Bundaberg Hospital *Commission of Inquiry*

STATEMENT OF JAMES PETER BOYD

I, DR JAMES PETER BOYD, Medical Practitioner c/- the Princess Alexandra Hospital in the State of Queensland makes oath and states:

Leave

1. I was at the Bundaberg Hospital for all of 2004 except for two months when I injured my Achilles tendon and was unable to work. That would have been around September of 2004. I believe that I was back working at the Hospital in November of 2004. Attached and marked 'JPB-1' is a copy of my application for leave dated 9 November 2005.

Audit Meetings

2. While I was working with Dr Patel he did have monthly audit meetings where we would discuss the deaths and complications that had occurred. Those meetings were attended by the doctors in the surgical division in the hospital including the orthopaedic surgeons, registrars, residents and medical students. I don't recall anything discussed at those meetings that struck me as being particularly alarming.

3. Dr Patel did say that he kept records of those meetings, although the meetings were not as far as I am aware formally minuted. The idea behind these meetings was to discuss difficult or interesting cases, complications and deaths.

4. We aimed to hold these meetings every month.

James Peter Boyd

Solicitor/Barrister/Justice of the peace

Dr Patel

5. I was usually present when Dr Patel was operating. I also performed some procedures under his guidance.

6. I recall that we performed a variety of operations while I was in Bundaberg including removing gall bladders, bowel resections for bowel cancer, breast surgery and upper and lower endoscopy procedures.

7. I don't recall ever being told what level the Hospital was, or the types of procedures that could be performed at the Hospital. I would have thought that it was a lower level hospital than Toowoomba Base Hospital (where I worked for the 2002 year) based on my experience of its staffing numbers and facilities.

8. Dr Patel would allow me to perform certain types of operations but if he felt the operations were too complex or difficult he would perform those procedures himself. He would also consider the circumstances of the particular patient, for example if a patient had co-morbidities or other problems such as obesity, Dr Patel would conduct the operation himself.

9. Also if there were time constraints Dr Patel would also perform the surgery himself.

10. I did not participate in any oesophagectomies while I was at the Hospital. I was aware that Dr Patel had performed several oesophagectomies as I remember staff of the Hospital informing me that they should not have been done in the Hospital as they were too complex. I also believe that I was told that there were poor outcomes as a result of those procedures but I have no direct knowledge of those procedures nor their ultimate outcomes.

James Peter Boyd

11. I don't specifically recall seeing Dr Patel being careless or rushing through surgery however on occasion he would become impatient. Nothing about Dr Patel's technique struck me as being particularly dangerous. He did have his own style of surgery but all surgeons have their own way of doing things.

12. He also was quite good at some procedures for example he told me that he had done a lot of bowel surgery and although I am no expert I felt that he was quite good at bowel surgery.

13. He also did some laparoscopic work, for example he would remove gall bladders laparoscopically. Dr Patel would say that he was not an expert in laparoscopic procedures. With my limited experience when I observed him doing laparoscopic procedures I felt that he was not as good with laparoscopic procedures as he was at some open procedures but he was still competent.

14. After surgery Dr Patel would usually discuss what went on during the operation and the course of treatment. Those discussions usually involved the surgical staff, including any JHOs or interns, and occasionally they would occasionally involve the anaesthetist. Sometimes Dr Patel discussed alternative treatments and how things might be improved in future.

15. I don't recall Dr Patel doing any surgery that struck me as being beyond the competency of the Hospital, although he did perform some more complex procedures. There were no oesophagectomies performed while I was in his unit at the Bundaberg Hospital.

16. For example I recall that Dr Patel did some operations on the pancreas and a few other organs that I thought were a bit difficult. Nothing that I observed struck me as being surgically dangerous.

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James Peter Boyd

17. Clinically there was nothing about Dr Patel's practice that gave me cause to raise anything with the Hospital administration. If anything the only thing that might have made me complain to the administration was Dr Patel's manner. He could be a bit harsh with people and he did talk a lot. I knew that he did annoy some people.

Notes in Patient Files

18. When doing rounds with Dr Patel, the usual practice was for the resident or JHO to write the notes in patient charts. Dr Patel would discuss the patient and the junior doctors would write the clinical notes. That is the usual practice of most consultants in most hospitals. Sometimes I would write in the chart myself and occasionally Dr Patel would write in the chart but most of the time it was the resident who made the notes on Dr Patel's behalf.

19. I don't ever recall hearing Dr Patel telling anyone what to write, or not to write, in a patient's chart. I have heard rumours subsequently that Dr Patel told doctors not to write certain things in patient charts, but those rumours surprised me and I don't recall Dr Patel ever saying anything to me along those lines.

Dr Gaffield

20. I was also supervised by Dr Gaffield for 6 months.

21. Dr Gaffield works in a different area from Dr Patel, Dr Gaffield mainly does plastic surgery and head and neck surgery. The practice was that Dr Gaffield would often refer patients to Dr Patel if he felt that the necessary treatment was outside his area of expertise. Dr Patel also referred cases to Dr Gaffield for the same reason. The system worked quite well as Dr Gaffield and Dr Patel complemented each others skills.

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James Peter Boyd

22. I was aware that other units preferred Dr Gaffield to operate on their patients; specifically I recall the renal unit preferred Dr Gaffield. I am not aware of the reason for that preference; I believe that it may have been a result of something that occurred before I got to the Hospital. I got the impression that there was some ill feeling between the renal unit and Dr Patel.

Complications

23. I don't recall there being an unusual number of complications from Dr Patel's surgery. I do remember there being some issues such as there being some anastotomic leaks and things of that nature. I recall that there were more of those with Dr Patel than Dr Gaffield but I put that down to the fact that Dr Patel did much more bowel surgery than Dr Gaffield.

24. In my experience in it not uncommon for leaks to occur in anastamosis.

Wound Dehiscence

25. I remember the issue of wound dehiscence being raised with the Director of Medical Services, Dr Keating. I remember there being some discussions about wound infections and dehiscence and it being suggested that there was a higher rate of dehiscence occurring than normal. I remember that being a concern but I didn't think that it was a real problem.

26. I remember that there would be a few cases of wound infections and dehiscence and then there wouldn't be any problems for several weeks. It occurred in bouts and it would have been something that occurred in a particular theatre or with a particular surgeon but it was an erratic problem.

27. I recall that we did look at the data on wound dehiscence and some people thought that the rate was higher than average. I remember other surgeons also having incidents of wound infections and dehiscence.

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28. I recall on one particular day Dr Howard Kingston, a VMO, and I did two operations and both became quite infected. I also remember Dr Gaffield also having problems with infections. There was a run of it at the Hospital for a short period and then there were no problems for a couple of months. I couldn't correlate the information with any specific surgeon or theatre. It was quite sporadic and it was difficult to pinpoint a specific cause.

29. As far as I can recall I didn't see anything about Dr Patel's infection control practices that gave me cause for concern. I never witnessed any breach in the standard sterile preparation technique that was used when Dr Patel was preparing for surgery.

30. I don't recall being present when any of the nursing staff discussed infection control techniques

Letter of Support

31. I also signed a letter of support for Dr Patel after he had left Bundaberg. A number of the junior doctors wrote to the hospital administration in support of Dr Patel. Dr Patel was very involved in teaching the junior staff and he was always available to advise the junior staff and the junior doctors felt that from a teaching perspective he would be missed. He was an enthusiastic teacher.

32. I participated in writing that letter because there was so much negative publicity and feeling towards Dr Patel and we couldn't see why he was being treated that way.

33. From my perspective, his surgical practices seemed to be okay, his hygiene and teaching were also good.

Patient P11

James Peter Boyd

34. I was involved in the treatment of Mr Bramich. The following is my recollection of the events surrounding his treatment but I have not had access to Mr Bramich's clinical records. The sequence of events is to the best of my recollection but may not be completely accurate.

35. He had been involved in an accident where a caravan had fallen on his chest. He came in on the weekend. I was not working when he came to the Hospital but I believe that he was under the care of Dr Gaffield. I came into work on the Monday after Mr Bramich was admitted. As I was Dr Gaffield's registrar I took over the care of Mr Bramich.

36. I believe I first saw Mr Bramich on the Monday when he was in Intensive Care. He had been diagnosed with fractured ribs and a chest injury.

37. When I looked at him he seemed quite well and he was soon shifted to the Surgical Ward. He had been stable for a period of 24 hours. Usually with trauma patients the first 24 hours is the most important. Things can happen further down the line but the first 24 hours is generally the most important period. Mr Bramich had a serious injury so he was still a patient that needed to be observed.

38. I don't recall there being any discussion about transferring Mr Bramich to another hospital that day. I remember discussing it with Dr Gaffield and I recall that we discussed the fact that he was stable and he could be managed in Bundaberg. We discussed the fact that he appeared stable, he had a chest drain and had been given oxygen and his pain was under control. Those were the main issues with his injuries. In the circumstances we decided to keep Mr Bramich in Bundaberg. There didn't appear to be any reason to transfer him to Brisbane at that time

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James Peter Boyd

39. Around midday the next day I remember that Mr Bramich started to bleed suddenly and he was rushed back to Intensive Care. I remember being told by the Nursing staff that he was bleeding from his chest. I was called to the surgical ward, I believe that I may have been the first doctor to arrive.

40. Mr Bramich was in a lot of pain and had blood coming from his chest drain. I thought that we need to do something straight away so I called Dr Younis who was the anaesthetist on duty and therefore in charge of ICU. Dr Younis came and looked at Mr Bramich and then he was transferred to Intensive Care.

41. The Intensive Care staff started resuscitating him there. Up until that point the issue was getting him stabilised, there was no discussion about transferring him to Brisbane at that stage. He needed urgent treatment, transfusions and oxygen. He also needed to be ventilated.

42. He was intubated and put on a ventilator in Intensive Care. He was moved into ICU within half an hour. Once we had him in ICU we called Dr Gaffield who was in theatre at the time. When Dr Gaffield arrived he put in another chest drain as the other was blocked. Dr Gaffield put in a larger chest drain in a different position as there was concern that the blood was not draining away from his chest.

43. I don't recall anyone discussing sending Mr Bramich to Brisbane at that time. It would have been very difficult to transfer him to Brisbane given how unstable he was then. The priority was resuscitating and stabilising him.

44. Dr Gaffield thought that he needed a CT scan to investigate the chest, at about this time Dr Martin Carter arrived. At that point Dr Carter brought up the issue of transferring Mr Bramich to Brisbane but by that time he was too unstable to put on the plane. We then took him down to the CT scan which Dr Gaffield requested to give more information about his injury.

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45. I believe after his CT someone contacted the ICU at the PA hospital as that hospital has a cardio-thoracic unit and would have been the appropriate place to send Mr Bramich. I believe that the PA ICU contacted a cardio-thoracic surgeon and the advice was to continue to give Mr Bramich blood and platelets and try and stabilise him. It was passed on that he would not necessarily be operated on then. I was told that the PA did not have any beds available at that stage.

46. During this time there was a lot of discussion going on between people and lots of phone calls between Bundaberg and the PA. I remember that a retrieval plane was arranged but there was still some concern that Mr Bramich was not really in a fit state to be transferred.

47. Dr Gaffield asked Dr Patel to have a look at Mr Bramich to see if he needed surgery or if there was anything else that might be done. Dr Patel advised against surgery as he thought that it would be impossible to find where Mr Bramich was bleeding from and that surgery wouldn't be the best thing to do for Mr Bramich.

48. While we were treating Mr Bramich he was being given blood but at the same time his blood pressure was low. Dr Patel thought that he might have had blood around his heart and that might have been affecting the function of his heart. An echo-cardiogram was performed to see if that was the case. Dr Patel then performed a pericardiocenteses to drain any fluid from the pericardial sack around the heart.

49. I had seen this procedure done in New Guinea but not in Australia.

50. I watched Dr Patel do this procedure. I did not see anything about the procedure that caused me any concern. I remember that there was a small amount of fluid that was drained.

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51. It is also important to remember that it was a very difficult situation and there was a mad rush to try and treat Mr Bramich and stabilise him and save him. Mr Bramich died later that evening.

52. The case was referred to the Coroner. I remember that I had to do a report about the incident and I provided that to the Hospital administration.

Patient P26

53. I was also involved in the treatment of P26. He had suffered a severe injury to his groin. When he came into the accident and emergency unit I remember that he was rushed to theatre straight from the emergency department. I was not present during the first operation. There were some other junior doctors who were there at the time but I can't recall their names.

54. I first saw him in ICU after his second operation, which was within a few hours of his injury. I know he was returned to theatre on two occasions. As I understand it he had undergone the first operation to stop the bleeding and save his life. He was bleeding from the groin from a major blood vessel. He had then undergone some fasciotomies which were to relieve the pressure on his leg as he had developed compartment syndrome.

55. The third operation was an exploratory procedure to his groin because he wasn't getting a good blood flow through his leg. We knew that because his leg was swelling and that indicated that there was a problem with blood flow to or from his leg. We performed an ultrasound to see where the problems with blood flow were occurring.

56. Dr Patel was exploring the vein to work out whether there was a blockage to the vein. During that procedure we found that P26's artery was also injured. From the outside the femoral artery seemed okay but when we looked closer

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we realised there was damage to the artery. The damage was on the inside of the artery and it may have been impairing the flow. Dr Patel proceeded to repair that.

57. Dr Patel used a synthetic graft because there was quite a defect to the artery. We had to take out part of the artery but there was synthetic gortex graft available in the theatre we used that. He also did a thrombectomy which involves putting a cannular in the artery down to the foot to take out any clots or damaged tissue that might be clogging up the artery. Afterwards the foot looked good, it was warm and there seemed to be blood flowing through it.

58. We did not do an ultrasound as it seemed as though he had a pulse in his foot and that the foot was getting better. There was definitely an improvement in the appearance of his foot it looked pinker and felt warmer. I remember feeling pulses in his foot.

59. After that operation he was returned to ICU. I then saw him daily after that.

60. I don't recall there being any discussion about transferring P26 to Brisbane at that stage. There did not appear to be any specific reason to transfer him.

61. He still needed a lot of pain relief and his dressings needed to be regularly changed as is expected with such a large fasciotomy.

62. When I saw him after surgery the pulse in his foot was not as prominent and his foot seemed a bit colder.

63. He was stable and he did not appear to be getting worse. There were discussions between Dr Gaffield and Dr Patel. Dr Patel did not think that P26 should have been transferred to Brisbane as he felt that his condition was stable and improving. Dr Patel felt that he would improve and Dr Gaffield

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seemed to share the same opinion. I also think that the orthopaedic surgeon felt that he was going to improve.

64. Dr Gaffield then took over the care for the patient.

65. The foot was not ideal but the general feeling of everyone was that he would improve and everything that could be done had been done. His pulse was weak but it could be faintly made out in his foot.

66. I don't recall who made the decision to transfer P26 to Brisbane, I believe that occurred on a weekend when I wasn't working. He had deteriorated and had a high fever despite antibiotics.

Dr Keating

67. I don't recall having any reason to complain to Dr Keating while I was there.

68. I know that there were some complaints from the ICU about Dr Patel but I was not involved in that.

69. I was also asked to prepare a report for the Coroner regarding Mr Bramich.

70. I remember Dr Keating asking me about wound infections. It struck me as odd and it appeared to me that it might have been a situation where someone had complained about wound infections. I got the idea that he was trying to gauge my feelings about Dr Patel.

71. Apart from those incidents I didn't have any other significant interaction with Dr Keating.

Signed. ..... Witness .....

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James Peter Boyd

MEDICAL CERTIFICATE

THIS IS TO CERTIFY THAT ON .....

I EXAMINED ....JAMES BOYD.....

.....

WHO IN MY OPINION IS *
WHO STATES THAT THEY WERE * SUFFERING FROM A PERSONAL ILLNESS

OR ..... Achilles Tendon Rupture

AND WILL BE *
AND WAS * UNFIT FOR WORK/SCHOOL

FROM ..... 7-9-04 .... TO .. 11-11-04 INCLUSIVE

OTHER COMMENTS (if necessary)

DOCTOR'S NAME AND ADDRESS PLEASE PRINT OR STAMP ►

SIGNATURE .....

0 8 2 6 5 0 3 A M X D 5 9

DR MICHAEL DELANEY

548 QUAY STREET
BUNDABERG 4670
PH 07 4154 2001

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* DELETE AS NECESSARY

21/07/05

Queensland Government
Queensland Health

Received
15 NOV 2004
HRM

APPLICATION FOR LEAVE

Note: Applications for any leave relating to parental leave eg. maternity, adoption, must be made on the Application for Parental Leave form HR013

EMPLOYEE ID	1	1	5	5	4	4	CREW ID						

EMPLOYEE DETAILS

Surname	BOYD	Given Names	JAMES
[illegible]	PHO	[illegible]	P.
[illegible]	SURGERY	[illegible]	0405 389 017

LEAVE REQUESTED

Nature of Leave	[illegible]	[illegible]	[illegible]
☑ Recreation Leave ☑ In Lieu of Sick Leave		/ /	/ /
☐ Long Service Leave ☐ In Lieu of Sick Leave (Min of 14 Calendar Days excluding public holidays)		/ /	/ /
☐ Long Service Leave for Study or Family Leave ☐ Full Pay (Min of 14 Calendar Days excl public holidays)		/ /	/ /
☐ Half Pay (Min of 28 Calendar Days excl public holidays)		/ /	/ /
☑ Sick Leave Medical Certificate Attached ? ☑		/ /	/ /
☐ Family Leave - Special Responsibility Relationship to self: Medical Certificate Attached ? ☐		/ /	/ /
☐ Bereavement Leave Relationship to self:		/ /	/ /
☐ Special Leave ☐ With Pay ☐ Without Pay		/ /	/ /
☐ Other (Please Specify) eg: SARAS, Exam, Study, Conference, Defence Service, Pre Natal		/ /	/ /
[illegible]	Previous dates: from / / to / /		
[illegible]	☐ Yes ☐ No If yes, on which date/s?		
[illegible]	☐ Yes ☐ No		

PREFERRED METHOD OF PAYMENT

[illegible]	Paid in standard fortnightly payments ☐ or Paid in advance (before commencement of leave) ☐ Leave applications requiring Pay in Advance are to be received in HR/Payroll no later than 3 weeks prior to the start of the leave period

Employee Signature	[signature]	[illegible] Date	09 / 11 / 04
Supervisor Signature		[illegible] Date	/ /
[illegible] Signature	[signature]	[illegible] Date	9 / 11 / 04.
[illegible] Contact No		[illegible]	
[illegible] Required?	☑ Yes ☐ No	[illegible] known	

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ESP Processed by	/ /	Date	/ /

[signature] 21/07/05