STATEMENT OF MARTIN LOUIS CARTER

I Martin Louis Carter, Director of Anasthetics and Intensive Care, of c/- the Bundaberg Base Hospital in the State of Queensland states:

1. I am currently the Director of Anasthetics and Intensive Care at the Bundaberg Base Hospital ("the Hospital").

2. I have held been at the Hospital for the past 4 years. When I first commenced at the Hospital I recall that Charles Nankovell was the Director of Surgery.

Qualifications and Experience

3. I did my initial medical training at Newcastle upon Tyne, from which I graduated in 1974 with a Bachelor of Medicine and Bachelor of Surgery (MBBS).

4. Following my graduation I worked in the United Kingdom for several years before obtaining my specialist qualification in anesthetics in 1981.

5. I am a fellow of the Australian and New Zealand College of Anesthetists (FANZCA), I also am a Fellow of the Faculty of Pain Management of the Australian and New Zealand College of Anesthetists (FFPMANZCA). I also hold a ~~FFARCC~~ FFARCS. I have a Post Graduate Diploma in Pain Medicine. MLC KO.

6. I have ~~conditional~~ LIMITED registration in Australia, which requires that I practice only in my field of specialty, which is anesthetics and pain medicine. However, I effectively also practice in intensive care. By virtue of my being the Director of Anaesthetics at the Hospital I am also the head of Intensive Care at the Hospital. In any event, the MLC KO.

Signed: . . . M.L.C. . . . .

Witness: . . Kristin O'Hara JP(Qual)

~~Solicitor/Barrister~~/Justice of the Peace/ ~~Commissioner for Declarations~~

70316

Hospital does not have a qualified intensivist so anesthetists are the closest things to intensivists available at the Hospital.

7. I HAD worked as an anesthetist for several years before joining the UK army in 1985. I remained in the army until 1995. During my service with the army I ended up working for the army in Germany where I ran anaesthetics for the army in Germany. MLC KO.

8. When I retired from the army I immigrated to Australia where I worked in the Darwin Base Hospital as an anesthetist for about 5 years.

History of administrators at the Hospital

9. When I first arrived, Dr Charles Nankovell was Director of Surgery, and the Director of Medical Services was Dr John Wakefield. Since I commenced there have been a number of Directors of Medical Services including Kees Nydam who acted as Director for some time.

DR NANKIVELL HAD BEEN PRECEED BY DR ANDERSON AS

10. ~~After Dr Nankovell left as Director of Surgery, Dr Pitre Anderson was Director of~~ SUCCEEDED BY AS DIRECTOR OF Surgery and ~~then~~ Dr Sam Baker ~~was~~ Director of Surgery. Dr Baker left and was replaced by Dr Jayant Patel. MLC KO.

Supervision of Dr Patel

11. When Dr Patel arrived he was appointed to the position of Director of Surgery. As he was the Director this meant that he reported directly to the Director of Medical Services who was Dr Darren Keating.

12. There was no one in a position to supervise Dr Patel's surgical skills. The other surgeons on staff included Dr Brian Thiele, who is a vascular surgeon, Dr Howard Kingston and Dr Pitre Anderson. However those surgeons were all Visiting Medical Officers (VMOs) and effectively part time. They were not in a position to supervise Dr Patel.

Signed: . . M L Coats . . . . .

Witness: . . Kristie O'Hare. JP(Qual)

Solicitor/Barrister/Justice of the Peace/
~~Commissioner for Declarations~~

70336

QUALIFIED

13. In my opinion anesthetists are not in a position to supervise surgery even though they are present in the operating theatre. During surgery there are a number of people in the operating theatre: At the head of the patient is the anesthetist and an assistant nurse, the surgeon stands at the side of the patient. To one side and behind him is the scrub nurse who assist the surgeon during the operation. There is also a scout nurse whose role is to obtain additional equipment for the surgeon and anesthetist if required.

14. The anesthetist is responsible for keeping the patient alive PAIN FREE AND UNRESPONSIVE while undergoing surgery, this includes monitoring the patients vital signs which includes blood pressure, heart rate, breathing etc. It also involves administering appropriate medication to ensure the patient remains alive. It is very difficult to also monitor the surgery at the same time. Furthermore, anesthetists are not specialists in surgery, ~~and~~ THEY are present during a wide variety of operations. MLC KO. MLC KO.

Dr Patel

15. In my opinion Dr Patel was not the worst surgeon that we had had at the Hospital, he was not the best surgeon but in my experience there have been worse at the Hospital.

16. Dr Patel was like many surgeons with whom I have worked. He was very confident and wanted to be in charge.

17. He was also unused to the fact that in Australia anesthetists and intensivists have a much greater role in patient care than in the United States. I UNDERSTAND THAT United States surgeons are more dogmatic about the treatment and control of what they perceive as "their patients". They are unused to the fact that in Australia a much more multi-disciplinary approach to patient care is the norm, especially in Intensive Care. MLC KO.

18. For example, I am the head of ICU. Dr Patel's patients remained under his care when they were in the ICU. However,I was pushing for joint ward rounds where both he and I would review patients together to allow a multi-disciplinary approach to patient care.

Signed: . . . MLCook . . . .

Witness: . . Kirstie O'Hare . . . JP(Qual)

Solicitor/Barrister/Justice of the Peace/
Commissioner for Declarations

7036

I had difficulty in obtaining Dr Patel's agreement ~~to~~ AND COMPLIANCE WITH this approach. I recall that Dr Patel started coming into ICU earlier each morning and completing his ward rounds before I arrived at the hospital. I believe he did this to avoid having to participate in joint ward rounds and to keep control over his patients. MLe KO.

19. When Dr Patel joined the Hospital he did two things for the hospital: First he reduced the elective surgery waiting list, and second he met the surgical targets for funding. He did this by working very long hours because he did not appear to have any life outside the hospital. I recall that he did work very hard.

Elective Surgery Waiting Lists

20. Dr Nankovell left the hospital due to what he said was a lack of support from the administration. He was replaced by Dr Sam Baker who also left the hospital. There was also Dr ~~Jayasekfra~~ JAYASEKERA who was a surgeon at the hospital for some time. MLe KO.

21. As a result of the departures of the surgeons, the elective surgery waiting list blew out. Basically the surgery was not being done. When Dr Patel took over he met the surgical targets through both performing a lot of surgery, and through an interesting use of figures. BY DQDSU (DISTRICT QUALITY AND DECISION SUPPORT UNIT) MLe KO

22. As I understand it, elective surgery is defined as anything that is not emergency surgery. Where a time and date can be booked for the surgery it becomes elective surgery. The ability to meet elective surgery targets is a major factor in ~~increasing~~ DECIDING the funding for public hospitals. I understand that Queensland Health funds public hospitals on a combination of the historical budget with a factor based on the ability to meet elective surgery targets. If a public hospital can meet or exceed certain elective surgery targets then the Hospital receives additional funding in the next year. MLe KO.

23. An example of Dr Patel using unusual means to achieve elective surgery targets AND DQDSU involves Accident and Emergency (A&E) admissions. If a patient is admitted into the A&E ward and goes straight to theatre then that is counted as emergency surgery and MLe KO.

Signed: . M.L. Patel . . . . . Witness: . Kristie O'Hara JP(Qual)

Solicitor/Barrister/Justice of the Peace/ ~~Commissioner for Declarations~~

70336

does not get counted in the elective surgery targets. However if that patient is kept on the ward for 24 hours and then goes to surgery then the surgery is no longer considered emergency surgery, and is counted as elective surgery. By doing this the elective surgery targets are met but obviously there is no effect on the waiting list for elective surgery.

24. I recall that there was pressure from the executive to meet the elective surgery targets for the hospital. There were regular emails from Dr Keating about making sure that the elective surgery targets were achieved.

25. On 28 February 2005 Ms Karen Smith, the theatre co-ordinator sent an email to Dr Keating advising that I was unable to perform Dr Delaney's surgery session on Wednesday morning as I was commissioning a new anaesthetic machine. Dr Keating was also advised that all staff anesthetists would not be available on the Thursday as they had to attend an inservice training service. On that afternoon I received an email from Dr Keating asking why the machine needed to be commissioned now and whether the inservice training could be staggered so that the evening theatre session could go ahead. ~~Annexed to my statement and marked with the letters MLC [insert number] is a copy those emails.~~ I DO NOT HOLD COPIES OF THESE E-MAILS MLC KO.

26. On 3 March 2005 at 2:48pm I received an email from Dr Keating asking if I could get an anesthetist to do PAC the following Thursday from 12:30pm to 13:30pm. The reason was to ensure that gynacology was not put back and their elective surgery targets could be met. I replied on the same day at 3:52 pm where I advised Dr Keating that there are 300 cases in PAC awaiting surgery and that in my opinion we could afford to cancel one clinic. At 4:45pm I received a response from Dr Keating advising that Gynaecology had an increasingly long waiting list and they did not need the clinic to be cancelled. ~~Annexed to this my statement and marked with the letters MLC[insert number] is a copy of those emails.~~ I DO NOT HOLD COPIES OF THE E-MAILS MLC KO.

27. On 4 March 2005 at 8:23am I replied to those emails saying that 30 gynaecology patients had been put through PAC and next week there would be 4 further operations

Signed: . . . MLC . . . . . Witness: . . Kristen O'Hare JP(Qual)

Solicitor/~~Barrister~~/Justice of the Peace/ ~~Commissioner for Declarations~~

70336

QUALIFIED

Doc: 78

and that the gynaecology would still meet its elective surgery target. On 4 March 2005 at 8:33 am I received an email from Dr Keating advising that the hospital was behind its elective surgery target by 142 weighted separations and that his request that I provide an anesthetist was no longer a request and that I was directed to ensure that an anesthetist was available for the session. ~~Annexed to my statement and marked with the letters MLC [insert number] is a copy of those emails.~~ I DO NOT HOLD COPIES OF THESE E-MAILS MLC KO.

28. The elective surgery waiting list and targets were very important to the administration. Dr Patel often bragged that he had brought ½ million dollars into the hospital by achieving elective surgery targets.

Transfer of Patients

29. The ICU at the Hospital is a level 1 facility. Under the COLLEGE guidelines for level 1 ICU's ventilated patients are usually kept in the ICU for 24-48 hours after which they should be transferred to a tertiary hospital. MLC KO.

30. Level 1 ICU's are designed for short-term ventilation where the patient recovers and is moved to a ward after a short period. Alternatively level 1 ICU's stabilize the patient and then transfer the him/her to a tertiary hospital.

31. However, I have always taken the view that a transfer to a tertiary facility should be done in the best interest of the patient, and as head of ICU that is the policy that I have adopted and encouraged.

32. For example sometimes it is not in the best interests of the patient or the paatient's family to transfer the patient to Brisbane. If a patient is going to die and there is nothing that can be done to save that patient then I would keep them in the Bundaberg ICU for beyond the 24-48 hour period. I do this because where there is no hope of recovery, a transfer to Brisbane is very disruptive for the family and when the patient passes away, the family are then faced with the difficulty of arranging to have the body

Signed: M L Cowley

Witness: Kristie O'Hara J.P.(Qual.)
Solicitor/Barrister/Justice of the Peace/
~~Commissioner for Declarations~~
Reg. No. 70336

returned to Bundaberg for the funeral. In those circumstances I would not transfer a patient to Brisbane.

33. The other circumstances where I would keep a patient in ICU for longer that the 24-48 hour period is where the patient is recovering and it looks as though the patient might only need ICU support for a further day or so, then in those cases I would keep the patient ICU beyond the 24-48 period as a transfer to Brisbane is unnecessary and also not in the patient's best interest.

34. When Dr Patel started at the hospital I remember him asking why I was keeping patients who were dying in the ICU, but wanted to transfer his patients to Brisbane.

35. Bundaberg ICU is a level one facility for a number of reasons. The designation depends on a range of factors such as the level and qualifications of the staff. The principal reason for the designation is because the Hospital does not have a specialist intensivist. Because of that the unit REGULARLY relies on telephone advice from the Brisbane Hospitals. MLQ KO.

Patient P34 and oesophagectomies

36. I recall that Mr P34 HAD developed cancer of the oesophagus. This type of cancer is a slow moving cancer but is a very painful condition and unless treated it is a very nasty way to die. When advanced the patient cannot swallow, eat, or drink anything, INCLUDING SALIVA He ~~was~~ also ~~a diabetic and~~ suffered from renal failure, MYOPATHY AND NEUROPATHY I agreed to anesthetize Mr P34 as he had ongoing problems with vascular access. MLQ KO. MLQ KO. MLQ KO.

37. There are a number of ways to perform an oesophagectomy and it depends on where in the oesophagus the cancer is located. Where the cancer is near the top of the stomach the procedure is less complex as it is a matter of performing a "pull through" where part of the bottom of the oesophagus is removed and the stomach is reattached to the remaining oesophagus. This is the type of operation that was performed in Bundaberg. Where the cancer is higher up in the oesophagus it might be necessary to replace the

Signed: M.L.Cook

Witness: Kristie O'Hara JP(Qual)
~~Solicitor/Barrister~~/Justice of the Peace/
~~Commissioner for Declarations~~
7036

part of the oesophagus removed with piece of colon. This type of operation was not performed in Bundaberg.

38. I remember BEING TOLD that there had been attempt to transfer this patient to Brisbane for an oesophagectomy, however as I recall FROM THAT CONVERSATION there was a waiting list of several months before he could receive the surgery in Brisbane. MLR KO.

39. Dr Patel had assured me that he could perform and oesophagectomy and he convinced me that he had done plenty in the past. An oesophagectomy is a complex procedure but it can be performed in a regional hospital. I recall that this procedure was performed at the Darwin Hospital when I worked there. The Darwin Hospital is about the same size as the Bundaberg Hospital. Oesophagectomies were regularly performed at Darwin. AN OESOPHAGECTOMY HAD BEEN PERFORMED LESS THAN A YEAR PREVIOUSLY IN BUNDABERG MLR KO.

40. Where I am faced with a choice of performing the surgery locally and transferring a patient to Brisbane in several months time, and I have a surgeon who assures me that he can competently perform the operation AND KNOW NOTHING TO THE CONTRARY then I will treat the patient locally. I AGREE TO MLR KO.

41. If a surgeon gives me an assurance that he can competently perform a procedure then I have to trust his judgment until I have reason to think otherwise.

42. P34 underwent the surgery by Dr Patel and he later died in ICU. I provided the anaesthetic service for Mr P34 as although he was quite ill he was, in my opinion, fit for anesthesia, otherwise I would not have provided the service. However in retrospect I have often questioned whether I should have anesthetized him given the ultimate outcome. However the surgery was really a palliative procedure as his underlying medical conditions meant that he was unlikely to live for more that a few years.

43. I recall Dr Jon Joiner and Toni Hoffman commenting to me that we should not be doing these operations in Bundaberg. WHEN I CAME BACK LEAVE AT THE END OF JUNE MLR KO.

Signed: M L Carl

Witness: Kristie O'Hara JP(Qual)

~~Solicitor/Barrister~~/Justice of the Peace/ ~~Commissioner for Declarations~~

Reg. No. 70336

QUALIFIED

Doc: 78

44. Dr Patel performed ~~6~~ 4 oesophagectomies whilst he was at Bundaberg. ~~Over this time~~ my judgement about his ability to perform these operations changed. AFTER THE DEATH OF P21. KO. M2Q

Patient P21

45. This was the last oesophagectomy performed at the Hospital. I did not provide the anaesthetic service for Mr P21 but as head of ICU I am aware of some of the problems that occurred with this patient.

46. I recall that after the procedure Mr P21 was still bleeding excessively whilst in ICU. We were unable to determine where the bleeding was coming from and after some time Dr Patel decided to take him back to theatre to try and find out where the bleeding was coming from. I was not present at this operation and I am unable to say what happened.

47. I recall afterwards that Dr Patel said to me words to the effect that he could not locate where the bleeding was coming from, when he was above the diaphragm the bleeding appeared to be coming from below it, and when he was below the diaphragm the bleeding appear to come from above it.

48. Dr Dieter Berens was the anesthetist who was present during the surgery on Mr P21. After the death of Mr P21, Dr Berens approached me to discuss P21, Dr Berens felt that the death should be reported to the coroner and a post mortem should be conducted. Dr Berens told me he was specifically concerned about Dr Patel's attitude towards Mr P21, he related to me that Dr Patel did not seem at all concerned about the post operative bleeding of Mr P21, but then after a short period of time he became sufficiently concerned to take him back to theatre. Dr Patel did not take patients back to surgery if he could avoid it.

49. Dr Berens was also concerned that the death of Mr P21 was not adequately investigated, Dr Berens wanted to know what had occurred in theatre.

Signed: . . M.L. Coulter . . . . .

Witness: Kerstin O'Hara JP(Qual)

Solicitor/Barrister/Justice of the Peace/
~~Commissioner for Declarations~~

Reg. No. 70336

JUSTICE OF THE PEACE QUALIFIED

50. By this stage I had also become concerned about the oesophagectomies that were being performed. Dr Patel had performed 4 oesophagectomies and 2 of those patients had died IN THE POST OPERATIVE PERIOD. I had done some research into acceptable survival rates for oesophagectomies, according to the literature that I had reviewed 90% of patients should survive at least 1 year after the oesophagectomy. As 2 of Dr Patel's 4 patients had died I was sufficiently concerned to raise this with administration. MLe KO. MLe KO.

51. Dr Berens and I went to speak with Dr Darren Keating the Director of Medical Services. At that meeting Dr Berens and I discussed with Dr Keating the fact that we believed that there should be an autopsy on Mr P21. At that meeting we discussed with Dr Keating that the issues that we felt needed to be investigated were that the patient had died, the haemorrhaging had not been dealt with, there was a significant delay between when the patient was admitted to ICU and when he was returned to theatre and the fact that Dr Patel had told me afterwards that he couldn't find where the bleeding was coming from.

52. At that meeting Dr Keating advised that Mr P21's funeral was to be held within the next hour and that if a post mortem was to be performed it would be necessary to contact the family and stop the funeral so that Mr P21's body could be returned to the hospital for a post mortem.

53. In the circumstances I felt that the family had suffered enough and that stopping the funeral would only add to their stress and grief. In hindsight I now realize that the family have suffered more because of the lack of a post mortem and that in retrospect we should have stopped the funeral. However at the time it was agreed by Dr Keating, Dr Berens and myself that we ought not to stop the funeral and I considered that was in the best interests of the grieving family.

54. However at that meeting I also discussed with Dr Keating my concerns about the survival rates of Dr Patel's patients and what the literature revealed on expected survival rates in ordinary circumstances. I also raised with Dr Keating that increasingly complex surgery was being performed at the Hospital and as a result the

Signed: . . . M L Cerl . . . Witness: . . . Kristie O'Hare . . . P(Qual)

~~Solicitor/Barrister~~/Justice of the Peace/~~Commissioner for Declarations~~

70336

QUALIFIED

workload of ICU was increasing. Dr Keating decided that there would be no more oesophagectomies performed at the Hospital.

55. I recall another instance where I spoke to Dr Keating about Dr Patel's surgery, and I think it was not long after the decision to stop performing oesophagectomies. I recall that Dr Patel wanted to perform a lobectomy. A lobectomy is the partial removal of a patient's lung and it is necessary to perform a thoracotomy in order to do a lobectomy. A thoracotomy is a procedure where a patient's chest is opened up. I remember speaking to Dr Keating about this and I believe I said to Dr Keating that "I don't think we should be cracking chests in this hospital." Dr Keating informed me that Dr Patel had assured him that the procedure was a lobectomy and not a thoracotomy. At this point I began to doubt Dr Keating clinical knowledge as it is impossible to do a lobectomy without first performing a thoracotomy.

Patient Mrs P44

56. I recall that on the day before Mr P21 was to undergo his oesophagectomy, 18 December 2004, Mrs P44 was in ICU on a ventilator. Apparently Dr Patel wanted a ventilator to be available for Mr P21 following his surgery, he had apparently been in ICU on the previous day, and had asked that Ms P44's ventilator to be switched off at midnight.

57. Ms P44 had suffered a massive ~~intracerebral~~ INTRACRANIAL (BOTH INTRA AND EXTRA CEREBRAL) bleed (a stroke). As a result Ms P44 had suffered an enormous amount of irreparable brain damage as a result of her stroke. Ordinarily a person can recover from a minor stroke however where a person has suffered as much brain damage as Ms P44 had suffered the chance of recovering any amount of brain function is almost nil. By having Ms P44 on a ventilator all that was being done was prolonging her death, in my opinion she would not have recovered. ML KO.

58. I am told that Dr Patel had apparently left instructions that Ms P44's ventilator was to be switched off at midnight. The anesthetist that was on duty that evening was, I

Signed: M L Cook

Witness: Kirstie O'Hara JP(Qual)
Solicitor/Barrister/Justice of the Peace/
~~Commissioner for Declarations~~
70336

JUSTICE OF THE PEACE QUALIFIED

believe, Dr Jon Joiner. Dr Joiner is a General Practitioner who also provides anasthetics services as a part time VMO. I am led to believe that Dr Joiner refused to turn Mrs P44's ventilator off as that decision fell outside his competence and expertise. Dr Joiner as a part time anesthetist and general practitioner would not have wanted to make any decision on whether OR NOT to continue ventilation. He more likely would have left that decision to me to make as the Director of ICU the next morning. MLe KO.

59. When I arrived the next morning Dr Patel asked me to look at Mrs P44. Dr Patel told me that he wanted the ventilator turned off so that he could to perform and oesophagectomy on Mr P21. He needed the ICU bed to be available for Mr P21 after the operation. After this discussion I informed Dr Patel that I would look at Mrs P44 and review her and make a decision on whether or not to continue with ventilation. I did not agree to turn off Mrs P44's ventilator, I only agreed to review her chart and make my own determination on whether or not ventilation should continue.

60. I examined Mrs P44's chart and in particular her CT scan (computed tomography). Her CT scan revealed an extensive intra-cerebral AND EXTRADURAL hemorrhage that was so severe that she had significant brain damage. The damage was so extensive that in my opinion there was no chance of Mrs P44 making any recovery from her stroke. MLe KO.

61. I did not perform a brain stem death test as it was not necessary in the circumstances. THERE WAS SUFFICIENT CLINICAL EVIDENCE A brain stem death test is necessary when there is some evidence of brain function, some sign of life and some doubt about whether there is any brain function. Mrs P44 had no sign of either, and her brain damage was so extensive that she had no chance of making any recovery. In those circumstances I saw no reason to perform a brain stem death test as her brain damage was so severe. I reviewed her CT scan and followed established medical practices in evaluating Mrs P44. MLe KO.

62. I considered that continuing her ventilation would only prolong her death and that in the circumstances her ventilator should be switched off. However, before switching off her ventilator I first discussed her condition with her family. I explained the extent of her stroke and subsequent brain damage. I also explained that if her ventilator was

Signed: M.L. Cook

Witness: Kristie O'Hara JP(Qual)

~~Solicitor/Barrister~~/Justice of the Peace/~~Commissioner for Declarations~~

Reg. No. 70336

Doc: 78

turned off she would be unlikely to breath on her own but that it was a remote possibility. I also informed them that there was nothing that could be done to save her. Her family were reasonably accepting of what I had told them and agreed that Mrs P44's ventilator could be turned off.

63. I turned off Mrs P44's ventilator. It was entirely my decision and in my opinion it was in the best interests of the patient and her family. Continued ventilation would only prolong her death, and not her life. Dr Patel's need to have an ICU bed available for his patient following the operation did not influence my decision at all. Aside from him asking me to review Mrs P44, Dr Patel had no involvement of influence in my decision.

Patient P26

64. Patient P26 suffered a lacerated femoral vein in what I understand was as a result of a motorcycle accident. I was not involved in his surgery, but was ~~briefly involved in his~~ AWARE OF HIM RECIEVING post operative care when he was in ICU. I believe that Dr Patel repaired the lacerated femoral vein but also discovered some problem on the arterial side, and Dr Patel attempted a repair on the artery. MLC KO.

65. P26 was then transferred to the ward from ICU. I recall that I was also involved in providing sedation for P26. I had no further involvement in P26's treatment however I have heard a considerable amount subsequently about his treatment. I have no other direct knowledge of this patient.

Patient Mr P11

66. I was involved in an audit into this particular case. I prepared a case report into P11, ~~annexed to this statement and marked with the letters "MLC1" is a copy of that report.~~ I also asked Dr Iftikhar Younis to provide a report on his recollections of this case. Dr Younis provided a hand written report which I transcribed, ~~annexed to my statement and marked with the letters "MLC2" is a copy of Dr Younis, hand written report.~~ MLC KO. MLC KO.

Signed: M L Coulter

Witness: Kirsten O'Hara JP(Qual)
~~Solicitor/Barrister/Justice of the Peace/~~
Commissioner for Declarations
70336

~~Annexed to my statement and marked with the letters "MLC3" is a copy of my transcription of Dr Younis' report.~~ MLC 140.

67. A copy of these reports were given to Dr Darren Keating.

68. I prepared these reports because I fully expected P11's case to be investigated by the coroner. The reason I did this is because at the time there was a suggestion that Mr P11's injuries may have been deliberately inflicted. I have no knowledge of whether or not that is true, but it was something that I heard at the time. Furthermore, there was to be an audit of his case by both the ICU and surgery departments. I am unsure whether Dr Patel ever completed a report into this case.

69. Mr P11 came into Accident and Emergency on 27 July 2004. He had sustained a severe crush injury to the right side of his chest when he was trapped under a caravan for ten minutes about 3 hours earlier. He was transported to the hospital by helicopter. Dr Younis was the ICU consultant on call on that day. Dr James Boyd, surgical Principal House Officer (PHO) called Dr Younis at about 7:45pm. P11 was admitted under Dr Gaffield, who was the surgeon on duty that day.

70. From his chart it appears that Mr P11 was in acute respiratory distress, with hemodynamic instability, he was pale, sweaty and desaturating. His consciousness level was fluctuating and he complained of sever chest pain when he was conscious. Dr Gaffield was also called in from theatre.

71. Bilateral large bore cannula were inserted as was an intercostal drain. The trauma screen radiology showed an enlarge heart and probable fractures to the 6th and 7th ribs. He was admitted to ICU for overnight observation.

72. On the next day 26 July 2004 he was awake and appeared comfortable and was discharged to the surgical ward on analgesia. His chest radiograph showed collapse and consolidation on the right with multiple rib fractures.

Signed: MLC

Witness: Kristie O'Hara JP(Qual)
Solicitor/Barrister/Justice of the Peace/
~~Commissioner for Declarations~~
70336
QUALIFIED

73. He continued to appear well until about 1pm on 27 July 2004 when he collapsed with a recorded blood pressure of 50 systolic. He was in acute respiratory distress and complaining of severe chest pain. The right side intercostal drain was non-functional. He was transferred to the ICU. While he was in ICU he was awake and talking.

74. I was then called in for review and to advise on the further management of Mr P11. It was decided that the patient was to be transferred to Brisbane to a tertiary hospital with the capacity to perform cardio-thoracic surgery, long term ventilation, and with a blood bank with the capacity to provide large volumes for transfusion.

75. I believe that Dr Gaffield asked Dr Patel to examine P11 as Dr Patel apparently had more experience in dealing with trauma patients. After that Dr Patel was involved in P11's treatment.

76. At this time the anaesthetist who was on duty, Dr Younis, was diverted to provide assistance to Dr Patel whose patient had suffered a perforation during a colonoscopy, that had been performed by Dr Patel. Dr Patel then returned to theatre. At the time it was decided to arrange a abdomino-thoracic CT scan to exclude any intra-abdominal catastrophe. The CT demonstrated marked change with the right hemithorax being full of blood with a mass displacement of the mediastinum to the left. There was no evidence of pericardial fluid.

77. Fluid resuscitation continued with P11 receiving in total.

   a. 11 units of blood;
   b. 4 units of fresh frozen plasma;
   c. 3,000 ml crystalloid;
   d. 2,000 ml colloid;

78. Dr Patel then reviewed the patient and decided to do an ultrasound guided pericardiocentesis, despite the evidence of the CT scan shown an absence of pericardial fluid.

Signed: . . MhCarter . . . . . .   Witness: Kristie O'Hare (JP Qual)
Solicitor/Barrister/Justice of the Peace/
~~Commissioner for Declarations~~
70336

JUSTICE OF THE PEACE QUALIFIED

Doc: 78

79. Dr Patel then had discussions with the family and advised them that P11was too ill to be transferred to Brisbane. He stated that P11 had suffered a pulmonary contusion leading to massive haemothorax.

80. The retrieval team was dispatched from Brisbane at 7:30pm and arrived at about 10:15pm, however the patient died despite all attempts at resuscitation.

81. A post mortem revealed that there was 3,000ml of blood in the right hemithorax and his right lung was collapsed. It also revealed that he had fractures to the 6th and 7th rib as well as a fractured sternum. The right ventricle had been abraded and the visceral pericardium perforated.

82. The cause of death was attributed to internal haemorrahage.

83. I listed my areas of concern in my surgical audit report. I provided a copy of my report to Dr Keating.

84. I was informed that Dr Patel was to do his own surgical audit on this case, however he never provided me with a copy of his report.

85. At no time prior to the post mortem did Mr P11's radiology of CT scan show that he had suffered a fractured sternum. Effectively this meant that no one at the Hospital was aware of this injury. ~~In my opinion the fractured sternum was the primary factor that resulted in P11's death.~~ THIS IS DUE TO THE BASIC AND ANTIQUATED NATURE OF TH CT SCANNER IN THE HOSPITAL THERE IS NO IMMEDIATE RADIOLOGY REPORTING MR KO.

86. In my opinion, because of the equipment available, the hospital staff were unable to diagnose the fractured sternum. I don't believe that Mr P11 would have had any chance of surviving his injuries unless he had been transferred directly to a major tertiary hospital with a cardio-thoracic unit such as the Prince Charles Hospital. He required treatment in a hospital that had experience in cardio-thoracic surgery which would have been able to open his chest and repair the injury. In my opinion he would

Signed: . . . . . Witness: . . . . . Solicitor/Barrister/Justice of the Peace/ Commissioner for Declarations

JUSTICE OF THE PEACE Reg. No. 70336 QUALIFIED

not have survived in any other hospital. The outcome of his treatment at Bundaberg was inevitable.

Complaints Processes in the Hospital

87. The Hospital uses adverse events forms for serious clinical problems. The adverse events forms are sent through to DQDSU, ~~which used to be called the Quality Assurance Unit. I don't recall what DQDSU stands form.~~ MHQ KO.

88. I have never received any feedback from DQDSU on any adverse event form that I have completed.

89. I don't recall any adverse event forms ever being discussed by the executive council meetings. This issue was raised by all of the clinical directors at the executive meetings on occasions at the Executive Meeting which occurs on a Friday afternoon. I recall being told that this would change in the future, and that feedback would be provided. However, I do not recall things changing.

90. I don't recall any staff complaints ever being made to me from my staff. Occasionally I would hear of complaints from nurses or staff from other medical units, but as those staff should take their complaints through their own internal channels I have not followed up those complaints. One instance I recall specifically was when a nurse complained about Dr Quereshi who was sexually harassing nurses and patients. I had no first hand knowledge of those incidents and assumed that the ICU nursing staff would have complained to the Nurse Unit Manager (NUM), Toni Hoffman and the complaint would have gone up through the nursing channels.

91. I don't know what the executive's attitude towards complaints was as I don't ever recall it being discussed by the executive.

ASPIC Committee

Signed: M h Cook

Witness: Kristie O'Hare JP(Qual)

~~Solicitor/Barrister~~/Justice of the Peace/ ~~Commissioner for Declarations~~

Reg. No. 70336

Doc: 78

92. I am the chair of the ASPIC Committee, that is a committee that deals with Anasthetics, Surgery, Pre-assessment clinic and Infection Control.

93. The meeting was designed to discuss on-going problems in those departments and allow a forum to discuss clinical pathways etc. I don't consider the committee to be particularly effective. The 2 hours per month that is allotted to the committee is not sufficient to discuss all of the areas that need attention, particularly given that the committee includes infection control.

94. The staff who attended the ASPIC meetings included the senior nurse from the pre-assessment clinic, surgical ward, theatre, theatre bookings, the head of infection control: Di Jenkins, my self as Director of Anasthetics and Intensive Care, the Director of Surgery: Dr Patel, the Director of Medical Services: Dr Keating, a representative from DQDSU, and the District Manager: Peter Leck.

95. There was a lot of ground to cover and only a limited amount of time in which to discuss it. I felt that the forum was inappropriate and should have been split up, however we often had problems in getting enough people to attend.

96. There was little cross-pollination between the various committees in the hospital. For example I was aware of some problems with peritoneal catheters that had occurred at the renal ward, however, this was never discussed at the ASPIC meetings. The numerous meetings are not integrated in any meaningful way.

Wound Dehiscence

97. The issue of wound dehiscence as I understand it was first raised by Di Jenkins the infection control co-ordinator. However I was not present at that meeting as I was away, I believe that Dr Patel was present.

98. I believe that most of the discussion occurred during my absence from the hospital. I understand that it proceeded to a formal audit.

Signed: . . M L Peck . . . . .

Witness: . . Kirsten O'Hare JP (Qual).

~~Solicitor/Barrister~~/Justice of the Peace/ ~~Commissioner for Declarations~~

70336

Doc: 78

99. ~~In my experience wound dehiscence usually occurs in clusters and occurs for a variety of reasons. I have no knowledge of the cause of this particular cluster of wound dehiscence.~~ MLC KO.

100. I was in the United Kingdom during this period.

Theatre Management

101. The theatre management committee was responsible for reviewing waiting lists and ways to improve theatre efficiency. On this committee was myself, Dr Patel, Karen Smith the elective surgery co-ordinator, and Jenny White the NUM of theatre.

102. There was often a discussion of workloads as there was an increasing amount of surgery being performed. I was constantly aware that the hospital did not have the staff for the amount of surgery that was being performed.

103. The Hospital is funded for 21 surgical sessions per week, for that there are 13 Full Time Equivalent staff in theatre. Rockhampton has 25 surgical sessions per week and has 29 Full Time equivalent staff in theatre.

104. I complained to Linda Mulligan, the Director of Nursing about the staffing levels in theatre, my particular complaint was that positions were never backfilled when staff went on leave. I was also concerned about the skill levels of new staff who may have a much lower skill mix than long term staff members.

Peritoneal Catheter Access Program

105. I was not involved in the audit of peritoneal catheters that occurred in the renal unit at Dr Miach's direction. AND WAS UNAWARE OF MLC KO.

Signed: M L Cook

Witness: Kristie O'Hare JP(Qual)

Solicitor/Barrister/Justice of the Peace/
Commissioner for Declarations

JUSTICE OF THE PEACE QUALIFIED Reg. No. 70336

106. I am involved in providing some vascular access services for the renal unit at the hospital. As an anaesthetist I am skilled at obtaining vascular access and I used to insert vascaths and central lines to assist the renal unit and Dr Miach.

107.I did not insert perma-caths as they require a surgical approach. I recall there being problems with perma-caths in the hospital, although I don't remember the specifics of the problem. I arranged with Dr Miach to have 1 session per week in the renal ward to insert temporary catheters for dialysis.

108.I did not have any other involvement in the peritoneal catheter access program set up by Dr Miach.

Dr Patel's surgery

109. As I said above in my opinion Dr Patel was not the worst surgeon that had been at the Bundaberg Hospital. Many of the patients that Dr Patel performed surgery on were already suffering from serious conditions. For example I recalled one patient who was suffering from pancreatic cancer, without treatment, death is inevitable for a person with pancreatic cancer.

110.Dr Patel did operate on some patients that would ordinarily be considered hopeless cases, such as P34, discussed above. In many cases the patients would have most certainly died if they had not received surgery.

Other matters involving Dr Patel

111. I recall one occasion when Dr Patel changed the medication that had been put on an ICU patient's chart. Dr Patel was unused to having anesthetists in ICU being involved in patient treatment.

112.I also recall having disputes with Dr Patel about the fluid intake of patients. Surgeons and Physicians have a different approach to fluid intake, surgeons are concerned about

Signed: . . M.L.Coles . . . . .

Witness: Kristie O. Hoare SC(Qual)
Solicitor/Barrister/Justice of the Peace/
Commissioner for Declarations
70336

JUSTICE OF THE PEACE QUALIFIED

urine whilst physicians, and particularly anesthetists are concerned about blood pressure and other indicators. IN ADDITION. MLC KO.

113. In this case Dr Patel had prescribed a diuretic in order to get the patients urinating sooner after surgery, whilst I considered that should not have occurred until at least 72 hours after surgery. Dr Patel thought differently than I about this treatment.

114. I also recall an instance where I was attempting to insert a central line into a patient. I was having difficulty so I left Dr Patel in the room with the patient while I went to get an ultrasound machine. When I returned Dr Patel was attempting to insert the central line. I was upset as clearly as an anesthetist, I had much more experience in inserting central lines than Dr Patel did.

Dated this 11TH day of AUGUST 2005

Signed . M.L.C. . . . . .

Witness . Kristie O'Hare JP(Qual)

~~Solicitor/Barrister~~ /Justice of the Peace/ ~~Commissioner for Declarations~~

JUSTICE OF THE PEACE STATE OF QUEENSLAND ATTORNEY-GENERAL'S DEPARTMENT Reg. No. 70336 QUALIFIED