QUEENSLAND

COMMISSIONS OF INQUIRY ACT 1950

BUNDABERG HOSPITAL COMMISSION OF INQUIRY

STATEMENT OF JASON JENKINS

1. I, Jason Jenkins, Vascular Surgeon, Royal Brisbane and Women's Hospital acknowledge that this written statement by me is true to the best of my knowledge and belief.

2. This statement is made without prior knowledge of any evidence or information held by the Inquiry which is potentially adverse to me and in the expectation that I will be afforded procedural fairness should any adverse allegation be raised against me.

3. I am a Vascular Surgeon and I am employed on a full time basis at the Royal Brisbane and Women's Hospital (RBWH).

4. I obtained my primary degree in medicine at Sydney University. I trained at St Vincent's Hospital in Sydney and I came to Brisbane in 1990. I worked at the Prince Charles Hospital for a year, and then I worked at the RBWH. I gained a General Surgical Fellowship at that time. I then trained in New Zealand, Sydney and Brisbane, and I obtained a Vascular Surgical Fellowship. Since 1997 I have been a full time employee of the RBWH. I have, amongst other things, worked as the Director of Vascular Surgery in the Vascular Unit there.

5. The Vascular Unit at the RBWH essentially services the geographical area from North of the Brisbane River to Townsville. We have a Vascular Trainee who is usually a Senior Registrar. We usually have 5 Vascular Surgeons. Two are full time employees of the Hospital, two are VMO's and one is a University based surgeon. The Unit is responsible for educating the trainee and I am basically the Supervisor for the trainee. I am required to report to the College of Surgeons on a quarterly basis in relation to the trainee's performance, weaknesses, counseling, things I have done to improve the performance etc.

6. The Vascular Unit at the RBH is a tertiary referral centre. If somebody calls, it is usually because there is a life threatening emergency. The way it works is that we may receive a telephone call from out of town. We will organize a transfer through Stephen Rashford at Queensland Emergency Medical System Coordination Centre. The patient will be assessed in the Emergency Department by a doctor there, and then by my Senior Registrar or myself. My Senior Registrar for the six months from July 2004 to January 2005 was Dr Mark Ray.

7. I appreciate that there is a culture within Queensland Health that people should be treated in their local communities, but for some specialties that just cannot be done. Vascular surgery is one such specialty for a variety of reasons. The problem is particularly acute in relation to renal problems. Renal patients have limited options in terms of fistulas. Once they run out of options, they can't be dialysed any more. For that reason, it is very important for a patient's long term survival that the doctor gets it right first time. If an operation is done poorly the first time, it basically decreases their long term survival options.

8. I am quite passionate about renal access (the creation of fistulas) because, until 2005, I had basically performed all that work from north Brisbane to Rockhampton and I was aware that one person could create lots of problems.

9. In the course of 2004, I formed the view that a Dr Patel at Bundaberg Base Hospital was carrying out operations which may have been beyond his level of training. There were patients who were coming to the RBH after operations at Bundaberg Base. That hospital could not offer vascular surgery as an option because it had no trained vascular surgeons in the hospital at that time. I remember on one occasion that a renal patient had been operated on twice by Dr Patel and was then transferred to Brisbane with little notice, for us to fix the problem. What I saw of Dr Patel's vascular work suggested that he had received very minimal training in the area (I remember, in particular, a brachio-cephalic fistula). I did not document my concerns. I called Dr Miach and said I didn't think it appropriate for Dr Patel to be operating on vascular patients, especially those with renal problems. Dr Miach said he had tried to stop him but that Dr Patel would go and find patients in the wards and operate without Dr Miach even knowing about it. I found this amazing because it breaches a very clear protocol within hospitals.

10. There was one particular case that came down from Bundaberg that made me very upset. The patient was an Aboriginal lady and I understand that she has been identified before the Commission as P52. She was referred to me to create a fistula, so that she could dialyse for renal failure. When I saw her, I noticed that one leg had been amputated and that she still had a bandage over the stump. She told me that the amputation had been performed about 6 weeks earlier. She said that the stump had not healed yet and I asked her to take down the bandage. I noticed on examination that the stump was still healing. That did not reflect poorly on the clinician. It is often the case when someone is suffering from renal failure that they heal poorly and slowly. I must say, however, that I was deeply concerned by three aspects of P52's treatment. In the first place, she told me that nobody had offered the option of trying to save her leg with a by-pass operation. In the second place, she told me that her surgeon had not reviewed his work and, indeed, had not seen her since the initial surgery. In the third place, the sutures remained in despite the lapse of six weeks since surgery, and that was just unacceptable.

11. I subsequently wrote a letter setting out my concerns. Now shown to me and marked JJ-1 is a copy of the letter.

12. I spoke to Dr Patel by telephone on one occasion in 2004 and I think that it was after the P52 incident. I said to Dr Patel that if he kept operating on vascular

areas, I would report him to the Medical Board of Queensland. I remember the conversation quite clearly because I have never made a similar threat to a practitioner. I remember that, when I raised my complaint with Dr Patel, he was rude. He basically said that he could do these operations and did not want to take the conversation any further.

13. The case of P26 was very startling. He was a 15 year old boy who was transferred to Brisbane on Saturday, 1 January 2005. When he arrived, he was extremely unwell. He was septicaemic as a result of an infected ischaemic leg. He had pus coming out of the groin wound where he had by-pass procedure at the Bundaberg Base Hospital.

14. I took him to theatre with Dr Mark Ray at which time we removed the infected graft and revascularised his limb with a vein bypass and did a rotation muscle flap to repair the defect. We assessed the status of his lower limb at the time in an attempt to determine if the limb was salvageable.

15. In the course of operating, I noticed a number of problems with the earlier surgery. In the first place, the femoral artery had been repaired with a by-pass graft, but the surgeon had used a synthetic substance, namely, gortex. Whilst that is not an unreasonable approach in some circumstances, where you have a motor bike injury and the wound is undoubtedly contaminated, a vascular surgeon would not use gortex. This is because the prosthetic would almost certainly get infected, and this, in turn, is likely to lead to the rupture of the artery and perhaps death. Essentially, good practice requires that gortex only be used on "clean" sites or as a stablising procedure. In the course of our work, we harvested a vein and replaced the gortex with that vein.

16. The other problem was that, in attempting to repair the femoral vein, I believe that the surgeon did not recognise the venous anatomy. He had ligated the femoral vein and the other end of the vein had actually retracted up inside the abdominal cavity and thrombosed. This meant, in simple terms, that the blood could not return from the extremities of the limb through the vein. If the femoral vein had been repaired properly, it is unlikely that P26 would have developed the problems he did with his leg.

17. There was a further problem. The Bundaberg Base Hospital staff had carried out fasciotomies to P26. This is where you make incisions to release pressure and allow the leg tissues to swell without damaging the muscle. P26 had been in severe pain for the week that followed the fasciotomies but it seemed that no one had realized there was something wrong. Effectively, the leg was ischaemic (that is, it was not receiving enough blood) and this was caused partly because the vein was tied off and partly because the fascitomies were inadequate. It was not recognised for 9 days P26's leg was deteriorating as was his general condition.

18. There are two types of ischemia. One is arterial gangrene where the patient is not receiving blood to the limbs from the arteries. The other is venous gangrene where the blood cannot make its way out of the limb through the veins. With P26 the problem was that the muscles had swelled so much in his leg that the venous

pressure was stopping arterial flow to his leg. As a result, he developed compartment syndrome.

19. We operated on P26 on a number of occasions to save his life. His leg was not salvageable. We amputated through the knee to save him and we also did a skin graft from part of his leg. The skin graft still has not healed. The result is that, six months after operation, this 15 year old boy still does not have a prosthesis.

20. I believe that if P26 had been transferred to Brisbane as soon as he had stopped bleeding, there is a significantly higher probability he would still have his leg. The problems would have been identified quickly and the ischaemia relieved.

21. What really takes me aback is that they did 3 operations in 24 hours at Bundaberg Base Hospital. I appreciate that sometimes you might have to operate twice. Those things can happen, but when you have to operate 3 times on the same patient, and you still haven't got it right, I would expect a clinician to recognize that he or she is out of their league. Even if you are working at the RBWH, I would expect you to call in a colleague and ask him to help you out.

22. I appreciate that hospitals in regional centres do not have access to the kind of equipment that is available at the RBWH. I appreciate that, against that background, one should not be quick to judge performances in those areas. I certainly recognize that the original surgery carried out in Bundaberg was appropriate and, indeed, saved the boy's life. Once that had been achieved, however, the staff should have transferred the patient to a tertiary referral centre which has specialists to deal with this kind of problem every day. At the very least, Dr Patel (who I now understand was the surgeon) should have called the RBH to discuss the problems he faced and discuss the case.

23. I did not make a written complaint to anyone after the P26 incident. I did discuss the incident with Dr Richard Ashby in January 2005 and asked him to look into the matter further and the surgical processes at Bundaberg. He stated that he would refer it to the trauma review committee. I did speak to the mother on a number of occasions and I figured that the follow up was best handled by them.

24. I think one of the problems is that Queensland Health runs a skeleton staff at certain times. It is as if they had the view that people don't get sick on holidays, and they don't get sick when the lights are out. The result is that residents have to look after a huge number of patients with very little supervision. The second obvious problem here was that the surgeon did not recognize when he was beyond his limits. The third problem, I suspect is that these regional hospitals sometimes have an ethos of not wanting to seek help from the bigger teaching hospitals. I assume it is because they don't wish to be seen as not coping, but we certainly see it a lot. Indeed, in my view, there are two hospitals which in the same boat as Bundaberg for that failing, namely, Caboolture and Hervey Bay.

25. I am not a person who has any experience of bullying per se. I would say that there is a culture, apparent to me within Queensland Health, that if you don't toe the line, you will be dealt with. I also find that Queensland Health is reticent to put directions in writing, and prefers to attribute changes in policy to people

outside Queensland Health. In my experience what tends to happen is that people recognize, what can happen if you annoy Queensland Health, and there is a tendency to isolate oneself within the hospital so as not to be noticed.

Signed at on July 2005

8th August 2005.

Dr Jason Jenkins
Vascular Surgeon
Royal Brisbane and Women's Hospital