Bundaberg Hospital *Commission of Inquiry*

STATEMENT OF IFTIKHAR YOUNIS

Iftikhar Younis makes oath and says as follows:

1. I reside in the Bundaberg District.
2. I studied at the Rawalpindi Medical College in Pakistan between 1977-1982 where I obtained the degree MBBS. I then obtained job as a House Officer at the Rawalpindi General Hospital. I then performed duties as a lecturer at the Rawalpindi Medical College before obtaining my Diploma in Anaesthetics from post graduate medical institute Lahore .punjab university in 1986.. Pakistan. I became a member of the College of Surgeons and Physicians in Pakistan in 1986. I continued my training and qualifications and became a Consultant Anaesthetist in Pakistan in 1995. after attaining my fellowship in anaesthesia from college of physicians and surgeons Pakistan In 1995. I was then appointed as assistant professor of anaesthesiology and head of anaesthesia department at the Holy Family Hospital in Rawalpindi. I worked for the Ministry of Health in Malaysia for three years from 1997. as anaesthesia consultant and then returned to Pakistan and continued to work as an assistant professor and consultant anaesthesist.
3. I travelled to Australia on 14 March 2002, at my own expense, for an interview before the Australian and New Zealand College of Anaesthetists. Presently I am finalising my studies to become a fellow of that college.
4. I then returned to Pakistan where I commenced seeking employment in Australia. I obtained a position as a Senior Medical officer at the Bundaberg Base Hospital ("the Hospital") in September 2002. I was employed under a Special Purpose Registration. My initial contract was for one year which has been renewed since then. I recently returned to Pakistan after the birth of my one child.
5. In my work at the Hospital I am required to work under the supervision of an Australian qualified anaesthetist and in this instance it has been Dr Martin Carter. I am part of the team that assesses patients prior to any operations. I work in theatre as required and I also perform duties in the Intensive Care Unit ("ICU") and the surgical ward in relation to pain management. I am involved in about 20 to 30 operations a week.
6. The other Anaesthetists that I have worked with at the Hospital include D rDeter berens, Dr mohammad yaqoob zia ,Yousif Farid, John Joiner, a locom that came up from Canberra and Alice McGrady. The Principal House Officers ("PHO's") I have worked with include Adam Butler and Lucinda Beckman.

Interactions with Dr Patel

Signed: ..... Deponent

Taken by: ..... Solicitor/Justice of the Peace

7. I first met Dr Patel in theatre whilst I was working under the supervision of Dr Carter. My impression of Dr Patel was that he was an average surgeon. I did not have a lot of social interaction with Dr Patel due to my family commitments. However we did talk professionally when required.
8. I was present when Dr Patel completed a number of different types of surgery, including esophagectomies and colon type surgery. There were never any forms of surgery performed by Dr Patel which caused me concern. However, the surgical work was Dr Patel's domain and I kept out of that. Each member of the surgical team had their own duty and my duty in the team was to ensure that the patient was anaesthetised and pain free.

Esophagectomies

9. I was involved in two or three operations of this type. I was involved in one such operation performed by a locum. surgeon I was under the supervision of Dr Carter for this operation which was prior to my involvement in operations of that type by Dr Patel. I was involved one or two such operations performed by Dr Patel.
10. I was involved in an esophagectomy performed by Dr Patel on patient P18. In that operation I had responsibility for anaesthetics. One or two days after the first operation on this patient he was returned to ICU because he had complications. I think the complication was wound dehiscence. I anaesthetised the patient on his return to ICU.
11. Later the patient was taken back to the operating theatre. Dr Jon Joiner was the specialist anaesthetist on call that night. I don't know the details I how Dr Joiner anaesthetised the patient on that occasion. After that the patient was moved back to ICU and then two or three days later again another operation was performed on him. I was the anaesthetist for his last operation. Accordingly, the patient was anaesthetised on four occasions and I administered the anaesthetic on three of those occasions. For the whole of the patient's treatment during this period the treating surgeon was Dr Patel.
12. The reason the patient was moved back and forth between theatre and ICU was because he had complications. It is not normal to expect that many complications. The patient was unstable for the whole of this period.
13. I know that after his last operation the patient was transferred to Brisbane where he died after a stay there for a couple of months with some complications. My knowledge of this is based on a review of the patient's charts which I performed on 22 June 2005. I performed this review of those charts because when I became aware of the inquiries into Dr Patel that patient leapt into my mind.
14. I cannot really comment as to the standard of surgical treatment of this

patient because my role in relation to him was confined to anaesthetics.

15. I was not involved in the treatment of patient P34. I think that Dr Carter may have been involved in this operation.

Desmond Bramich

16. I was involved in the treatment of Desmond Bramich. I recall that I was on call when I was called to assist with this patient in the ward. When I arrived Dr Gaffield and his PHO (who may have been Dr James Boyd) and other staff were already present. The patient was gasping for breath and in obvious pain. He was struggling for respiration. He was sitting on his bed. His saturation level was going down. His condition was critical. I worked as part of the team to assist this patient and stabilise him.
17. The patient's blood pressure was really bad, although his saturation was starting to come up so I requested that he be moved to ICU as early as possible which was a better place to manage him. I planned to intubate him as well. Intubation involves administering a tube connected to a machine down a patient's throat. The purpose of intubation is to control the patient's breathing.
18. Once the patient reached ICU his condition once again deteriorated. At this time his blood pressure and oxygen saturation level was not stable at all. Another drain was placed into him by Dr Gaffield. The patient was ventilated 100% oxygen and a central line was also placed into him. Even then we were not happy with the condition of the patient. We administered some inotropic which helped to bring the patient's blood pressure up.
19. At about 2-3pm Dr Gaffield had to leave the care of Mr Bramich as he was required to perform an operation in theatre. At about this time I decided to do a CT Scan for the patient. My boss, Dr Carter reviewed the patient who said that a CT scan of the patient's abdomen should be done. That scan was done in Dr Carter's presence. There was also discussion between Doctors Gaffield, Carter, and myself (prior to Gaffield leaving) concerning whether the patient needed to be transferred to Brisbane. It was agreed that he should be. My main concern was that the patient be stabilised before he was transferred to Brisbane.
20. My recollection is that Dr Carter said that he could not see anything on the CT scan. He then discussed this result with Dr Gaffield. Mr Bramich's condition was still not stable and I was not happy with his condition.
21. My recollection is that Dr Patel then came onto the scene and basically took over the care of the patient. It was at about 5pm when Dr Patel decided to attempt to perform a pericardiocentesis. This procedure involved Dr Patel inserting a needle into the sac around the heart in an attempt to withdraw fluid therefrom. Dr Patel used ultra-sound to assist him in the placement of the

needle. I was in and out of the immediate area around the patient at this time but whilst I was present on and off, I witnessed Dr Patel make at least ten attempts at getting the needle into the correct location to withdraw the fluid. I recall the motion Dr Patel used to insert the needle was a stabbing motion. Dr Patel also stated that he wanted at one stage for the nursing staff to provide him with a larger needle for this procedure. The Nurse Unit Manager brought a needle after about a fifteen to twenty minute break to Dr Patel, and he then used this larger needle for the procedure. Dr Patel had his PHO with him at this time and was instructing the PHO in relation to the procedure. Dr Patel did manage to draw a quantity of about 2-5ml of blood from the sac. Generally, if this procedure is necessary to improve the patient's condition and it is performed successfully there is a sudden improvement in a patient's condition. This did not happen after the attempt by Dr Patel on Mr Bramich.

22. At the time of the treatment of Mr Bramich I was of the view that something better should have been done for him. I believe that the 'stabbing' actions by Dr Patel during the pericardiocentesis would have caused the patient extra distress. Although the patient had been anaesthetised by me during this time, I think he would have felt pain from the stabbing actions by Dr Patel. This is because in the condition the patient then was I could not completely anaesthetise him without endangering his life. The pericardiocentesis procedure and the way in which it was done could have contributed adversely to the patient's condition, however I cannot be sure of that because he had been unstable before Dr Patel performed it. It is possible that Dr Patel could have punctured a coronary vessel whilst he attempted the procedure, however I could not be sure whether or not that actually happened.

23. When it is obvious to me that I am having problems performing a particular procedure I seek assistance of another person. Similarly, I believe that when Dr Patel was not successful in inserting the needle into the correct location, he should have asked a colleague for assistance as he certainly was not finding the correct location.

24. I recall the retrieval team from Brisbane came at about 9:00 o'clock that night.

25. Later I provided a handwritten report of the treatment of Mr Bramich to Dr Carter. Now produced and shown to me and marked "IY1" is a true copy of that report.

Affidavit sworn on 9 August 2005

at Brisbane in the presence of:

. . . .

Deponent Solicitor/~~Justice of the Peace~~

Signed: . . . . Taken by: . . . .

Deponent Solicitor/~~Justice of the Peace~~

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MANAGEMENT SUMMERY

REGARDING BRAMICH DESMOND. URNO 086644.

as directed by DR MARTIN CARTER.
DIRECTOR ANAESTHESIA & ICU.
BUNDABERG BASE HOSPITAL.

I was consultant on call for FLOOR & ICU on 27/7/04. I received a telephonic call from (at about mid day) DR JAMES BOND surgical PHO regarding above mentioned pt in surgical ward. I immediately attended the pt.

MR BRAMICH DESMOND was in acute respiratory distress & haemodynamic stability, pale, & desaturating. His conscious level was fluctuating GCS 10–13 and was c/o severe chest pain, when he was responsive (Sitting at 75° on his bed.

As a team work & other surgical doctors commenced and paramedical staff we ~~[illegible]~~ fluid resuscitation. His chest tube (Rt lung) was not functioning properly. I requested to review the drainage system. DR ~~[illegible]~~ also ~~[illegible]~~ joined us from O.T.

I planned to ~~[illegible]~~ shift the pt to O.T. Meanwhile (in the ward pt,s did respond to our prompt resuscitation.) on arrival in I.C.U pt again deteriorates (respiratory distress + Haemodynamic instability)

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I requested the surgeon to [redacted] insert another big sized intercostal drainage tube as I was not satisfied with the 9/c catheter already in place.

In view of impending cardiorespiratory collapse I decided to intubate & ventilate & available invasive monitoring.

Surgeon managed to insert another 9/c drainage tube and there was a big gush of blood in the drainage tube.

At about 2.30 PM I requested my director to review and give me a hand and advise for further pt management.

DR Carter immediately accompanied me to I.C.U. He discussed with the surgeon about option of shifting the pt to Brisbain in a cardiothoracic unit for better pt management in case he requires immediate surgical interference and better I.C.U & blood bank back up services.

Surgical PHO communicated Brisbain hospitals and had a positive response from P.A hospital.

I personally talked to DR Gagiel in O.T about this development. He was almost finishing his surgery in O.T but he said that he will review the pt after just finishing the case but it would be better to arrange a CT scan (Thoracoabdominal) before a final decision is made.

Meanwhile pt was given blood Transfusion Hb% raised from about 6 gm% to 10 gm%. Oxygenation satisfactory. and BP was reasonable on any vasopressor support

DR CARTER very kindly accompanied the pt to C.T scan room as I was busy in an emergency laparotomy.

At about 7.00 PM after finishing my anaesthesia I reviewed the pt in I.C.U and found that his BP again was very low. started on vasopressor as per protocol.

Dr Patil (Director of surgery) also

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reviewed the pt. He decided to do a ultrasound guided pericardiocentesis in suspision of a cardiac temponade. Results of the procedure ???
(There was 2-3 ml of blood on one syring aspiration which immediately clotted later on.)

He had a detailed discussion with the family and explained pt's condition and answered there relevent concerns about the pt. He explained them that we have no plan to shift the pt to BRISBANE (No good reason to move him - Diagonosis after CT. pulmonary contusion → Haemothorax maynot and the pt is also haemodynamically very unstable by that time (about 9.00 PM)
After about 20 minutes of that detailed discussion surgical PTO DR JAMES BOYD told me that he has recieved the telephonic message that air retrieval team from Royal Brisbane hospital is on the way to BUNDABERG.

Dr in my presence conveyed this latest development to the family.
At about 11.00 PM the retrieval team doctor had a detailed discussion with the family about pros & cons of shifting the pt in that critical and unstable condition. Any way it was decided to shift the pt after another aggressive resuscitative effort (as per their protocol.)
Just before final move pt arrested. Standard CPR (advance) done for about 20 – 25 minutes. Another intercostal 16 G cannula → R/c drain inserted on left side (Gush of blood stained fluid from left side of Thorax) by DR James Boyd surgical PITO.
Resuscitation terminated at 02.10 AM as there was response to CPR. and death declared to the family by retrieval team doctor.

Dr. Younis
Anesthesia