tube was inserted without complication and drained approximately 200mls of blood. The nursing notes reveal that the water in the tubing was swinging, which is indicative of a transfer of pressure to the tube during inspiration, and that there was also bubbling in the canister, which is indicative of the chest tube draining air from the pleural cavity. Further clinical evidence that the chest tube was working effectively was the improvement in P11's oxygen saturation levels from 92% on admission to 100% after insertion of the chest tube. That is, with the insertion of the chest tube P11's gas exchange improved.

42 Trauma series x-rays performed in the emergency department confirmed the multiple rib fractures and the correct positioning of the chest tube. I understand that P11 was later found to have a severe sternal fracture. P11 did not complain of any sternal pain on admission to hospital. The trauma series x-rays did not specifically focus on the sternum and no evidence of fracture was seen on initial presentation or was later reported by the radiologist. Subsequent x-ray report dated 26 July 2004 stated 'lung fields far better aerated...there has been considerable improvement since the previous study' An x-ray on the morning of the 27 July 2004 showed further improvement in lung expansion and there was no evidence of blood collecting in the right lung.

43 P11's injuries were severe, life-threatening, injuries and I treated them as such. After P11 had been stabilised I arranged for his admission to the intensive care unit under the care of Dr Gaffield. I did not have any involvement with P11's care beyond this point.

44 I understand that P11 passed away a number of days after admission. I recall that the police requested that I write a short statement with respect to my involvement with P11's care for the purpose of a coronial inquest.

P21

45 I have had the opportunity to consider P21's clinical record.

46 I recall that P21 was a 77-year-old man with a 40cm mass at the gastroesophageal junction who elected to undergo surgical intervention.

47 I understand that P21 was consented for a laparotomy and an oesophagectomy on 20 December 2004 by Dr Athanasiov. I saw P21 very briefly with Dr Patel prior to the surgery.

48 This was the first occasion on which I had seen an oesophagectomy. Dr Patel had told me that he had done oesophagectomies in the past. I was not aware however of the outcomes of any of those operations. Dr Patel commenced the operation at approximately 9.30am. I together with Dr Athanasiov assisted Dr Patel. Dr Berens was the anaesthetist.

49 As preparations were being made to move P21 from the operating table, I was informed that he was bleeding into the Bellovac drain. I am aware that Dr Berens says in his evidence that he raised concerns with Dr Patel about bleeding. I cannot recall any conversation between Dr Berens and Dr Patel in this regard. I don't say it didn't happen; I just cannot recall it. I contacted Dr Patel and notified him of the concerns after which Dr Patel returned to the operating theatre and reviewed P51. We observed P21 over the next 20 minutes or so and during this time his bleeding appeared to settle. That is, the observable rate of discharge from the drain lessened. P21 was transferred to the intensive care unit.

50 I then assisted Dr Patel with the next operation. I cannot recall being advised of P21's condition during the course of that operation. At some later stage however P21's poor condition, and in particular his ongoing bleeding, was brought to our attention. P21 returned to theatre at approximately 5.00pm that

evening for the purpose of locating the site of the bleeding (the second operation).

51 Dr Patel performed the second operation with Dr Athansiov and I assisting. On opening the abdominal cavity a significant amount of blood was encountered, approximately 2.5 litres. After an hour of attempting to find the site of the bleeding Dr Patel determined to remove the spleen, on the basis that there was some oozing from the spleen. The bleeding continued however after removal of the spleen.

52 I have read the evidence of Dr Risson particularly at pages 2811 and 2812 and say that I broadly agree with what he says. I would not say however that my suggestions were frantic. The situation was certainly urgent because Dr Patel was unable to find the source of the bleeding. I made a number of suggestions to him as to what the source might be. He did appear to consider my suggestions but was still unable to find the source of the bleeding.

53 After some time Dr Patel stated that he was able to isolate the site of the bleeding. This was at the lower 5 cm of the thoracic aorta at the level of the diaphragm. This area is very difficult to access.

54 As the actual point of the bleeding was unable to be accessed, Dr Patel made the decision to re-open the chest wound. Upon entering the chest cavity, it again was difficult to expose the point of bleeding.

55 Towards the end of the operation I suggested to Dr Patel that the abdominal cavity be packed in an attempt to stem the bleeding. I thought, although I did not verbalize this, that this approach might buy some time to enable Dr Patel to re-evaluate the situation. Dr Patel rejected the suggestion.

56 There may have been a number of options open to Dr Patel. For example, he may have been able to do a sternotomy to improve access or clamp the aorta to restrict bleeding. These are extreme steps.

57 After two hours, Dr Patel determined that he was unable to stop the bleeding. P21's wounds were closed and he was returned to the intensive care unit

58 I recall that Dr Patel commented that P21 could not be transferred to Brisbane as his condition was too unstable.

59 Dr Patel advised Dr Athanasiov and I to go home and he would 'sort out' the patient.

60 It is my understanding that Dr Patel spoke with P21's family and managed P12 in intensive care thereafter. I understand that P21 passed away the next morning.

61 I did not see P21 after the second procedure.

P26

62 I have had the opportunity to review P26's clinical record. I have some limited independent recollection of the events but I have, in making this statement, relied essentially upon what is written in the notes.

63 I understand that P26, a 15-year-old male, was injured in a motor bike accident on 23 December 2004 at which time he suffered a deep left groin laceration. I understand that P26 underwent 3 operations on 23 December 2004, performed by Dr Patel. The first operation was a femoral vein repair. The second operation was for fasciotomies for compartment syndrome. The third operation was for a femoral artery repair. I was not involved in any of these operations.

64 I first saw P26 on Tuesday, 28 December 2004 four days after the operation. I was advised that P26's left lower limb was improving and that the management plan was to monitor his improvement until he was able to undergo skin grafting for the fasciotomy sites. I have a vague recollection that that advice was given to me by Dr Boyd. I was also informed that Dr Patel was on leave and that P26 was under the care of Dr Gaffield.

65 I attended the patient on the 28 December 2004 on this date the leg was swollen and there was mottling appearance of the left foot. Reading Dr Patel's notes on the 26 December 2004 it was noted that the ankle was warm but the left foot was cold with diffuse mottling. Dr Patel wrote that patient P26 may

loose some foot tissue secondary to microemboli. The plan was to continue current management. There was no plan to transfer the patient.

66 On my review I was advised by the previous treating team that the leg was improving and swelling expected to settle, P26 reported improved sensation and pain in the left foot. Pulses were present.

67 I saw P26 on 29 December 2004 with Dr Gaffield at which time his left leg was still very swollen. The left foot was improving with deceased mottling and pulses were present on Doppler ultrasound. The plan was to continue current care and skin graft the fasciotomy sites as the swelling improved.

68 I am now aware of a note made on the file at 10.50pm on 29 December 2004 concerning the absence of a pulse. I was not aware of this entry in the notes when I examined the patient on the 30 December 2004. Had I been made aware I have no doubt that I would have immediately investigated further. I have no recollection of the clinical nurse consultant or any other member of staff raising the absence of a pulse with me on 30 December 2004 or 31 December 2004.

69 On 30 December 2004 the left foot was improving with decreased mottling and increased sensation. On the afternoon of 30 December 2004 P26 was suffering with a temperature and his white cell count was found to be high. The left inguinal (groin) wound was red and oozing and there was concern that there may have been an early infection. A search for other possible causes of infection was also done eg. central venous line infection, urine infection and blood cultures. P26 was on antibiotics at the time.

70 It was my practice to check for a foot pulse on each occasion when I undertook a ward round. I was aware that the absence of a pulse was a matter of significance. Had I not been able to find a pulse I can say that I would have certainly made a note of it and notified Dr Gaffield

71 I have since had the nursing notation dated 10.40pm, 30 December 2004 drawn to my attention. It seems unlikely that the surgical resident medical officer would have still been on the ward at that hour of the night. I note that

the (after-hours) medical resident officer on-call was not requested to review P26 despite nursing concerns. I cannot recall further the nursing concerns brought to the attention of the medical staff during the course of the ward round on 31 December 2004.

72 I last saw P26 on the morning of 31 December 2004, in the company of Dr Dobinson. The note prepared by Dr Dobinson records that the left foot was about the same; the left leg was less swollen. I can not recall any deterioration in the left leg mottling at that time. I definitely recall that there was no infection and no blistering of the foot. Blood cultures performed the previous day were negative. I was concerned about P26's temperatures and the groin infection so I requested that Dr Gaffield review the patient.

73 Dr Gaffield reviewed P26 on the afternoon of 31 December 2004 at which time the left leg dressings were taken down and the leg was reviewed. I can not recall whether I was present at the time of Dr Gaffield's review.

74 I understand that P26 was transferred to Brisbane on 1 January 2005 and that he subsequently underwent a left lower limb amputation.

P22

75 I have had the opportunity to review P22's clinical record.

76 P22, was a 94-year-old nursing home patient, who presented to the Bundaberg Hospital on 30 July 2004 with a significantly distended abdomen, abdominal pain into the groin, 3-day history of loss of appetite, chronic constipation, and confusion. P22 had a past medical history of prostate cancer, biliary stents, and a laparoscopic cholecystectomy. A provisional diagnosis of pseudo obstruction was made and an urgent colonoscopic decompression recommended.

77 P22 underwent a colonoscopic decompression on 31 July 2004 performed by Dr Patel, with Dr Boyd assisting. I was not involved in this operation.

78 Dr Patel reviewed P22 at 7.30am on 1 August 2004 at which time he noted that the abdomen remained markedly distended. Dr Patel recommended P22 return to theatre for a colon resection and ileostomy.

79 P22 underwent a laparatomy for subtotal colectomy and ileostomy on 2 August 2004 during which he suffered a colonic perforation resulting in a spillage of faecal contents into the abdomen. P22 was transferred to intensive care unit and ventilated. I first saw P22 whilst he was in the intensive care unit. The intensive care unit notes record that P22 was suffering cardiovascular failure, respiratory failure, and renal and gastrointestinal failure secondary to major operation and age.

80 During the period 2 August 2004 to 11 August 2004 I reviewed P22 daily with Dr Patel. On 2 August 2004 P22 was commenced on nasogastric feeding. On the 4 August 2004 P22's ileostomy and gut function had returned however no oral feeding was commenced initially as P22 was drowsy and had delayed swallow >30 seconds and there was a risk of aspiration. Nasogastric feeds were slowly increased. Difficulties were encountered with feeding as P22 would pull out the nasogastric tubing. P22 was transferred from intensive care unit to the general ward on 10 August 2004. Some limited thickened fluids only were able to be taken orally on the 11 August 2004. P22 was commenced on dysphagia (difficulty with swallowing) diet and high protein/energy supplements. P22 continued to be drowsy however he was actively encouraged to feed orally with care to the risk of aspiration.

81 P22 continued to deteriorate. Discussion regarding prognosis was made with P22's family on the 15 December 2004. A decision was made not to actively resuscitate the patient if he should go into cardiac or respiratory arrest.

82 On 15 August 2004 P22 was commenced on a morphine infusion. On 16 August 2004 he was said to be in respiratory distress.

83 At 1.25am on 17 August 2004 nursing staff record that P22 was pulseless and not breathing. Death was pronounced by Dr Zia at 1.40am on 17 August 2004.

84 I independently completed The Cause of Death Certificate. This was later reviewed with Dr Nydam.

85 I recorded the cause of death as "*malnutrition* due to or as a consequence of *general deconditioning* due to or as a consequence of *poor oral intake occurring post-operatively* due to or as a consequence of *emergency sigmoid colectomy*". P22 had significant nutritional issues given that he had a very poor oral intake for three days prior to his surgery and given he was not able to feed after the operation until 4 August 2004. I believe that this significantly contributed to P22's general deterioration. There were also issues with respect to cardiac function, respiratory function (chest infection) and renal function which were due to his poor physiological reserve at 94 years of age. At no time did I discuss with Dr Patel the cause of death or the contents of the death certificate.

P52

86 I have had the opportunity to review P52's clinical record.

87 I understand that P52 was admitted to hospital on 16 September 2004 for a left below knee amputation. P52 is a diabetic who had a history of previous toe amputations. I was not involved in any of the previous toe amputations.

88 I recall seeing P52 prior to her surgery on 20 September 2004. I think that I may have seen her on 18 September 2004 although I am not completely sure of the date.

89 The below knee amputation was performed on 20 September 2004 by Dr Patel. I assisted Dr Patel with the operation. The operation was performed without complication.

90 Subsequent to the surgery P52 was drowsy and confused due to renal failure. P52 was referred to Dr Smalberger, physician, who on-referred P52 to Dr Miach and the renal team.

91 P52 was dialysed over the next three days and she clinically improved. Dr Patel reviewed P52 on 27 September 2004 and it appears from the chart that P52 was doing well. On that day, Dr Miach had charted that P52's care was to

be transferred to the renal unit. P52 was seen again on 28 September 2004 at which time her wound was healing well. Dr Patel recorded in the chart that he accepted the transfer of care to Dr Miach's team. Dr Patel also recorded that P52 was to be seen in outpatients in two weeks for removal of the sutures.

92 P52 was under the care of the medical team until the 4 October 2004. On 4 October 2004 a request was made by the medical team for a surgical review of the wound. I attended P52 on 4 October 2004 and at that time my impression was that the wound was looking good. There was a small area of wound breakdown but no obvious infection. The plan at that time was to continue to review the wound and for regular dressings. This was the last occasion on which I saw P52.

93 It appears that P52 discharged herself on 6 October 2004 against medical advice. P52 was advised of the risks of discharging against medical advice by Dr Ben Waterson.

94 It appears that on self-discharge, no arrangements were made by the medical team for outpatient surgical follow-up. It is my understanding that follow-up appointments would usually be arranged by the ward clerks after a note had been made in the chart. Further, the surgical team was not made aware of P52's self discharge on 6 October 2004. Had the surgical team been informed, a follow up could have been arranged for continued monitoring of the wound.

95 It appears from the chart that, on 11 October 2004, P52 had an appointment booked to see Dr Miach as a private patient but that she cancelled the appointment.

96 It appears that P52 subsequently suffered an infection in the below knee amputation wound, as a result of the sutures being left in for about 6 weeks. She subsequently underwent an above knee amputation.

P44

97 I have not had the opportunity to review P44's clinical record.

98 I initially assessed P44 when she came into emergency on 18 December 2004. P44 had a very severe head injury. She was stabilised and a CT scan was ordered.

99 On receiving the CT scan results I contacted the neurosurgeons at the Royal Brisbane Hospital. The opinion of the neurosurgeons was that P44 had suffered a significant head injury with major bleeding into the brain. The neurosurgeons were of the view that P44 was not likely to recover from the injury. I recall that I discussed P44's poor prognosis with her family.

100 I am unaware of any request by Dr Patel to turn off P44's ventilator on 19 December 2004. It is my understanding that Dr Patel and Dr Carter made the decision to turn off P44's ventilator on 20 December 2004. I was not involved in the decision making process.

P170

101 I have had the opportunity to review P170's clinical record.

102 P170, was a 31-year-old male, who presented to the Bundaberg Base Hospital on 30 September 2004 with a two year history of a right groin lump and one year history of increased right scrotal swelling. He had been suffering with lower abdominal pain and nausea for the preceding week. P170 was referred to the surgical team for reduction of a right inguinal hernia.

103 P170 was admitted on 10 October 2004 and underwent a right inguinal hernia repair on 11 October 2004. The surgeon's report states that Dr Patel performed the operation and that I assisted. In actual fact I performed the operation under Dr Patel's direction and instruction.

104 During the operation I identified the spermatic cord and separated the sac off the cord structures. Dr Patel closely directed me throughout the course of the surgery. He gave specific instructions with respect to where I was to cut/dissect and I complied with those directions. Unfortunately, during the operation vas deferens was inadvertently divided.

105 The complications of the surgery were discussed with P170 and he was discharged home on 12 October 2004.

106 P170 was readmitted on 3 December 2004 for drainage of a right hydrocoele. I assisted Dr Patel with the surgery which involved drainage of 80mls of liquefied haematoma and excision of the haematoma sac/wall.

107 On 7 December 2004 P170 was readmitted to hospital with a provisional diagnosis of scrotal infection with possible recurrent haematoma. An ultrasound was carried out on 8 December 2004 at which revealed a right fluid collection (4.5 x 1.4 x 4.5cm). I conducted a physical examination, which revealed a right scrotum of increased size, wound infection and diffuse erythema of scrotum.

108 On 9 December 2004 P170 was returned to theatre where a large scrotal haematoma was evacuated and a drain was inserted. I conducted the operation with Dr Athanasiov assisting.

109 P17 was discharged home on 17 December 2004.

The contents of this statement are true and correct to the best of knowledge and belief.

Dr Sanjeeva Kariyawasam

28-7-5.