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Transcript of Proceedings

MR A J MORRIS QC, Commissioner

SIR LLEW EDWARDS, Deputy Commissioner

MS MARGARET VIDER, Deputy Commissioner

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IN THE MATTER OF THE COMMISSIONS OF INQUIRY ACT 1950

BUNDABERG HOSPITAL COMMISSION OF INQUIRY

COMMISSIONS OF INQUIRY (No. 1) 2005

BRISBANE

..DATE 16/08/200

..DAY 42

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THE COMMISSION RESUMED AT 10.32 A.M.

PETER WILLIAM HAROLD WOODRUFF, CONTINUING
EXAMINATION-IN-CHIEF:

COMMISSIONER: Just before we resume the evidence, I'd like to place on record our appreciation for the efforts undertaken by Mr Boddice and his team who arranged the inspection this morning at the Skills Development Centre and Mr Boddice, if you could pass on to Mr Phil Driver, the Chief Executive Officer our much profound appreciation.

I think it's worth saying that after months of evidence about problems in the health system, it was a wonderful insight to see one of the good news stories about Queensland Health, not only good news story in its own right but a strong indication of solutions to some of the problems that we've encountered. Apart from that it was also gratifying to see that Sir Llew's skills on the simulated surgery facility haven't diminished over the years. Please pass on our thanks.

MR BODDICE: Thank you, Commissioner.

COMMISSIONER: Mr Andrews?

MR ANDREWS: Commissioner, before commencing with Dr Woodruff, this afternoon's schedule is, subject to receipt of a statement from Dr Wakefield which will be supplied by the legal team from Queensland Health. It is proposed that Dr Wakefield will be available to be called this afternoon. Tomorrow's evidence will be the examination in Bundaberg of Mr Chase. It's anticipated that Mr Chase will be called at the DNR office in Enterprise Street at Bundaberg at 10 a.m. tomorrow.

COMMISSIONER: Good. Thank you.

MR ANDREWS: Dr Woodruff, we concluded yesterday by having the benefit of your opinions with respect to a number of patients who died as a result of or partly as a result of Dr Patel's failure to perform to a reasonable standard for a surgeon. You have some other tables. Now, for instance, there is Table E which interested the Commissioner yesterday for it had a number of patients who were relatively young.

COMMISSIONER: Well, I think of them as young, Mr Andrews, because they're younger than you and me.

MR ANDREWS: Well, there were even more than a small number of those.

COMMISSIONER: I wonder if we might repeat the process we did yesterday, Dr Woodruff, of just going through these patients one at a time and giving us a fairly nutshell summary of what

went wrong starting with P71?-- Thank you. P71 - well, this group that we're looking at now are those patients who - the group in Table E are patients where Dr Patel contributed to or may have contributed to an adverse outcome, and P71 underwent the excision of his rectum and he had a suprapubic catheter placed, that is, a tube to drain the bladder placed through the abdominal wall rather than directly through the ureter into the bladder, and that it was the opinion of one of Dr Patel's colleagues that the patient sustained a urethral injury whilst undergoing the removal of his rectum, and Dr Patel's note of the abdominal perineal resection states that he found a large carcinoma of the rectum invading both the prostate and the bladder, and that during the removal of this tumor, he accidently tore the bladder neck, and that raises the question of his technical prowess, it's dependent on the extent of the tumor involvement and is very hard from a retrospective review of the photos to positively attribute this event to technical deficiency, but I think it is a very uncommon occurrence of a rectal cancer excision, so - and it certainly is something we would not expect to happen. So I think it's reasonable to attribute its occurrence to a technical deficiency.

Thank you.

D COMMISSIONER EDWARDS: And the pathology did show a cancer?-- Affirmative. I can - that's the completion of the operative notes and then the progress notes summarise the situation and one of these, I believe, will be the histology. I would have to search the - as you can see the notes number more than 500 pages and this program does enable me to search for the word "histology" but to do that I have to feed in the disc of the patient, his histology.

But you were satisfied that it was-----?-- Yes, I was satisfied it was a carcinoma.

COMMISSIONER: I think the next one was Mr B whom we've heard about already in evidence.

D COMMISSIONER VIDER: Yes?-- We have, and the key feature here is in attempting to repair the inguinal hernia, the vas deferens running from the testes to the penis are divided and that should never happen during an inguinal hernia repair, but in addition to that inadvertent division, there was a scrotal haematoma or a collection of blood clot forming in association with the operation which is also a marker of deficient technical performance.

COMMISSIONER: I think, Mr Andrews, you might be able to assist me, but my recollection is that we maintained the suppression order in relation to that name because of the potential embarrassing nature of the problem.

MR ANDREWS: That's correct, Commissioner.

COMMISSIONER: Yes, and P10.

MR ANDREWS: I'm instructed that Mr B… 's referred to as Mr B.

COMMISSIONER: Mr B, yes?-- P10, sigmoidcolectomy, high anterior section, colonic obstruction followed by a breakdown of the wound, a wound dehiscence, the wound split apart on the first post-operative day and that I would mark as a technical deficiency. If I could just elaborate, if we look at the survey information in the bottom right-hand corner, these are the questions that I asked in relation to each of these patients, and in the case of P10, "Did Dr Patel contribute to the adverse outcome?" "Maybe". "Was he outside his scope of expertise?" "No". "Was the patient management reasonable?" "Yes". And looking at the extended survey, which was subsequent to the production of the original published report, "Was this patient terminal?" "No". The condition of the wound a major dehiscence, the operation was classed as a major abdominal procedure, the operative type was curative, the patient was not considered to be immunocompromised and there was no transfer and there was no involvement of other medical practitioners in this case. That is just an expansion of how the information that we're running through has been collated.

Doctor, we've heard considerable amount of evidence about the incidents of wound dehiscence and I think it would summarise the evidence fairly to say that in all surgery, wound dehiscence is a risk and a competent surgeon might expect to experience instances of it at occasional intervals, the concern here is that Dr Patel seems to have experienced it much more than occasionally; is that consistent with your analysis?-- Yes.

And it's also been suggested that wound dehiscence can result from a number of conditions or a number of circumstances: one is poor suturing technique or poor closure technique; another one is an inflammation or an infection of the wound; another one is faulty materials, faulty suturing material and that sort of thing; are you able to identify what the cause, not just in this case but in other cases, what these dehiscences show about Patel's technique?-- Yes, I believe I can. And could I demonstrate my findings in that regard?

Certainly?-- These are summarised in the hard copy table marked H. And here, the same arguments apply to the determination of the denominator that applied in the analysis of his 88 associated deaths. When I published the original report, his performance did not seem to be as deficient, relatively speaking, but I didn't have an accurate denominator, but having narrowed the field down to break down the surviving patients where Dr Patel contributed to and may have contributed to an adverse outcome, and reduced that to 31 and then 23 of these have major technical problems and you can see them listed there, wound dehiscence, seven, infection or haematoma, 12, anastomotic leak, five, and in fact, one patient appears in two of those columns, that's the patient Swanson, that is a quite unacceptable incidence of technical deficiency in such a small group of patients.

Yes?-- And supports the determination that his technical performance was inadequate.

D COMMISSIONER VIDER: And doctor, in support of that, Dr de Lacey's evidence where he has seen 151 of Dr Patel's patients for follow-up treatment, he has categorised his opinion or assessment of the complications as the three you've got there and he's added a fourth which is incisional hernia?-- Mmm-hmm.

So I can't remember the exact numbers that he's seen but it's the exactly the same four categories that he's got as complications?-- Right, and it's not surprising that he's found incisional hernias which are a later sequelae.

Yes?-- That don't come to light in the case records of the primary admission.

Yes.

MR ANDREWS: Doctor, 23 patients out of 23,000 wouldn't be a significant rate, would it? What's the denominator that you're speaking of? 23 out of - you mentioned 31, but I'm not sure what your denominator was?-- We narrowed the denominator down in this instance to something of that order.

Something of what order, 31 do you mean?-- I haven't got the exact figure at my hand, but it's considerably, it's considerably less than the 220 - well, 88 of those died. If we-----

An approximation will suffice, probably?-- Well, I think it's out of 31.

So 23 out of 31?-- Mmm-hmm. I might sound a little vague here, it's not that the figures aren't there, I'm just having difficulty working out-----

COMMISSIONER: No, I wouldn't be concerned doctor, I think I understand entirely what you're saying. I wonder whether it's possible to go back to the list and just go through the rest of them in similar way. P175 I think is the next surviving one?-- Well, P175 is the gentleman who following his tall cell variant carcinoma of the thyroid with metastatic secondaries into lymph nodes, was subsequently found to have a swelling under the jaw and Dr Patel elected to excise that and a salivary fistula resulted because it proved to be a salivary gland rather than recurrent tumor, but to put that in context, because this is one of the patients that appeared both in Dr de Lacey's study and also in this one. It's interesting to read the comments of Dr Patel in relation to this, and he - it will be one of the pages that are listed here at the moment, he actually, was actually of the opinion that this was most likely a salivary gland.

And yet he resected it anyway?-- But with some justification, because the patient had lymph node involvement at the time of

the original operation, then presents with a further swelling, very hard to tell whether it's a metastatic lymph node or, as Dr Patel rightly suspected, a abnormal salivary gland. The simpler way of determining an answer would be to do a fine needle aspirate, but he elected to excise it much like the excision biopsy of a breast lump, I presume, and the reason I've classified it as technically deficient, it was excised in such a way that a fistula resulted.

Yes?-- And should you excise a salivary gland adequately, there should be no fistula.

So really there are two issues: one is whether he should have performed the more simple technique to determine whether an excision was necessary?-- Mmm.

And secondly he - his technical aptness was suspect as to the way in which the excision was performed?-- Correct. The difficulty I'm having today is that I've prepared all of these notes to support what I'm putting before the Commission, but I'm conscious that it's taking me too long to search through this list, I don't think-----

Doctor, I don't think you need feel any concern about that. Candidly, we're more interested in your conclusions rather than asking you to support your conclusions. If anyone here wants to challenge what you say about a particular patient, you'll have every opportunity to get the documents, but for the moment, subject to, Mr Andrews, to what you think, I think we'd be very happy just to hear your conclusions in relation to the patients and leave it at that.

MR ANDREWS: That's the more practical course, Commissioner?-- We've discussed, I believe, Mr Bramich.

COMMISSIONER: Yes, I think P180 was the next; we're dealing now with the surviving patients?-- Well,P180. The ones that are marked with the blue unmarked boxes are the surviving patients.

All right?-- So I'll go on to-----

P190?-- P190 underwent a herniotomy associated with a Hydrosol and the Hydrosol sac was ligated and the Hydrosol recurred following this ligation. It was aspirated but recurred again. The parents were understandably anxious to have definitive treatment and the patient was given a note to return in a further six weeks, but I think from my assessment of the case notes, the patient went elsewhere, but I'm not absolutely certain on that point.

And this was a very young patient?-- Aged eight.

Eight years old, yes. What are your conclusions about Patel's performance on that occasion?-- Well, it's a reasonably simple condition. One would expect it to be successfully treated at the primary, at the primary attempt, and I think it is technically deficient to have three goes at it and still

not totally cure the problem.

Yes. P400 is someone about whom we've heard some evidence?-- Right.

I think she was one of your cases of wound dehiscence, wasn't she?-- Correct. She is one of the cases with wound dehiscence. There's a further suggestion that the left kidney may be obstructed. Now, with ovarian carcinoma, it could be obstructed by tumor. One of the technical complications of sigmoidcolectomy is damage to the ureter, I'm not able to say anymore, but there is sufficient indication of inadequate technique in the development of a wound dehiscence itself.

P15?-- P15 was admitted following his fourth attack of cholecystitis, he underwent a laparoscopic cholecystectomy, he developed a post-operative haematoma and bile leak. Both those occurrences occur from time to time but neither of them should occur and they're more likely to occur with deficient technique. He developed a further haematoma in the abdominal wall which required a return to the operating theatre and he subsequently developed an incisional hernia. A very deficient technique in two or three counts.

D COMMISSIONER EDWARDS: The bile leak to which you refer, was that regarded - was there a cause found for that?-- I don't believe so - I can't - I have not identified the cause of the bile leak.

But it would be a poor technique outcome to have a continuing bile leak?-- It is, although bile - of the various complications that occurred here, that is perhaps the most reasonably accountable in the hands of a good surgeon because of the occurrence of accessory bile ducts that could be overlooked at the original operation. Certainly the haematoma formation and the hernia are absolute technical deficiencies. Marilyn Daisy, a 44 year old, underwent an amputation of a toe in January '04 and then further circulatory problems related to her diabetes and renal failure saw this process extend, finally resulting in a major amputation, and this patient also had problems with dialysis access. Dr Gaffield placed a PermCath for further dialysis in November of '03, but Dr Patel performed a below knee amputation on the 14th of October '04 and the patient was transferred to the Royal Brisbane Hospital for the development of a permanent access, and I'm aware of some of the problems-----

COMMISSIONER: Yes?-- -----that have been aired about the management of this patient. I think it's not quite as simple and straightforward as one might initially view it in that there's a change of medical practitioner, there're at least three people involved in Bundaberg and the patient is sent off for another procedure to another hospital having not fully completed the management of the amputation, and whilst that in no way defends the oversight of leaving sutures in place for six weeks, it does explain how this can occur and it's the type of occurrence that unfortunately has occurred to more than patient Daisy.

Yes. What then are your reasons for placing this on the list of adverse outcomes in respect of Dr Patel?-- Because although you can explain it, it doesn't exonerate it.

Yes?-- P56 is a example that we've heard about on many occasions of a PermCath insertion not working, the patient was transferred for more appropriate attempts at access. Ian Fleming presented with rectal bleeding. He was noted to have some abdominal tenderness and a localised segment of the colon was seen to be abnormal on CAT scanning. The patient is recorded by Dr Patel as wishing to proceed with surgical resection, but following the sigmoidcolectomy, he returned with a serious sanguineous discharge from the wound. This was initially managed conservatively, but obviously there's a more significant complication because it didn't clear with conservative management. The purulent discharge continued and the wound required to be completely laid open before the infection resolved.

The bleeding continued post-operatively. A colonoscopy on the 20th of November reported multiple large diverticula or little out pouches on the wall of the bowel 30 centimetres from the anal verge and on reviewing the histology of the resected specimen, with diverticula extending to the resection margin, it suggests that the offending bleeding diverticulum was not excised. I can't categorically state that to be the case but there is more of the problem remaining and continuing to behave by way of bleeding after the operation. Therefore, the operation was inadequate in its-----

Is this a case, would you say, of Dr Patel operating outside his expertise or simply not having appropriate technique?-- I would consider it more attributable to technique, although it's been brought to my attention that this is one of the conditions that he'd been censured in Oregon, so that suggests to me that he's outside the scope that others have defined would be appropriate for him. One would normally consider an intelligent, competent general surgeon to be capable of this procedure. This is not as difficult as the carcinoma of the rectum that we considered earlier in this list that was invading into the bladder. This is a much simpler operation than that one.

You raise an interesting point, Doctor, and it's something that has puzzled me for some time. When one looks at the procedures which Patel was banned from performing in Oregon, it is not as if he was being banned from performing the most complex procedures. It's not open-heart surgery or even the things like the oesophagectomies and the Whipple's procedures we've been talking about here. It seems that he was banned from practising even a fairly simple or comparatively simple surgery. Is my impression correct?-- Well, I don't - I don't think that is quite the way I see it, Commissioner.

Yes?-- I received this document yesterday from Mr Devlin and I found it very interesting because I was drawn to attachment A of the document where it says, "The major surgeries that he's precluded from are abdominoperineal recessions, oesophageal surgeries and gastric surgeries and soft tissue malignancies." Then it listed high risk patients and post-operative patients. But that particular list that he was specifically precluded from doing, and there are other cases mentioned earlier in the document, resections of the liver, surgeries involving the pancreas and any constructions of ileo anal pouchs, and if - please stop me if I-----

No, no, no?-- If we look at the last table.

MR DEVLIN: I have got a copy of those orders if you want it up on the screen?

COMMISSIONER: That might be useful so everyone can follow the evidence. This is the table H, is it, with the three-----?-- If I go to one of the very capable functions of this program and search for the word "motivation" and click on that, and we talked to this yesterday, this identifies all the patients in whom I told you, Commissioner, yesterday, that I

couldn't understand what his motivation was for being involved here.

Yes?-- And I only came to this realisation last night. But if we run down that list, the first one is an oesophagus, the second one is a pancreas, the next one's an oesophagus, the next one's a complicated carcinoma of the thyroid. It doesn't quite fit my hypothesis. The next one is another pancreas. The next one is yet another pancreas. The next one is another oesophagus. Coral Lee doesn't also fit the hypothesis, a complicated thyroid parathyroid operation. Nor does P276. But James Phillips is yet another oesophagus, and moments later there's a renal failure patient and that is also mentioned in Dr Patel's censure from Oregon. And I wonder whether this is not the missing piece of the mosaic that I was ignorant of yesterday: I wonder if his motivation for doing these quite outlandish operations is not to try and re-assert in his own mind that what he's been precluded from doing in Oregon he is in fact capable of doing, and that he is, in effect, re-credentialing himself if only in his own mind. Speculation, sir, but a very interesting list in the light of this document that Mr Devlin gave me yesterday.

I wonder, Doctor, whether we could take a moment to repeat that process with the 13 deceased patients and compare their operations with the things which Patel was banned from doing in United States?-- Well, if we look at the perioperative deaths.

You've got the six Patel adverse ones?-- All right. We'll look at the six Patel adverse ones. The first one is a hepatobiliary case where the problem resides in the region of the pancreas. It's a cholangiocarcinoma just distal to the cystic duct where the duct enters the duodenum as it passes through the pancreas.

MR DEVLIN: Might I just interrupt for a moment. It will be helpful if the doctor, for the record, gives the name of the patient rather than say, "The next one".

COMMISSIONER: Yes. I think you were dealing then with P98, weren't you?-- I was. My apology,P98.

Yes?-- The next one-----

Nagle?-- Eric Nagle, is a patient who had a problem with a Tenckhoff catheter and we discussed at some length yesterday. Resulted in the production of a haemopericardium and pericardial tamponade. Gerard Kemps, an oesophagectomy. P236, a carcinoma of the pancreas. P224, the complicated multisited cancers both of the lung and the thyroid. And P215 with another pancreatic lesion.

So out of those six deaths, I think four were either pancreas or oesophagus?-- Correct.

And we might as well then look at the other-----?-- Not terminal.

Yes?-- Mr Bramich we have discussed at length and these, of course, were not terminal patients and so, advanced cancer is not going to feature in this list. P238 is, however, a very complicated pancreatic procedure which as I mentioned yesterday was referred quite wisely to the Royal Brisbane Hospital by Dr Baker but considered by Dr Patel within his scope of his practice when she re-presented with a further complication. P28 was a sigmoid colectomy with bleeding diverticular disease but a particularly difficult case as I mentioned yesterday because of his previous radiotherapy for his carcinoma of the prostate and that, I believe, would rightly fall to the province of a colorectal specialist.

Yes?-- The last of that list is another oesophageal patient, Mr James Phillips.

Then can we bring up the final - I think it was table D3, the remaining three deaths that you identify as having a contribution from Dr Patel?-- These are non-perioperative deaths and the group that I considered had an adverse contribution from Dr Patel and they are P180, who was admitted with a five-day history of constipation and abdominal distension. It was - she underwent surgery of an incarcerate epigastric hernia. The bowel was damaged during the course of this operation, perforated and required oversewing, which is a technical deficiency and would, I believe, have contributed to her delay in convalescence. And the abdominal distension produced shortness of breathing and vomiting and developed pneumonia, aspiration possibly pneumonia. A complicated case but not quite - well, correction. She does fall within the ambit of the cases that are mentioned in the paper from Oregon. Mr Grave, another transhiatal oesophagectomy and partial gastrectomy. And P273, a patient with a long history of recurrent renal infections and the lady who had hypothyroidism who I consider inappropriately had a colonoscopy, but this is not of the same clinical magnitude or impact as the others that we've been talking about.

It would seem from that that something like eight out of the 13 were operations which Patel was banned from performing in Oregon?-- Correct, mmm.

Yes. Look, I'm sorry, Doctor, I took you off your course. You were taking us through table E and the non-fatal patients which you attribute to Dr Patel's contribution to an adverse outcome?-- Well, I think I'd finished my comments on table H, which put in perspective the occurrence of his major technical complications.

Yes. So perhaps we can go back to table E. I think you got as far as, was it Mr Fleming?

MR ANDREWS: The next patient seems to be P214.

D COMMISSIONER VIDER: Could we just go back to Mr Fleming for a moment, to that commentary on him?-- Right.

In that histology report, the next bit - no, there was a bit you had on the screen before where you talked about the margins?-- Right.

My point was going to be we've had evidence that Dr Patel's surgical technique appeared rough and sometimes it appeared that he didn't adequately establish a good visual field. From that histology report, the one that talked about the specimen, it had the size of the specimen, the 70 by 30, 30?-- There it is.

With the diverticula extending to the resection margins, would that be consistent with someone not necessarily having a good visual field?-- That would be - that would be one of the explanations. It would be consistent with someone not having a good visual field but it's a deficient excision. Whether it's because he couldn't see adequately, he didn't decide on the appropriate amount to resect, I can't say.

No. Poor technique?-- Mmm.

COMMISSIONER: I'm sure medical people in the room understand what you're talking about but just let me make sure I do. This is a situation where the cancerous part is right up to the edge of the resection, suggests that Patel may have left some inside?-- Well, this is a patient with non-cancerous pathology.

Yes, yes?-- And the pathology he's suffering - Mr Fleming is suffering little out pouches or diverticulilei of the large bowel and these are prone to infection, perforation and haemorrhage. They tend to congregate more on the left side of the bowel, the sigmoid area, but can be found with a far more diffused distribution, and the deduction that I've made on reading this chart is that an insufficient segment of bowel was removed. There's a strong probability that the bleeding diverticula that produced the presentation in the first place was not excised at the operation.

I see?-- It is possible that he got the offending one in the first operation and a subsequent diverticula bled - diverticulum bled, but I think with this histology, showing the pathology right up to the edge of the resected specimen and then the subsequent colonoscopy showing further residual diverticulilei suggests to me that the original technique was inadequate.

Thank you. Perhaps, as Mr Andrews suggested, we can move on to P214?-- P214 presented with an invasive adenocarcinoma of the rectum and it was a suggestion with her postvoiding bladder scan that there may be some slight leakage due to nerve damage which could have occurred at the time of the operation. I don't believe I have much more to add to that particular case. I considered that Dr Patel may have contributed to the adverse outcome. It may have been unavoidable to produce some damage to the nerves to the bladder during the excision of this cancer of the rectum

which lies adjacent to the bladder, but I think, overall, the patient's management was reasonable.

The next surviving patient in your table E is P216.

MR ANDREWS: Doctor, while you're bringing up P216, on the occasions where, such as with the last patient, you concluded that Dr Patel's technique may have contributed to the adverse outcome, if you were dealing with a surgeon whose competence you were sure of, that is a surgeon you regarded as very competent, and you saw an adverse outcome, you, I assume, would err on the side of caution and assume that the adverse outcome was probably not caused by the surgeon; would that be correct?-- I think you're correct in that it requires some judgment and consideration but-----

Where you have a surgeon such as Dr Patel, who had an alarming statistic of about 23 out of 31 instances of very poor technique, does it assist you in determining whether the maybes are more likely to be cases where instead of possibly causing an adverse outcome, Dr Patel is more likely to have probably caused an adverse outcome?-- Yes.

So where you say "maybe", you'd be saying maybe whoever the surgeon was, wouldn't you?-- Yes.

But because it's Dr Patel and having regard to the other evidence you've seen, do you think that many of those maybes are probablys?-- Yes.

Thank you?-- But can I just add, Mr Andrews, that as I approached this challenge case by case, I've tried to be as objective and as dispassionate as possible and it's only when we've had the benefit of this program that enables us to analyse certain categories and groups that you find so many of the maybes lumping together to form a pattern which has changed my view of the technical capability of the person I've been studying.

D COMMISSIONER EDWARDS: I take it then that, really, we have 48 patients, 17 deceased and possibly 31 could have had difficulties if you look at that table?-- Which table, Commissioner, are we referring to?

The ones you've been talking about at the moment with the - where you said that there were, if I recall-----?-- Table E.

Yes. I'm just interested in summing up the number of patients relative to the deaths and adverse outcomes?-- Well, in table E there are 48-----

48?-- -----patients and-----

COMMISSIONER: That has the 13 deaths amongst it, so 35, I think, surviving patients.

D COMMISSIONER EDWARDS: I think it is 31, I thought he

suggested. That's why I'm a little-----?-- Well, I think in the 48 poor outcomes contributed to by Dr Patel there are in fact 17 deceased patients.

And 31-----?-- And 31 surviving patients.

Yes.

COMMISSIONER: Right?-- And of those 31, 23 have major technical problems that we talked to.

D COMMISSIONER EDWARDS: Problems. Right, thank you.

COMMISSIONER: Yes.

D COMMISSIONER EDWARDS: That really is the major story, isn't it?-- Correct.

COMMISSIONER: I would like to continue working through those 23 if we can, just so that we have a thumbnail sketch of each of them. I think the next one was P216?-- P216. This patient was referred to Dr Patel following a failed resectomy. It was noted when the histology of the excised specimen came back to the person who did the original operation that the resectomy had not been completed on the right-hand side. So Dr Patel set about to do a re-do operation but this was complicated by the formation of a haematoma and swelling and the haematoma proved quite recalcitrant and persisted for some time but eventually cleared or was considered to be clearing spontaneously. But that is indicative of a deficient performance, that level of haematoma formation in what is a relatively straightforward, simple operation.

I think the next of those 23 is P222, the last one on the current page?-- Well, this patient on CT finding showed a metastatic renal cell carcinoma and was booked for a left nephrectomy. She developed a secondary spread of this cancer to the bone of the left arm, the humerus, and developed infection from the nephrectomy wound and it was considered to possibly be an adverse outcome induced by Dr Patel because of the infection. However, the presence of anaemia and renal failure are significant contributing factors. And so, I'm not so resolved in my commitment to an adverse outcome in this particular case. It's a less than optimal outcome.

The next one I think is Trevor Halter?-- A laparoscopic cholecystectomy. He developed a subhepatic haematoma which become infected. This was drained by Dr Patel. A further laparotomy was followed and despite this, he was still not progressing satisfactorily and on the 9th of December he was transferred to the Royal Brisbane Hospital because he was still requiring ventilation. He had continued sepsis and he was developing serious complications, that is the adult respiratory distress syndrome, in both lung fields. This is undoubtedly a litany of deficient management following his original laparoscopic cholecystectomy.

I think P127 might have been the next one?-- This patient had a moderately differentiated carcinoma of the colon excised. It seemed to be invading the pericolic fat. This is one instance of a wound dehiscence where perhaps surgical technique was not the sole contributing factor and it is perhaps worth bringing up the operation note of Dr Gaffield who actually repaired the hernia - the dehiscence. That's an indication of the location of the pathology in the distal colon.

Just while that's up, in accordance with normal medical practice where it has listed "surgeon Boyd/Patel", would that be in fact Dr Boyd operating under Dr Patel's supervision?-- That's - yes, sir, that's how I'd read that.

Right?-- I haven't - once again - and I do apologise for this - I am having difficulty locating the operative note.

Doctor, there is no need to apologise. I can assure you we take your word for these things without having to be shown the documents to back them up. That's unless, as I say, anyone wishes to challenge your evidence in-----?-- If pushed I can do it but I am conscious I am wasting precious time to do it.

In any event, we might take the morning break now and resume at about quarter to 12.

THE COMMISSION ADJOURNED AT 11.32 A.M.

THE COMMISSION RESUMED AT 12.00 NOON

PETER WILLIAM HAROLD WOODRUFF, CONTINUING
EXAMINATION-IN-CHIEF:

COMMISSIONER: Thank you, doctor.

MR ANDREWS: Commissioner, do you recall which patient on table E Dr Woodruff-----

COMMISSIONER: I think we got to P127. I am not quite sure whether-----

MR ANDREWS: After P127 I think the next one is P238.

COMMISSIONER: I think that's actually one of the deceased patients.

MR ANDREWS: Thank you. P74 isn't - yes, P74 is the next one?-- Thank you. P74 attended the day surgery unit for removal of skin lesions. Both he and the first patient on the list had the same Christian name. The nurse addressed the patient by just the first name. There was

no formal nursing handover, the arm band was not checked by Dr Patel, the anaesthetist, nor the nurse, and the wrong operation was performed on P74. This turned out to be an OGD, a tube down the oesophagus, to examine the oesophagus, stomach and duodenum. Caused him no ill-effect and the mistake was appreciated and they then went on and performed the planned process which I believe was a minor operation elsewhere.

COMMISSIONER: Just good luck that the other P.. wasn't listed for a vasectomy, or an amputation or something?-- Mmm. But it does underline the importance of protocols in this regard. It is a problem that happens far more widely than just in Bundaberg, of course.

But it is also, as I understand it, a problem that best medical practice has had under control for at least 50 years with checking of arm bands, and certainly whenever I have been to hospital, at every step of the way you are asked your full name and your date of birth so that that sort of mistake doesn't happen?-- It certainly shouldn't happen. Unfortunately, it does happen.

The next one is P401. This is a young man?-- This 21 year old was attempting to jump from the roof into the swimming pool and landed half in the pool and half on the surrounds and fractured his femur, suffered a nasty fracture, and whilst recuperating from that developed appendicitis. Dr Patel removed his appendix but he went on and developed further sepsis and required to have a pelvic abscess and a pericaecal abscess drained. The patient was referred to the Wesley Hospital and had this done appropriately down there. Once again, sepsis following a gangrenous appendicectomy is one of the challenges of managing these patients and that's why I class this as a "maybe" contribution to the adverse outcome from Dr Patel. I believe the patient's management was satisfactory.

Next we have P2?-- This 74 year old gentleman was to have skin lesions excised and he is one of the patients I have reclassified. Initially I considered him a maybe. He was on anticoagulation, Warfarin and this undoubtedly contributed to his post-operative bleeding. He developed a haematoma in the shoulder area, another one in the ear and required to have these evacuated or one of these evacuated in the operating theatre. Also the skin cancer - although this gentleman has had 166 skin cancers, so he is recorded as having told one of the doctors, in the chart he has had 166 excised and certainly one or two of those you would expect to be incompletely excised and this has proven to be the case on this occasion. That is one of the clinical indicators of surgical performance that is of statistical significance in assessing outcomes. So for that reason I reclassified him from "maybe" to "adverse maybe".

The next one is P5?-- This patient was down to have a parathyroidectomy, post-operatively developed a deep venous thrombosis or knot in the leg. There was no chemical

prophylaxis for this, despite having a previous history of a DVT in 1998. There were stockings, however, used as a form of mechanical prophylaxis - not as effective as chemical. So that could be considered a deficiency of management. Perhaps more important, no parathyroid tissue was identified in the histologic examination. So although the patient was listed for a parathyroidectomy, in fact she didn't have a parathyroidectomy, and I support that with this histology report. In summary, the right upper parathyroid turned out to be nodular thyroid tissue and the right lower parathyroid was with follicular adenoma. So that's quite deficient, to set out to do a parathyroidectomy and in fact not obtain any parathyroid tissue.

D COMMISSIONER EDWARDS: And also remove - did he remove that much of the thyroid?-- No, I think what he considered to be a parathyroid was a little nodule of adenoma and that's probably the only bit of the thyroid he took out.

COMMISSIONER: The next we have P5 - oh, that was P5?-- That's correct.

Next on your list is P259 who is a deceased patient but we don't seem to have covered her previously amongst the deceased patients you dealt with?-- This – P259 is a 72 year old patient who was admitted with vomiting and a tender abdominal mass. Provisional diagnosis of bowel obstruction was made. She presented with a complex surgical history having undergone an aortofemoral bypass in 1993, a bypass from that graft to the kidney in '98. She had advanced respiratory disease. Despite this she was still smoking, which is an additional risk factor. She was being cared for by Dr Miach and Dr Kerswell for chronic renal failure and initially managed conservably but she was noted to be in a very poor respiratory state and came to laparotomy to deal with her bowel obstruction and ran into problems post-operatively with poor saturations, she was very drowsy, perhaps as a consequence of not only hypoxia but also oversedation. Combination of these events, she became progressively acidotic with minimal or no urinary output and succumbed. And looking at her details underlines the complexity of this case. That's the original aortorenal bypass performed by Dr Thiele in '98 and it gives some indication of the complexity of the surgery, the previous replacement of the aorta and then a graft from that across to the right renal artery. It documents her admission and the concerns that her family had regarding her care, recounts a third presentation in two days with pneumonia, and the inability to keep her tablets down. Then on the 3rd of October, the patient was seen by Dr Patel who expressed the opinion that she'd require a laparotomy but best to wait until the morning when she is considered to be rehydrated, electrolytes corrected, transferred to the intensive care unit that night for monitoring. He records discussions with the patient and the family, the obtaining of consent and leaves her nil by mouth fasting for possible surgery. At 5 p.m. he records that - I am not sure of the third word "I have" something "this patient briefly from her earlier stay in

intensive care in hospital records. Small bowel obstruction with large distended loops." "Small bowel obstruction with large distended loops of small bowel atrial fibrillation, dehydration, the abdomen distended, soft, minimally tender, no signs of peritonitis." He outlines his plan: "Hydration, nasogastric suction, repeat the blood samples, group and match two units of blood for the proposed or anticipated surgery, place a central venous pressure line, administer intravenous antibiotics", they have been started, and a plan to the operating theatre tomorrow unless she deteriorates overnight. And that, I think, is a good game plan, surgically speaking. At 7 o'clock the following morning, neuro obs, she is awake and alert from the cardiovascular viewpoint. Her heart rate has been in the range of 80 to 100 overnight, although it has increased to 130 after Ventolin. She is continuing to fibrillate - atrial fibrillation although despite that her blood pressure remains stable. Her abdomen mildly painful but it remains distended and minimally only minimally tender with no guarding. There has been good decompression with the nasogastric suction. There is no rebound tenderness as one would expect with peritonitis. The fluids - he comments, "She remains dehydrated with low urine output and low central venous pressure." Her laboratory tests, in particular the white cell count, is normal. The haemoglobin is normal at 133. And the electrolytes are satisfactory. Although the creatinine is elevated at 0.23, upper limited normal being in the region of .12.

MR ANDREWS: Doctor, if you are able to identify, when looking at these notes, what it is that caused you to include P259 in a list of persons where Dr Patel has contributed or may have contributed to her death, would you alert me?-- Sure. Without continuing to go through it, I can't recall the answer to your question. I am sorry, Mr Andrews.

I would be pleased to have you continue to go through it?-- That operation he finds a small bowel obstruction and releases the offending band that is responsible for the obstruction. He records that this operation was done under a general anaesthetic with the patient lying supine. He used a midline incision. He notes cerous peritoneal fluid which he aspirates from the abdomen. He notes contracted terminal ileum, particularly at the ileocaecal junction where the small bowel joins the large. He traces this back up the bowel to the transition area where the bowel is obstructed. He follows the emptied part of the bowel back to the obstructed area. He finds and describes a circumferential type band which he excises and there is massive dilatation of the bowel above this level back towards the stomach and he relieves this by milking the contents back into the stomach and aspirates in excess of a litre of fluid from the stomach, which is probably the best way of ridding the body of this fluid. There are other options but that is probably the safest way of doing it. The jejunum - he says - he reports serosal surface is found to have partially haemorrhagic necrosis, and he washes it out with copious irrigation of normal saline and uses some Novofil for suturing the linear alba, and then staples the skin. So

that is an example of a bulk closure but that's an accepted technique for closing a midline abdominal wound. He reports that at 7.45 p.m. on the 5th that the patient remains drowsy, more awake than last night after Narcan, and that even suggests to me that the way he has put that in there, that he has perhaps been a little critical of the amount of narcotic that the patient - this elderly sick patient has received overnight, but that's perhaps reading more than I am entitled to into the case notes. The urinary output he says is still low. The patient is stable haemodynamically. The abdomen is not distended. Nasogastric output minimal. He then records the performance on the ventilator and notes that her oxygen saturation or the PAO2 is in the 70s and assesses her as being hypoxic, large secretions, good urinary output, electrolytes okay. He plans to administer some albumin intravenously to increase the osmolality of the blood. X-ray of chest, cleaned out her respiratory tree to facilitate her breathing and he concludes that she will probably need to be supported with her ventilation - put on the ventilator. Then at 7.20 a.m. he reports sudden marked deterioration. The patient's liver function tests are abnormal. There is an increase in the enzyme levels, an increase in the prothrombin time and the INR. Urinary output has now become poor and the blood and sputum are both positive for escherichia coli, a nasty bacteria. He plans to give two units of fresh rosine plasma and commence or administer gentamycin, 250 milligrams intravenously. So he is very concerned in the deterioration in the performance and he notes then the following day that she is developing a metabolic acidosis, which is a marker of significant biochemical deterioration. She has no urinary output. Her heart rate is in the 80s, her blood pressure has come down, it is 106 on 45. The abdomen has become distended and she's showing metabolic acidosis biochemically. He plans the possibility of a second look laparotomy because this development of deterioration with reduced urinary flow and the metabolic acidosis is pathognomonic or highly indicative of a - of the development of dead bowel, and the way to confirm or refute that diagnosis is to take the patient back to the operating theatre. So he discusses this or plans to discuss this with Dr Carter and in the meantime administers some blood because her haemoglobin has fallen from that previous level of 133 to 82, which is low. At operation the - the second operation, he resects the right colon and performs a cholecystectomy because he finds that she has developed a bilious ascites. That is the fluid - the abnormal volume of fluid within the peritoneal cavity is bile stained. This has come about because the gall bladder is gangrenous and has been leaking bile. The caecum is also gangrenous. I have difficulty with the next line, although whatever it is it is normal. I think it is the transverse colon but he does not - at. 4 there is patchy dusky subserosal areas of the ileum and subserosal haemorrhagic areas within the jejunum and ileum are both segments of the small intestine. So performs the colectomy. This is done with an end-to-end anastomosis to the transverse colon. I am having difficulty here. Colectomy, stapled and transverse colon. I think it says no anastomosis. Performs a cholecystectomy. I am unclear as to the detail of the colectomy at that stage. He plans to continue with

ventilation, correct the acidosis and the coagulopathy with blood products fluids and inotropic support. And then appears the report to the police of events that occurred and there may be some clarification of the second operation. The second operation on the Monday it was found she had ischaemic caecum and gall bladder which were both removed. She was on the adrenalin affusions and passed away at midnight. A tragic outcome. It is very hard to say how much of this is technically deficient performance, how much of it is fulminant disease and there are ways - there are things you can do in releasing a small bowel obstruction, such as inadvertently tying off a major artery that could cause the ischaemia. In someone in atrial fibrillation, I think it is a more likely explanation, the patient is likely to have thrown a blood clot from the heart into the blood vessel supplying the intestine and the gall bladder region and that has given rise to the infarction. If that is the explanation, then Dr Patel really could not have prevented this outcome.

COMMISSIONER: That's why you class - you told us yesterday there were - they were the 13 instances of deceased patients where Patel adversely affected the outcome, this is only a maybe rather than a definite?-- Correct. Correct.

Right. The next of the patients on the list is P26 about whom we have already heard a great deal. I just wonder whether there is any new light you can shed on that case?-- Certainly. This young man was transferred by helicopter to Bundaberg after an accident at 10 a.m. and the timing, I believe, is very important in this case. His wounds included a deep extensive groin laceration and a lacerated femoral vein. The femoral vein bled profusely and very nearly produced an exsanguination or very early result in bleeding to death. It was controlled by packs or compresses held digitally into the wound and the retrieval team reported from the scene of the injury that there was a considerable amount of blood evident at that point. When he arrived at Bundaberg, the blood was dripping through these packings that were being held in place.

His vital signs when he arrived, his heart rate was 150, his blood pressure was 80 and he was very pale. He was resuscitated in a quite exemplary manner via a 16 gauge and a 14 gauge cannulae, in two cannulae. Initially, the fluid or the blood was 0 negative, in other words, this is blood from the universal donor, when a patient's life is considered so threatened that waiting an extra half an hour, three quarters after an hour to cross match the blood is considered to be life threatening in itself, you can take the liberty of administering non-cross matched blood in an event to save the person's life. This was done and I think underlines the gravity of the situation. In fact, he received 11 units of blood which is considerably more than his blood volume when combined with seven litres of fresh frozen plasma and crystalloid solution, so a considerable amount of fluid was required to resuscitate him. He was taken straight to the operating theatre and the principal finding responsible with this life threatening state was a one centimetre laceration in the left femoral vein at the subvena femoral junction. In addition, he had transected rectus femoris with a lacerated fascia and adductor muscle and that's described quite graphically on the CAT scan report. The femoral artery and nerve to be considered to be intact, they were commented on in the operation note, and I'll come back to that point. The pubic ramus or the periosteum of the pubic ramus was on view and that is indicative of the extent of this soft tissue injury. An indwelling catheter was placed into the bladder and the pressure pack was removed. Following clamping of the femoral vein so that the bleeding was controlled, this laceration was sutured with 05 proline - the vein was sutured off, ligated, ligatus. The artery and the nerve were explored and there was a thorough wash-out performed. Dead tissue and foreign body debridement was carried out and the adductor fascia approximated. A drain was placed in and the wound closed and he was sent to theatre for an X-ray and a CT scan. When he returned from there, it was noted that his foot remained pulseless and cold and he was considered to have a compartment syndrome, which is in summary, tight spastic muscles which are considered to have swollen and been contained by the fascial compartment that they normally reside in to such an extent that their environment is threatened. The treatment for that is to release the fascia by taking the patient back to theatre for a fasciotomy and this was performed. But when he was returned to the Intensive Care Unit at 1750 hours, there was still no pulse, the pulses were absent below the groin. An ultrasound scan was done at that time and that is also very informative and I will come on to these findings shortly. His urine output was 130 mls per hour, normal being anything - normal being roughly a ml a minute or 60 mls an hour, so he was now well resuscitated and his kidneys were coping with the insult that they had been subjected to. But the urine was noted to be dark and was considered to contain the waste products or the degeneration products of dead and dying muscle, that's myoglobin. The urine tested positive for blood and he was considered to still be in a degree of shock despite this adequate volume replacement. The leg was considered clinically to still be threatened. A number of causes were entertained in the charts

and I'd like to visit that, however, it was noted the pulses were absent and for that reason it was considered that - I think my program's letting me down at the moment - oh no. My apologies. So the continued threat to the leg was considered to be ischaemic and thought to be possibly due to the venous obstruction, but a comment is made in the chart, "If no improvement, may need to consider transfer to the Royal Brisbane Hospital." However, an ultrasound was performed and the patient was taken back to theatre and that reconstruction re-established circulation to the leg, but the leg by this stage had infarcted, and I think in the consideration of the gravity of this situation, it's worth going through the details of the case from the actual case records, but to just complete this flow chart, the patient had a successful revascularisation as far as the vascular surgery went, but not sufficiently timely, and then Dr Patel went on leave on the 26th, on Boxing Day, handing over to Dr Gaffield. The patient deteriorated rather suddenly from the viewpoint of sepsis, which I'll demonstrate with reference to the blood test results, and was transferred rather belatedly to the Royal Brisbane Hospital early - around the New Year. Let's view some of these findings in the chart. We've referred to the O negative uncross-matched blood, I don't think I have to visit that again, but this is a significant finding: and this is the result of a myoglobin estimation in the urine. It was performed at 1920, 7.20 p.m. on the night of admission. The measurement of myoglobin was 721,000 micrograms per litre, the reference range being less than 10. That is indicative of a great bulk of destroyed muscle at - by 1720. The ultrasound examination performed a little later indicates the difficulty that the clinician is confronted with in this situation. The report reads as follows: "This was a technically difficult examination and most of the findings were equivocal. The patient's left leg was bandaged and there was significant haematoma. The findings are very non-conclusive and of poor diagnostic value. Repeat examination may be required at some stage." This just indicates the difficulty confronting the people managing the patient at this time.

MR ANDREWS: Doctor, before you proceed, there were - the third last image we saw on screen, I think, was - showed events at about 1720 on that day. The patient, as I understand, was injured somewhere around about 10 a.m. on the same day?-- Mmm.

Is it the case that there was a critical period of time within which to save the patient's leg?-- Yes.

And is that - can you tell us what that critical period was?-- The critical time is considered to be of the order of six hours from time of injury. In the largest series of lower limb arterial injury that I could locate in the literature, 550 cases published by three English surgeons, but work done in Durban, states that the leg may well become non-salvageable after four to five hours of ischaemia and whether the - the case is largely dependent on two or three other factors: the other factors are the level at which the artery is injured; the nature of the arterial injury; the presence or absence of

coincidental soft tissue injury and the state of the collateral circulation, and in visiting each of those points in the case of P26, I think we can develop a clearer picture of what was happening. The great bulk of lower limb arterial injuries are penetrating injuries, either gunshot or stabbing, 70 per cent, and that - the massive loss of blood draws attention to the arterial injury in a very dramatic fashion, they have a better amputation rate than blunt injury. Blunt injury in this series of 550 is associated with a considerably - a significantly higher amputation rate.

And this was a blunt injury, was it?-- This was a blunt injury. The majority of injuries in the leg - in the superficial femoral artery are, in P26' case, the artery that was involved was the common femoral artery and the significance of the common femoral artery is that it divides into two at the - just immediately below the inguinal ligament, in the groin crease, it divides in the profunda or the deep artery into the superficial artery that runs down behind the knee and usually with occlusion of the superficial artery, there's time bought by time flow through the deep or profunda artery, but if you move an inch or two further up the arterial tree and occlude the artery at that level, the poorsity of blood flow is even worse into the leg and the blood flow is - or the leg's survival is then dependent on branches coming via the internal iliac artery through the gluteal vessels, through the pelvis and down through the hamstrings and anastomose being the deep femoral artery through that mechanism, but when, as in case of P26, there is a gross fracture of the pelvis with both the pubic and ischial bone fractured and the acetabulum fractured, there's a serious compromise of that circulation as well.

And so what about the first, the management until 1720 hours on the first day, would you - would a reasonable surgeon have done differently anything?-- No, I believe-----

A reasonable surgeon in Bundaberg?-- No, I don't believe anything further could have been done for this patient in Bundaberg.

COMMISSIONER: Does that mean it was a reasonable surgeon in Bundaberg wouldn't have kept the patient in Bundaberg?-- As we heard from the retrieval doctor, he was in no fit state to be taken from Bundaberg until the haemorrhage had been controlled and he'd been resuscitated.

Which was the first operation?-- That's correct.

And I think everyone who's spoken about this patient accepts that the first operation was life-saving and Dr Patel deserves the credit for saving the boy's life?-- Mmm.

But from that moment on, from what you've said, he was on a very short timetable to lose his leg?-- I believe, and for the points I've just outlined, that his leg was irretrievably lost most likely by, by half past two or 3 o'clock in the afternoon, and I believe that having stopped in Bundaberg to

go through the resuscitation and repair, there is absolutely no question of getting to the vascular operating theatre of the Royal Brisbane Hospital or the PA Hospital in sufficient time to save that leg, and I think there were delays in the diagnosis and I think that the - perhaps it's a little academic after establishing what we've just established, but I think they do help even the balance of the picture, the blunt injury that he sustained, in effect, stretched the artery and the arterial wall is in three layers, the outer two are far more elastic than the inner layer, and so when the artery's stretched, the inner layer disrupts and it tends to coil itself up, like a handful of cellophane, it's a thin internal layer and in that form it produces a thrombosis and very often, its external examination of the artery is disarmingly normal, you can look at the artery, you can even in a young healthy patient feel a pulse because the clot is so soft, the artery is so elastic, it will be an abnormal pulse, but the patient is shocked anyway and all his pulses will be abnormal, and so you can be misled into believing the circulation is better than it in fact is, particularly with these blunt injuries, and all vascular surgeons have encountered late diagnosis of blunt arterial injuries, even in units at Houston and places like this dealing with trauma on a frequent basis.

Doctor, is the result of all of that, that whilst Patel may have mismanaged the patient following the first operation, the likelihood is that the leg could not have been saved even with the best possible management by Patel?-- Correct.

Is there any prospect - as you understand the patient later had a amputation through the knee - was there any prospect of a better result from that such as a lower amputation had the patient been transferred to Brisbane sooner?-- I believe not, because the operation that was done to re-establish circulation did in fact re-establish circulation. Dr Risson's observation of a posterial tibial pulse I think is a reliable observation because he records that the other pulse, the dorsalis pedis was absent. I'd be more concerned if someone had recorded both pulses present or neither pulse present, because it can be difficult to observe, but when-----

It adds to the credibility?-- If one finds one and not the other, I think that is a valid observation, it was supported with the Doppler and it was supported by Dr Mark Ray who examined the patient on his admission to the Royal Brisbane Hospital, and he - who now is a colleague of mine working at PA - told me that pulses were present from the reconstruction on admission to the Royal Brisbane Hospital.

So ultimately, we can put this very sad case down as an instance of mismanagement by Patel but not mismanagement which was causative of any ultimate harm?-- Correct - as far as the leg goes.

Yes?-- I believe the mismanagement became more apparent during the subsequent course of clinical progress in Bundaberg and I think particularly - this particular blood test result is very informative, and I think does underline mismanagement

in Bundaberg, and I would like to draw the Commission's attention to the white cell count, and you'll see that on the - around the 29th of December, it's remained roughly normal from the 26th through to the 29th, but it's grossly abnormal on the 30th, it's risen from 10 to 18 and then goes on to 19 and a half on the 31st. And if one looks also at the nutrafills or the reactive white cells in the bloodstream, they're becoming elevated on the 28th. So this patient is becoming septic, clearly septic around the 28th, and should not have been allowed to get into that state. It's quite apparent from the features of the loss of sensation and the spasm of the muscles that are described in very clear detail in the progress notes that there is dead muscle in the leg, it's confirmed by the blood test result that we alluded to earlier - sorry, urine test result, and it's further supported by this development of the sepsis, and I believe the patient's management is definitely deficient from about this time on, but I think, I think it does highlight - forgetting the tragedy of this case - it does highlight the difficulties associated with lack of continuity of care.

Yes?-- And when people hand over cases, the need to pay particular attention to how that's done and with the realisation that one never quite gets on top of a case that you've inherited from someone else, particularly a complicated case that's not going well, as you do with patients that you admit yourself and look after it from the first day. So there are a lot of compounding problems in this situation.

Doctor, legal philosophers have a concept of wrong without injury, you know, if one discharges a firearm at random or blindfolded, that's a negligent thing to do, but unless the bullet actually hits someone, there's no legal claim for damages. What you seem to be telling us is that this is another instance of negligence, if you like, or suboptimal treatment which ultimately did no harm because the patient got to Dr Ray and ended up as well treated as he could have been, even if he'd been transferred a few days earlier; is that right?-- Correct, with a little reservation, in that he was undoubtedly sicker.

Yes?-- But recovered from that sickness because of his resilience and youth, he could have gone through the process without testing his chances to the degree that he did if he'd been transferred earlier, but he would not be any better today if he'd been transferred earlier.

Yes. So the only ultimate impact on the patient is that he went through a - in terms of - impact of suboptimal treatment, is that he went through a longer period of recuperation and perhaps more pain than he need to have done?-- Correct.

Mr Andrews, unless you want to cover anything else in relation to P26, I thought we might break for lunch now and continue with the next patient after.

MR ANDREWS: One last thing.

COMMISSIONER: Yes.

MR ANDREWS: With respect to P26, the suboptimal treatment that he underwent at the Bundaberg Base Hospital, would it be right to think that it led during his eight or so days at the Bundaberg Hospital to P26 being at risk of losing his life?-- Yes. Once again, this is a matter of degree, but the more septic one becomes, the more at hazard and at risk is your life.

And his degree of septicaemia, is it something evident to you from looking at the charts?-- Yes, very much so.

And is it a degree that suggests that he was at significant risk of losing his life had he not been transferred to Brisbane?-- Eventually the process that became evident on the 28th of December would have, left untreated, would have killed him.

Thank you.

COMMISSIONER: And if it had not been such a young, fit and healthy patient otherwise, that delay would have been fatal if, doctor, it had been you or me lying in that ward in Bundaberg, we wouldn't have survived until the 31st of December?-- I - we wouldn't have done as well as P26, I can't-----

You can't draw the line with certainty?-- No, no.

MR ANDREWS: I have nothing further, Commissioner.

COMMISSIONER: All right. Well, we might resume at 2.15 if that suits everyone? Thank you.

THE COMMISSION ADJOURNED AT 12.57 P.M. TILL 2.15 P.M.

THE COMMISSION RESUMED AT 2.16 P.M.

PETER WILLIAM HAROLD WOODRUFF, CONTINUING
EXAMINATION-IN-CHIEF:

COMMISSIONER: P270 was the next-----

MR ANDREWS: Yes, Commissioner?-- Which case are we looking for?

P270

COMMISSIONER: There she is. Again, just an issue of-----?-- This is another example of a wound dehiscence and, therefore, classified as technically deficient.

Linda Parsons?-- This 45-year-old patient was admitted for a hernia repair. The progress of this wound repair was of infection with a purulent discharge. Another deficient outcome, a little harder to sheet home with certain to the performance of the surgeon but indicative or more likely to occur with substandard technical performance.

Right. P35?-- This six-year-old has a right femoral hernia repair, bloodstained urine which is not a normal accompaniment of a hernia repair. Raises a question of an associated injury to the bladder. The situation resolved fairly quickly. In fact, the patient went on to have the opposite side hernia repaired fairly shortly thereafter. So not a major adverse event but not a normal expectation.

P36?-- This patient as outlined there in the summary presented with a subacute bowel obstruction. He eventually developed ischaemic colon distal to the anastomosis and required a return to the operating theatre to drain the content of the intestine by producing an outlet to the skin, termed an ileostomy, and I think that this is one of the patients I've re-classified. I've done so because I believe to perform the surgery he did at the original operation without some form of colostomy and/or diversion was an error of judgment.

Right. P288?-- This 74-year-old gentleman had a low anterior resection, that is a removal of the rectum. He had a post-operative anastomotic leak. This was treated by a colostomy and a mucus fistula. Following the closure of the colostomy he was admitted with a wound infection and this, once again, raises questions of surgical detail and technique

P37?-- This patient is 73 years, admitted with acute abdominal pain. Past history of serious cardiac disease. Treated with a coronary stent. The patient continued to suffer pain, considered a consequence of an incarcerated ventral hernia. Ten days after the repair of that hernia

wound breakdown was noted and a CT scan reveals a collection or perhaps a haematoma or even pus in the wound. The original operative note also records a tear which would be considered a mishap during the course of this operation. The outcome eventually required the formal evacuation of this collection or haematoma from the wound. So that's led me to classify this as an adverse outcome attributable to Dr Patel.

Next on the list is P297, who I think is one of the maybe class who unfortunately didn't survive?-- This lady as indicated is an 88-year-old who deceased on the - on Christmas Eve '03. Did you wish me to-----

Perhaps if you can just explain why you regard that as a maybe?-- Right. Well, this patient was suffering chronic renal failure and, once again, underwent a low anterior resection, a complicated removal of the rectum. She died fairly shortly after surgery - nine days in fact. And at that time she was in anuric renal failure; in other words, she was not passing urine. There are many possible explanations for that. Being a chronic renal failure, she might have just exacerbated that. Removing the rectum does put the uretus at some risk and it is a very uncommon and rare but feasible - or possible complication that the uretus could have been damaged in the course of this operation. So that-----

D COMMISSIONER EDWARDS: Did the - sorry, finish?-- And for that reason I think that the technique is questionable and the motivation or judgment in doing this form of surgery in Bundaberg in an 88-year-old questions one's motivation or judgment.

And did the pathology show a malignancy?-- I will have to refer-----

Or was it due to obstruction?-- It showed malignancy, Commissioner.

Thank you.

COMMISSIONER: Thank you.

D COMMISSIONER EDWARDS: But at 88, it's still a pretty risky operation?-- A challenging operation and there are undoubtedly better places and more expert colorectal surgeons that would have a greater chance of success in a difficult situation like that.

Thank you.

COMMISSIONER: The next one is P298?-- This 52-year-old was admitted or viewed at outpatients with bilateral inguinal hernia, also noted to have an umbilical hernia. These were repaired. He was discharged but has been reviewed by Dr Barry O'Loughlin Director of Surgery from the Royal Brisbane Hospital. He assessed P298, noting that his main complaint was of pain pre-operatively which still persisted post-operatively and was further complicated by pain

in the left testicle. It was recorded in the chart that, slowly, these complaints are settling. Dr O'Loughlin reported that the wounds were healed, there was no hernia obvious. There was tenderness in the left inguinal region. Testicles were normal both left and right. He diagnosed ongoing neuralgia and suggested an injection of local anaesthetic or hydrocortisone or, if that failed, the removal of the mesh used for the hernia repair. An ultra sound information at 3.08 reported that the - that there were changes in the spermatic cord which were rather puzzling and suggested an interruption of flow or possibly a thrombosed varicoseal.

What are your concerns about Dr Patel's performance?-- That the persistence of pain and the possibility of a thrombosed vessel during the course of the procedure. I can't say with certainty that that occurred during the procedure but it's a coincidence that raises questions of possible substandard performance but, again, that is not a strong attributing of the event to Dr Patel.

P40 is the next?-- A removal of the sigmoid colon or diverticular disease, the outpouchings we talked of earlier this morning. He underwent a laparotomy. The mass was considered unresectable and he was therefore treated with a stoma proximal to this lesion and a mucus fistula. Following the closure of the colostomy he developed iliac fossa pain and became distended and tender. This raised the question of abdominal sepsis and he was subjected to a laparotomy. This revealed two litres of fluid from the - within the peritoneal cavity, which was drained, and on testing the operative note records a two millimetre hole in the small bowel and this was almost certainly responsible for this leak. That in itself is a technical problem and the patient failed to improve as one would have expected and a further laparotomy or exploration was required, and on that occasion the collection had advanced to produce an abscess and the abscess was drained and the intestinal content were diverted away from the pelvis with the formation of this loop ileostomy. So that's - that is a technical performance that is definitely deficient.

Next we have P38?-- Colectomy with the formation of an ileorectal anastomosis, a procedure that he'd had his authorisation or accreditation withdrawn in America, and the patient failed to prosper and at a subsequent laparotomy by Dr Gaffield, there were 1200 ccs of bile stained fluid within the peritoneal cavity, obviously a leak from the anastomosis, and this was treated with another loop ileostomy to divert the bowel content away from the site of the previous operation.

Just on that subject, the evidence we heard from Dr de Lacy was to the effect that leaking anastomosis is one of those things that occasionally happens but yet again it seems to have happened far too often with Dr Patel. What are your views on that?-- I have the figures of the premium colorectal unit in Aberdeen. I've had this paper presented at the 500th anniversary of the college in Aberdeen just two or three weeks ago. I have them with me but I just can't recall the figure

offhand. Can I-----

I'd be interested, yes?-- The paper was entitled "Impact of Early Anastomotic Leak on Long-term Survival after Gastrointestinal Surgery", and the principal author was Professor Cukowski, who was a resident of mine when I was a junior doctor in Aberdeen, and is a further extension of the networking that is so deficient in the practice of many IMGs when they're deployed to remoter areas of the country and I think was evident in - well, was evidently lacking with Dr Patel. But in answer to the question of leak, it - the overall - there was a 30-day mortality rate associated with leak of four per cent, an overall mortality followed to four years of 31 per cent, the 30-day anastomotic leak rate was three per cent or 16 to 435 patients studied. And that, I think, answers the question.

Thank you, yes. The next is Nancy Swanson?-- This later I've referred to in the complications section because she was unfortunate enough to suffer multiple complications but they included the formation of an abdominal wall collection and - I just can't recall her second complication but I'd have to read right through it-----

D COMMISSIONER EDWARDS: Bowel leak over-----?-- The bowel leak, that's correct. So she's had an anastomotic technical problem as well as a collection in the abdominal wall.

COMMISSIONER: And finally,P306?-- This 62-year-old patient perforated the diverticulum and developed an abscess. She suffered a protracted period of recovery, metabolic dysfunction. This was further complicated by a wound infection that predispose it to a wound dehiscence and she also suffered a thrombosis in the left leg, which was a particularly serious one, extending up into the iliac veins and that makes it a life-threatening thrombosis. The stoma retracted, which is indicative of a deficient formation of a stoma and was so deficient it required a second operation because of the subcutaneous fistula. So that is unquestionably deficient technique.

Doctor, I think that concludes all of the patients that you regarded as having an adverse outcome that was either certainly or probably or possibly caused by Dr Patel. An I ask you in general terms to express your views as to what all of this evidence shows us regarding Patel's competence as a surgeon?-- I have no hesitation in saying that his performance was incompetent and that this performance is far worse than average or what one might expect by chance.

Had he been, for example, your Registrar producing this sort of results, not that you'd have a Registrar doing oesophagectomies and so on, but is he someone who you would, for example, support for membership of the College of Surgeons?-- The membership of the College of Surgeons is a far more complex and laborious process than that.

Yes?-- But we have seen some very effective remedial handling

of deficient performances in a number of other practitioners. So, I think one of the lessons we can take from this is (a) we should have appreciated, well, an audit such as this, that there was a problem that needed addressing. I believe with the skills laboratory you saw this morning and supervised management in an appropriate environment, that someone such as this might well have had different outcomes.

Yes?-- So that might seem to be avoiding your question but-----

No, not at all, no. And it's likely, as we understand it, that had the Medical Board known of his American history, if he'd been allowed to practise in Australia at all, it would have been subject to precisely the sort of supervision that you speak about?-- Yes, correct.

Mr Andrews, I'm inclined to think that Dr Woodruff's statement otherwise speaks for itself, so are there any specific issues you wished to canvass?

MR ANDREWS: Yes, two matters that I believe don't appear in the statement. Dr Woodruff, you - am I right in thinking that it's your opinion Bundaberg is not unique?-- Correct.

And that there have been Bundaberg like incidents in and outside Queensland in recent history?-- Yes.

At Mackay, Toowoomba, Mount Gambia and Lismore?-- Yes, and that list goes on too.

And if despite all precautions a surgeon, for instance, slips through the net into some area, the best way to pick up aberrant surgical practices is through morbidity and mortality programs?-- Yes.

If privileging and credentialing haven't picked it up to begin with and if supervision hasn't picked it up to begin with, then you would advocate improved morbidity and mortality meetings?-- Yes.

And despite your careful language in the witness box, seeking not to over dramatise anything, would it be fair to say that Dr Patel's complication rate could be fairly described as frightening?-- Yes.

And ought a proper, more - regime of morbidity and mortality meetings pick up a frightening complication rate in a short time?-- Very, very likely. In fact, Mr Andrews, on the very last page of my submission I've suggested a process of audit and review which I believe would - if followed, would put an end to occurrences such as we've discussed here in Bundaberg.

And that process which appears here at annexure A, plan for audit and review, is a process you recommend not simply from your experience in the medical world but from your experience in the air force?-- And as a commercial pilot and having gone through the process myself, and having a son who is a Boeing

captain and see him go through it every six months.

Thank you. I have no further questions.

COMMISSIONER: Doctor, I have got no desire at all to cut you short but I know that you're on a timetable as well as us. Is there anything else in your statement that you would like the opportunity to develop? We have all read it and we will certainly be reading it a number of more times before we finalise this inquiry, but is there anything in particular you'd like to focus on?-- No, thank you, Commissioner, I think you've been more than generous with the Commission's time in my regard.

Doctor-----

D COMMISSIONER VIDER: I would just like to ask Dr Woodruff one question. I notice in your statement in paragraph 6, Doctor, you mention that you're on the board of the Australian Council of Health Care Standards?-- Correct.

Would you consider that this organisation provides a framework that could adequately be used to assess the competence for patient outcomes that are desirable in hospitals today?-- As a board member, we've been very conscious of the emphasis in the past on corporate governments and myself with two other board members in particular, who have a clinical bent, are trying to move the focus of accreditation more back towards clinical governance to answer that very challenge that you allude to and I believe that that's where the future lies.

Yes. Thank you.

COMMISSIONER: Doctor, there's something I want to raise that's really unrelated to what's in your statement but it goes back to the full report. A concern has been raised and I would like to explain to you precisely what that concern is. As you know, Dr Miach has been one of the initial and principal critics of Dr Patel and was one of the first witnesses to give evidence here. In this report, it emerges in the course of investigations, Dr Miach's file was consulted at the Bundaberg Base Hospital. It was ascertained that there was some oversight in Dr Miach's registration in that his specialist's registration in Victoria or his specialist's qualifications in Victoria hadn't been formally recognised by the Medical Board in Queensland. However, rather than bringing that matter to Dr Miach's attention, which could have been rectified in hours, whoever came across that fact decided to include it in the report and it was then leaked and became published in the Australian newspaper and other newspapers in a way that evidently caused Dr Miach a certain degree of embarrassment. Firstly, can I ask: did you have any part in the investigations or the writing of the report relating to those issues?-- No.

and secondly, can you give any insight into the way in which those matters came to be in the report or came to be leaked to the press?-- No.

Thank you, Doctor.

MR ANDREWS: Commissioner, I wonder if the parties could indicate for how long they anticipate cross-examining Dr Woodruff? I'm wondering whether to arrange for another witness to be called promptly or-----

MR MULLINS: 15 minutes.

COMMISSIONER: Mr Boddice?

MR BODDICE: At the moment, just one matter, so only about five minutes.

COMMISSIONER: Mr Devlin?

MR DEVLIN: About 20 minutes.

COMMISSIONER: Mr Allen?

MR ALLEN: Five or 10 minutes.

MS FEENEY: At this stage I have nothing.

MS HUNT: Excuse me Commissioner, we may have just a couple of questions for Dr Woodruff as well.

COMMISSIONER: That's on behalf of the-----

MS HUNT: Mrs Mulligan.

COMMISSIONER: Mrs Mulligan, all right.

MR ANDREWS: Sounds like a quarter to four.

COMMISSIONER: It does. But also given that we've some inquiry people have to leave this evening to get up to Bundaberg for tomorrow's hearing, it sounds like we should put off - I think it was going to be Dr Wakefield, wasn't it going to be the next witness?

MR BODDICE: That's so.

MR ANDREWS: In the circumstances, I wonder when the parties have had the opportunity to review Dr Wakefield's evidence, whether they'd be kind enough to indicate whether any of them require Dr Wakefield for cross-examination, because on the brief perusal at the break, much of it seems uncontentious though informative.

COMMISSIONER: Yes, or if the cross-examination was going to be limited to only a few minutes each, we might proceed with him this afternoon, so perhaps the parties can consider that, let Mr Boddice know through Mr Boddice's instructing solicitor and that message can be got back to Dr Wakefield.

MR BODDICE: Yes, he's not here at the moment, he's contactable, or alternatively we could arrange for him to be here Thursday if the parties-----

MR DIEHM: I can indicate that I haven't even had a chance to begin to look at Dr Wakefield's statement. We got it as we broke for lunch and it's very big so-----

COMMISSIONER: Well, that's another good reason not to try and schedule Dr Wakefield this afternoon. Yes, if a message can be got to him not to waste his time.

MR BODDICE: Yes.

COMMISSIONER: Not to waste it any further.

MR DIEHM: Yes, thank you.

COMMISSIONER: Mr Mullins, sounds like you're up.

MR BODDICE: Commissioner, could I just ask one thing in further evidence-in-chief?

COMMISSIONER: Yes, of course, sorry, Mr Boddice.

FURTHER EXAMINATION-IN-CHIEF:

MR BODDICE: Dr Woodruff, could you just have a look, this is Annexure A to your statement which is the audit and review program. Is there anything, for the purposes of the Commissioners, that you wanted to highlight over and beyond what appears on that sheet or do you accept that it's just self-explanatory; what you're setting out there?-- I believe it's self-explanatory, although I'd be happy to elaborate on any points that I haven't expressed clearly.

No, I just wanted to give you the opportunity because you said it's based on your experience in the aviation industry as well?-- Well, the - my understanding of where we're at in surgery is somewhat akin to where we were in aviation when we were moving from the tutelage and the Tiger Moth era into the modern simulator era, and I think along with the increased complexity and sophistication of modern surgery comes a requirement for a better disclosure, more accountability, and I think they're lessons to take from aviation in that regard as well. The pilots have an environment where they can freely bring to the attention of their colleagues near misses and they can work out ways of ensuring that these trends are corrected, and I think we now have the technology, we have the responsibility to be doing the same in surgery, and I hope that this is one of the positives that comes from this Commission.

And one of the key factors in the aviation industry is the no blame system which is to look at why it happened rather than looking at whose fault it was?-- In surgery, historically there's been a very defensive attitude, it permeates the whole system of denial, trying to conceal adverse outcomes or even

pretend they don't occur, and I think this has been a timely reminder - or more than a reminder, but this is a golden opportunity to ensure that we have a more proactive open response to assessment of our performance or outcomes, and is not going to happen if we're subverted to overbearing punitive adversarial challenge. It's got to come from a change of culture and a willingness to be open and frank and to come to grips with the requirement for better performance.

D COMMISSIONER EDWARDS: Doctor-----

COMMISSIONER: Doctor, could - I'm sorry, Sir Llew.

D COMMISSIONER EDWARDS: No.

COMMISSIONER: Can I draw another analogy from the aviation industry? Generally, after a crash of any magnitude, there's an investigation by the Federal authorities and the outcome of that investigation and the notes and so on are regarded as being subject of what's now called public interest immunity - we used to call it Crown privilege - but what it means is that those investigations and reports are immune from being used in subsequent civil proceedings. It strikes me that a lot of the problems you're talking about can be blamed largely on my own profession, the legal profession, because the increasing predominance of medicolegal litigation makes people defensive, particularly makes people defensive about putting things down in writing that might be used against them, and I wonder whether as part of this audit plan, you would see some merit in insulating that process from scrutiny in subsequent civil cases?-- I would, correct. In fact, when I discussed this process with my son, he said, "Dad, you're using the term audit and review, you're starting on the wrong foot. We call it check and training."

Yes?-- Because we want to get to what's going on and we want to make sure it doesn't happen again, and I think that's a very good point.

Yes.

D COMMISSIONER EDWARDS: Could I - you mentioned the change of culture. Are you meaning the whole health system and within hospital, within reporting, what do you mean by a change of culture that will prevent or attempt to reduce the incidents that we are referring to in this Commission?-- I've long held the belief that so long as the public are kept ignorant of the true state of affairs, we will never get the situation moving as far towards correction as I believe it should be, and I think the two things that have really given us a golden opportunity are the way the media have managed to capture the public interest in health care and the way the Commission has produced a number of revelations, and I think that if we start from that premise and accept that this isn't a Bundaberg issue, it's not a Queensland issue, it's a national issue and start from the top down, I think you'll find that that carries with it increased recognition, responsibility from the grass roots up as well, the clinicians will become more interested

in the system, more committed to the system, less likely to withdraw from it, I think it will go a long way towards improving the workforce crises, et cetera.

Are you suggesting a self-regulating or are you suggesting a imposition from down - above down so that these are the rules and these are the regulations or are you feeling it's really a professional matter of openness that should be encouraged through meetings and with the reserve power that should be there occasionally?-- Well, drawing on my aviation exposure, I believe strongly that it should be self-regulating from within and in the first instance, and in this document I mention that clinician-based group would have three recommended outcomes, either the instigation - this is point 8 - a remedial action, that's the training aspect, nothing required, or I'm not wishing to conceal anything, if they do find deficient performance, it should, in my opinion, be referred to the Medical Board because I think they have sufficient statutory powers and competence to get beyond a Kangaroo Court and look into situations that need to be looked into with some sort of judicial governance.

Would you see that there'd be some better mechanism within the system so that the Patels are detected much earlier and internal action is taken rather than going to the Medical Board which will take many months again and a legislation that stops certain action and so forth? Isn't this a real audit problem and then be prepared to act by people within the system?-- I believe that we're on the cusp of recognition at all levels, from senior political levels right down to the workface clinical level, and I believe that with encouragement of the cultural change, with the facilities that are developing with the technology, that we could produce - and the appointment of appropriate personnel - we could produce vast change at the moment. I believe that if we followed a audit data trail as outlined in that document, and then identified a performance that tended to outlier somebody such as myself, for instance, and many others, spending a week in Bundaberg with Dr Patel, we'd be able to give as meaningful a judgment on the situation as a check captain riding around with a crew for two or three sectors in a work schedule. So I would very strongly advocate something along the lines of Annexure A.

COMMISSIONER: Thank you.

MR BODDICE: And Dr Woodruff, as part of that process, to take up what Commissioner Morris raised, is one of the things that may assist that openness from the surgical team in discussing it the fact that whatever is discussed can't then be used in later legal proceedings?-- I think that would be a very positive contribution to the process. It's well known that one airline reneged on its confidentiality clause with the pilots in the investigation of a major event and that has dried up the process in that airline in that country for the subsequent decade or so, and they are still paying the price for that break of confidence, and I think that there is no reason why clinicians can't behave with the same commitment

and contribution to the system as their colleagues in aviation. So I would - I think it's worthy of a trial.

Do you think that at the moment that part of the difficulty in getting people to embrace the no blame idea and discuss things frankly is the concern that if they admit to something, it could be used later on?-- It's - yes, it's a multifactorial thing but that's a very important factor.

Thank you.

COMMISSIONER: Thank you Mr Boddice. Mr Mullins or?

MR DEVLIN: May I go next?

COMMISSIONER: Yes, certainly.

MR DEVLIN: Thank you.

CROSS-EXAMINATION:

MR DEVLIN: Doctor, you saw yesterday for the first time the stipulated orders from Oregon, I think we've got it down there.

COMMISSIONER: You're aware, doctor, that learned counsel represents the Medical Board of Queensland?-- Yes, thank you, yes.

MR DEVLIN: Thanks, Commissioner.

If you go to the second page of that, I'll just take you through this quickly. This is a document concealed from the Medical Board; do you understand that?-- Correct.

Down at - sorry, go back one please? Down at 2.1, the orders are, as it were, agreed between Dr Patel and the regulating authority in Oregon recite at 2.1, second sentence, that, "Following an extensive peer review of 79 patient charts, Kaiser" - being the hospital, isn't it?-- Correct.

"Restricted licensee's surgical practice to exclude any surgeries involving the pancreas, any resections of the liver and construction of ileoanal pouches"; do you see that?-- Correct.

Later we'll see - and we'll come to that in a moment - a condition that excluded Dr Patel in Oregon from doing those particular procedures; correct?-- Correct.

You have identified about eight procedures directly referable to those descriptions?-- Yes, we went through those this morning.

You went through them earlier, I won't go back over them. In 2.2, the agreement, as it were, which later reflects in orders recites this: "Kaiser also implemented a practice improvement plan that entails mandatory second opinions before undertaking all complicated surgical cases, chart reviews, proctoring"; what's proctoring?-- Well, oversight or-----

Mentoring?-- Mentoring.

Thank you, "Attendance of surgical meetings and continuing education courses on improving communication skills and preventing malpractice losses." Now, those measures which appear to have been put in place by Patel's former employer would appear to meet all of the shortfalls in this man's practice?-- They would certainly make a huge improvement on outcome and also, I believe, in some way reflect the type of environment that one works in in a major tertiary hospital. It's not, it's not a punitive requirement, but it's - it's almost a mode of-----

Almost a given?-- A given. You're working with learned colleagues in a bank of 20 operating theatres, any substandard performance is very evident and it just doesn't happen, and-----

Now, when he goes to a provincial hospital though, the chance for that kind of mentoring, that kind of supervision is dramatically lessoned; correct?-- Correct.

Particularly if he doesn't tell the registering body that these orders already apply to him and in his place of origin?-- Correct.

Now, part of the theme of your evidence, if I may say so, is, and correct me if I am wrong, you got a sense from what you saw there that this man lived in splendid isolation in a professional sense?-- Correct.

The most startling statistic you found was not a single letter to another colleague?-- Correct.

How does this sit though, that junior staff regarded him as quite a reasonable teacher? Is there an inbuilt conflict in that or can you be in splendid isolation and yet teach the less experienced medical practitioners?-- I think you can in the substandard way, but I think that gets back to my assessment of Dr Patel. I overall consider him to be an intelligent man, I consider him to be an extremely industrious man and I didn't get the chance to point that out in the case of P26 this morning, but he not only operated on him three times on the 23rd, but he saw him three times on the 24th and a couple of times on the 25th.

Mmm?-- He'd done a weeks' work on that one patient.

I think he saw him-----?-- Within 40-----

I think he saw P26 before he left on holidays, Boxing

Day?-- He did, and wrote the chart on that day, in other words, an extremely industrious man, and I think in a different environment with the requirements that Kaiser recognised as well, he could well be a productive contributor. I have seen worse surgical performances, I must say, in my career than Dr Patel's.

COMMISSIONER: Without taking away from the colour of Mr Devlin's phrase "splendid isolation", it seems to me the problem was more that he was king of his own dung hill, he was in charge, as Mr Devlin points out, he had junior doctors around him to whom he was the mentor, but he had no-one at either an equivalent or a higher level to keep an eye on him, and that strikes me as the biggest problem resulting from the fact that he was appointed Director of Surgery in a position where there was no other clinician senior to him?-- Correct, and if I may add, the same situation has arisen with highly regarded fellows of the Australian College who, when changed from one environment to another, particularly an environment of isolation, eventually - not eventually, but have ultimately become an outlier in their performance. This has been recognised and the isolation has been appropriately dealt with and they - I can think of two examples, are now making very positive contributions, and that, I think, is part of the solution that we must develop because of our increased reliance on overseas-trained doctors, we must not put them into challenging isolated positions without having them networking with appropriate colleagues in more central areas.

Doctor, I just wonder though whether, being a little bit candid about the - there's a sort of untruth at the heart of the whole problem, Bundaberg isn't and never was an Area of Need, they had, as we've heard, exceptional surgeons who worked in the local community, who worked for the private hospitals, who had worked at the public hospital, who were willing to work at the public hospital, Dr Nankivell, Dr Sam Baker, Dr Brian Thiele, Dr Anderson and so on. It seems to me that when you talk about cultural problems, the real cultural problem here is a system which prefers to have a Jayant Patel as Director of Surgery than making the necessary arrangements to utilise the surgeons who already exist in the community?-- Well, that - you're correct in defining a process that's evolved, for one reason or another, and must be corrected to get us moving back in the direction that we need to go.

Yes, Mr Devlin.

MR DEVLIN: At least in Patel's case, he was a relatively senior overseas-trained doctor?-- Correct.

Is it perhaps a weakness in Queensland and Australia's reliance on overseas-trained doctors that the more senior of them seeking a seachange or seeking to escape another situation, might be less amenable to peer support than more junior doctors who might come here or who might even originate in the Australian education system; do you see my point?-- I'm sorry, I missed it.

I'll put it in a clearer way: is it possible that Patel might have found it difficult to accept peer direction and support simply because of the person he was, that is, a senior surgeon from one of the big jurisdictions?-- Well, that's quite possible, but I think in a proper and enculturation and supervision and introduction into the Australian health care system, you should not be accredited to go out into that environment without having the appropriate boxes ticked, having satisfied the right requirements and b, being part of a hub and spoke type network so that it's an ongoing process.

So two issues arise from that, I'd suggest to you, for your comment, orientation on a much more formal and detailed level?-- Mmm.

And perhaps rotating through a large centre first before going to the regions?-- That would be ideal.

Okay. Can we just move to one other feature of this Oregon order, and that's down on paragraph 4, thank you operator. 4.2, "The licensee will obtain a second opinion preoperatively on complicated surgical cases." Now, I'll interpolate that 4.2 was amended to change it from being somebody chosen from the board's investigative committee to some other suitably qualified practitioner. So the note of 4.2 is, "Licensee will obtain a second opinion preoperatively on complicated surgical cases." Did you see much indication of second opinions being obtained preoperatively on the complicated cases?-- None.

And are there more beyond the eight which would commend themselves to you as cases where as a matter of professional competence, he ought to have sought a preoperative second opinion given the prospective complexity of the procedures?-- I'm sure they exist, I can't answer your question specifically because I just don't have the numbers.

I just don't want to waste the time of the Commission today, but would you be prepared to revisit your list of cases from that point of view?-- Of course.

If there was a failure of a significant magnitude, because you've talked about a number of patients with comorbidities and potential complications?-- Of course I'd be happy to, I think that's a slightly-----

COMMISSIONER: I think it's a bit repetitious because, as I understand it, you've identified those cases where you question Patel's motives that those are invariably the more complex operations that you felt shouldn't be performed at Bundaberg, and as I understand it, they would be the ones that respond to Mr Devlin's question as well?-- Mmm.

That he should have sought a second opinion if he was going to do them at all?-- That's correct.

Yes.

MR DEVLIN: Thank you, your Honour, I'm prepared to move on.

If I can show you this document, thank you. Going to now a specific case just briefly. This is in relation to Mr Bramich. Going up on the screen is the adverse event report form which I think might be part of Exhibit 163, the statement of Raven.

COMMISSIONER: Yes.

MR DEVLIN: This is a report on an event with a major consequence by Karen Fox and D Atkin emanating from the ICU on the 27th of July 2004. We know Mr Bramich passed away on the 27th of July or just after into the next day, the note is, "ICC drain, no water in underwater seal section." Have you seen this document before?-- Only at the lunch break.

And does it accord with your own investigations?-- Well, it does, yes.

Going over the page, the conclusion from the process following the form as written by the shift supervisor, Toni Hoffman, was a way to deal with the matter or action taken, "An increased awareness of the need for water in the underwater sealed drainage. Unsure of who set up the unit. Emergency situation."?-- Yes, I agree with that.

In the course of looking at this particular case, did you turn your mind to the issue of delay in transfer?-- I did, that was one of the factors considered.

And in your opinion, what is the single most significant failing in this case?-- The findings as outlined in this piece of paper.

Did you find any significant factor in delay going to an issue of professional competence by any nurse or medical practitioner?-- I'm sorry, I missed that question?

Did you find any particular feature in the delay issue going to any particular nurse or medical practitioner's professional competence?-- I didn't find any individual professional competence lacking, but there is no question in my mind that had Mr Bramich been managed with appropriate underwater seal drainage, he would have survived, but I think it inappropriate to once again attribute the failure of an underwater seal drain to one solitary individual: there's Dr Patel in charge of the case; Dr Gaffield, who's the patient was admitted under; there's the charge nurse; there's a whole succession of members of the team that should be working collaboratively together to ensure that an oversight such as this doesn't happen.

Thank you. Now, in relation to the patient P175, you say that that's one patient on your list common with that of Dr de Lacy. Do you recall reference to him? Please go back to your record if you need to. I think we have finished with that document now, thanks. I think there was a suggestion in Dr de Lacy's evidence - and I stand to be corrected by anyone who wishes to do so - but I think he made passing reference to the wrong organ being removed in P175's case. Firstly, as a general question, did you see any examples of the wrong organ being removed in your review?-- I - in my review I can place my finger - perhaps it is going to be necessary to do it now - on the page in which Dr Patel preoperatively says, "This swelling in the neck, I believe, is most likely the salivary gland but because the patient has had tumour in the lymph node, I believe I should take it out for the purposes of biopsy and perhaps cure."

COMMISSIONER: Doctor, Mr Devlin will correct me if I am wrong but my recollection is seeing Dr de Lacy in the witness-box where you are now sitting pointing out a position under his chin line as being the position which a junior doctor had noted as the site of the swelling and Dr Patel removed a lump which turned out to be the salivary gland from another position lower down the neck. Now, I am not sure whether that's exactly right, but that's my recollection.

MR DEVLIN: Thank you, Commissioner. I can't advance that, Commissioner.

WITNESS: I mean, I suspect that Dr Patel took out the lump that he intended to take out. I also was convinced by his notes that he thought it was most likely a salivary gland but he could not exclude it from perhaps being a metastatically involved lymph node and that the best thing to do was put it under the microscope.

COMMISSIONER: And-----?-- That's the way - from my reading of the notes.

From what we know about Patel's apparent dishonesty in other areas, the thought crosses one's mind that he might have written up the note subsequently to create that impression, but you think the indications, from the whole of the notes you have seen, is that he was really generally quite honest even if he gave a rose-coloured version of his operations?-- I think this is a very important point and I would ask that you bear with me while I identify the page.

Yes?-- Because then we can answer your question, sir, of whether or not we think it was an entry made out of sequence with the rest of the chart. It will take me a little time to find it, unfortunately. Well, this history on the request form, which would be written at the time of operation, documents "cervical adenopathy on CT. Metastatic disease. Query thyroid". This, I think, is the note I am looking for. That's of the original operation. So it is subsequent to that. Here is the note of the excision biopsy. "Metastatic

papillary carcinoma 2003. Total thyroidectomy right neck to section now neck mass." I am not sure - I think it is neck mass. "Probably submandibular salivary gland excised under GA." Now, it is on a separate piece of paper. He has dated it. He has other witnesses to what he actually did in theatre that day. Dr Berens was the anaesthetist, but it doesn't permit - it doesn't exclude the possibility that you raised.

MR DEVLIN: So I will just read to you Dr de Lacy's description briefly. "The site of his wound is under the angle of his right jaw. A mass was removed which on histology proved to be normal, right submandibular gland". So you don't find yourself in disagreement with that description?-- No.

Thank you?-- There it is there. I reviewed that. That was posted - that letter was posted in the case notes.

COMMISSIONER: Yes?-- And that formed part of my review.

MR DEVLIN: Dr Woodruff, then turning your mind to a consideration of what a competent surgeon might do, do you see that as evidence of Dr Patel's surgical incompetence or something that might happen, a suspect organ being removed?-- I - on balance, I think it is suboptimal performance but I think it is not unreasonable to adopt that course of action in a regional environment. It is not one of the glaringly atrocious examples. It is one that could be argued in either direction, I believe.

COMMISSIONER: It wouldn't raise your eyebrows if you saw it from a surgeon in another regional hospital about whom you had no concerns?-- Well, it would but it would prompt a phone call or a discussion, but what would concern me - and I am not in a position to answer this - would be if he had replaced that page in the chart and rewritten it with dishonesty of intent. I mean, that is the really critical offence.

Yes?-- And unforgivable. But if he - if that is a genuine account of how he played the situation, it is not how I would play it, but it is understandable and almost acceptable.

MR DEVLIN: On a couple of occasions you have mentioned Dr Patel's detailed notetaking?-- Mmm.

Did you encounter situations where you suspected the truth of his entry?-- I did - no, I didn't come across examples of questionable truth, but there were instances where I believe the notes have been changed - and this program enables me to identify that. The thing that is missing at the moment is the key that tells me what the number is for changed notes.

COMMISSIONER: Mr Price is in the courtroom. He might be able to assist you.

DR PRICE: It was on the sheet.

WITNESS: I know but I had the key here before I went to lunch.

COMMISSIONER: Feel free to come forward if you can assist. Mr Price is the designer of this software.

WITNESS: I have found the number but I still haven't found the sheet. But if I press 25.

MR ANDREWS: Commissioner I understand that Mr Price is Dr Price and a vascular surgeon himself.

COMMISSIONER: Dr Price, I do beg your pardon.

DR PRICE: Is that the group? 24, I think.

WITNESS: I think these 25 notes - it was here - here it is. We have found it now. Thank you very much. 25 on the key sheet here is accurate records. Operation notes. Changes in notes is 95, my apologies. In those three patients there are, I believe, evidence of changed notes and I think I can show you what I mean by them. And in my statement I summarised it by saying I wasn't too sure what we could deduce from this. The consent form, I am looking for.

COMMISSIONER: Number 42, the third item down, it looks like?-- If one looks at the consent form, he has listed a number of conditions "bleeding, infection, poor wound healing, bile leak, pancreatic leak, abdominal sepsis". I am not sure of the next one. "Blood clots and pulmonary embolus", and then there is a definite change in the slant of the writing. It is sort of up and down slant to that point and then for the last two "pneumonia" and "death", it is in my opinion - and I have run this past one or two other observers and they share the same opinion - that it is definitely in a different style and was made at a different time. But the significance of that, I don't know. Whether he added it after answering the phone or whether he came back on a different occasion after subsequent events, I don't know. That's one example.

COMMISSIONER: Mr Andrews, if Ms Murphy can make a note of these particular items, it might be useful to get a forensic document examiner like Mr Marheine to review them and provide us with a report.

MR ANDREWS: It was P236, was it not, Commissioner.

D COMMISSIONER VIDER: This one, yes.

WITNESS: And this - similar occurrence in the case of P243, and to my eye it looks as though "F and G, DVT query pulmonary embolus and ARDS query" - I am not sure of the other initials - have been added in a different pen and possibly at a different time to the five items appearing higher on the list. So that was a second example. And the third example is in the case of P26. If anybody can spot the annotation that draws attention to this.

MR DEVLIN: 46, perhaps?-- 46 - well, I think that was the ultrasound report we looked at this morning which is a typed

report just showing how complex the procedure. It is a complex and difficult casenote. I am conscious of wasting the Commission's time. I would be quite happy to find this example and give it to.

COMMISSIONER: Why don't we have the afternoon break and that would give you 10 or 15 minutes?-- All right.

MR BODDICE: Just before we rise, in respect of Bundaberg tomorrow.

COMMISSIONER: Yes.

MR BODDICE: As we apprehend matters, we don't see that we really have an interest in Mr Chase.

COMMISSIONER: I think that's probably right.

MR BODDICE: Could we do it on the same basis that Mr Diehm raised, which is we look at the transcript and if there is an issue, we raise a question about his telephone evidence in respect of that.

COMMISSIONER: Certainly. And the same offer extends to anyone else, Mr Mullins, Mr Allen, Mr Devlin. I think the only party for whom the evidence is critical is Mr Leck. Yes.

MR BODDICE: Thank you very much.

COMMISSIONER: Look, since you have raised that, can I also telegraph a concern I have - and I am speaking quite openly about this. Last time I checked, which was at lunch time, there is still no indication when we will have a decision from the Supreme Court. It does worry me that we're running out of our scheduled sitting time. I have proceeded on the footing that whilst we can't down tools generally pending that outcome, it would be undesirable to put Mr Leck or Dr Keating in the witness-box before we have that decision. It occurs to me that perhaps, Mr Diehm, we might have to explore the option of perhaps extending the time of the inquiry for a week or two to accommodate that. Although your client, I believe, has provided a statement already, we haven't got one from Mr Leck.

MR DIEHM: A draft was provided.

COMMISSIONER: A draft was provided by your client.

MR DIEHM: Work is continuing on it but my client's position is a little different to Mr Leck, in the sense he has not applied to the court for an order in any form that he be not required to be called as a witness.

COMMISSIONER: Yes.

MR DIEHM: That's one difference - one of a couple of differences between the orders that are being sought. So that means that there is little or less of a reason to have the precaution that you have mentioned in terms of not having his

evidence before there is a decision. It doesn't mean that it should happen.

COMMISSIONER: No.

MR DIEHM: Commissioner, the thing that has struck me over the last couple of days, as I hear and see information about what witnesses remain to be called and what you said yesterday about a timetable, was that I am somewhat skeptical that we will finish the evidence next week anyway.

COMMISSIONER: I think you are right to be skeptical, yes.

MR DIEHM: Yes.

COMMISSIONER: I have kept up a brave face because I have been determined to finish on time, but it is looking less and less likely that we will be able to get through the necessary witnesses.

MR DIEHM: That being-----

COMMISSIONER: And still have time to give the parties a fair opportunity to put in submissions and write a report.

MR DIEHM: Yes. Commissioner, I gathered from what you said yesterday there will be an extra week of sittings in the week commencing the 5th of September.

COMMISSIONER: Well, no, what I said is that we would have that week available if it became necessary.

MR DIEHM: Yes.

COMMISSIONER: I had still been optimistic of not utilising it.

MR DIEHM: Yes. In any event, if it were to be the case that - well, perhaps if I could put it this way: I would have suspected that the earliest Dr Keating would be sought to give evidence would be towards the end of next week in any event.

COMMISSIONER: Yes, but we would need a statement before then, that is to say a final statement.

MR DIEHM: Yes. That's being worked on, I can tell you, Commissioner, in terms of updating it and completing it. I am not sure - I can't tell you when it will be ready. But my hope would be that it would be early next week in any event.

COMMISSIONER: Ms Feeney, can I - I don't want to put you on the spot but are you able to help at all as to what your client's position is at the moment.

MS FEENEY: I am not, actually, Commissioner. There have been some developments over the last few days that I have had to take some further advice and I am not in a position to say anything much at the moment, I am sorry, Commissioner.

COMMISSIONER: Again, I-----

MS FEENEY: And I am not trying to be difficult. There have been some issues and I am waiting on some further material.

COMMISSIONER: I understand. Are those developments likely to change the prognosis with respect to the sort of things I have been canvassing?

MS FEENEY: Yes, yes, it might.

COMMISSIONER: Okay. When do you expect to have - to know that situation?

MS FEENEY: Hopefully by no later than Thursday afternoon.

COMMISSIONER: Yes, okay.

MR BODDICE: Commissioner-----

COMMISSIONER: We will do our best.

MR BODDICE: Could we raise one other matter? There was, for example, a statement from a Dr Kelly that was distributed.

COMMISSIONER: Yes.

MR BODDICE: I just wanted to see whether, Commissioners, you had a problem with this: I had raised with - I think it was Mr Andrews - certainly one of the counsel assisting - that one way to deal with that, because it is issues which seem to be peripheral, in a sense, was that we would put in statements, in effect, in reply to those.

COMMISSIONER: Yes.

MR BODDICE: And then the parties could consider whether there is a need for anybody to be called in respect of those matters.

COMMISSIONER: I certainly urge that and I don't think there is anyone present at the moment from the AMA but the AMA has suggested six witnesses. My expectation is that they will all deal with the sort of systemic issues rather than specific Bundaberg or Patel issues. It may be that they're things that can be addressed by putting in submissions or statements in reply rather than spending a lot of time cross-examining witnesses.

MR BODDICE: And that's something that in a preliminary sense I have canvassed with Mr Tait, that we thought that might be a way we could address those issues as well and then once both, in effect, the statements and the replies to those statements, a decision can be made as to whether there is a need for oral evidence.

COMMISSIONER: Well, we will take - Mr Allen?

MR ALLEN: Excuse me, Commissioner. Is it still the case, as indicated yesterday, that whatever occurs the week after next will not be sitting days?

COMMISSIONER: That's definitely the case, and one of the Commissioners will not be in Brisbane that week, so that's immutable.

MR ALLEN: Thank you, Commissioner.

COMMISSIONER: We will take a 10 minute break now.

THE COMMISSION ADJOURNED AT 3.37 P.M.

THE COMMISSION RESUMED AT 3.58 A.M.

PETER WILLIAM HAROLD WOODRUFF, CONTINUING CROSS-EXAMINATION:

COMMISSIONER: Yes, Mr Devlin.

MR DEVLIN: Thank you, Doctor, that last entry that you might have thought was inaccurate, were you able to find that one?-- Yes, it's - reverting to P26, it's page 121 of - and, again, I don't know that I can read too much into it but I think the most important thing is it shows the concentration I had on trying to find changed notes and this is - these are the best three examples I've been able to come up with and I don't want to make too much of them but in this instance I thought that Dr Patel, who normally signs his name well below his entry, usually a line or two below his entry, seems to have added to the chart subsequent to his signature, but what he has added is pretty innocuous. It is, "Manatol ordered for" - I'm not sure of that last word.

In fairness, the day being Christmas Day might have something to do with it?-- But as you'll know, it's 7.40 a.m. and he's still there at 9.40. And as the day progresses - I mean, he spent a lot of time and effort on trying to help P26.

COMMISSIONER: Indeed, that could be an instance of a genuine addition to the note. He wrote it out, signed it and then thought of something quite genuinely that should have been included and inserted that beside his signature.

MR DEVLIN: Okay. Thank you. If we go now to the last matter of interest that I alerted you to at the break, P220, I think it is one that we haven't looked at it in any detail and if I remind you of what you said in your statement about it. At page 5 paragraph (d) you said - you listed P220 with some of the more serious matters of P224, P236, Kemps, Nagle, P98 and P215. If you could just go to that us and give us the feature, just briefly the feature, that you say makes this one stand out as a serious matter?-- There appears to be some discrepancy in the transcripts and evidence that I've read to date and that caused me to revisit this one and I found it a little confusing when I first re-read it but I think it's clear to me now. And I think if we follow the sequence of events, P220 underwent a upper endoscopy at the Friendly Society Private Hospital and was transferred from there after that endoscopy for an abdominal CAT scan. The CAT scan - I think this is also informative. The CAT scan was performed and reported. It's an urgent request because obviously there was a worry or concern about P220. The person doing the report doesn't know who ordered the CAT scan and who to speak with and it underlines the difficulties of not having a reliable, established service. I mean, it was reported by a Dr Nicholas Humphreys in Armidale and it is of concern, the report, and he

comments, "The differential diagnosis includes ruptured gastric outlet duodenum ulcer", and he asks the question, "Was a biopsy performed causing a perforation? If the gallbladder is still present then the appearances could represent gallbladder rupture although less likely. Assessment of pancreatic tumour is needed although pancreatitis thought to be less likely." It's interesting that doctor contact was not made for this referral and that he's very concerned with what he's seen on the CAT scan but doesn't know who to speak to. His own fax paper is obviously very inappropriately dated and that raises questions about the reliability of the phone number. I can't comment on that. But it just shows some of the difficulties and the breakdown that occurs with regional service. But going on from there - and I very carefully re-read Dr Strahan's statement and this is a letter from him referring a patient which he says, "Arranged transfer to the Bundaberg Base Hospital for a CT scan of the abdomen and further investigation", and that outlines the findings, which were quite significant. The patient gave a six-week history of nausea and anorexia associated with epigastric pain and there was a finding on endoscopy of a query leiomyoma and the distal duodenum was not visualised. The patient was then taken to theatre and in Dr Strahan's statement he says by Dr Patel, but in the operative note the surgeon is down as Dr Walker. Now, I don't know who Dr Walker is. I did a search of the Medical Board records. I couldn't find a Dr Walker other than Phillip Walker, who works at the Royal Brisbane and I don't think it was him. He's a vascular surgeon. But Dr Walker has actually drawn a diagram of his findings, which does include a perforation plus a four centimetre craggy hard mass in the head of the pancreas, with lesser omental adhesions, query inflammatory, query malignant and it's quite clear, diagram of operative findings on laparotomy by Dr Walker. And then on the histology confirms the presence of a moderately differentiated adenocarcinoma. Dr Walker's operative note, we just saw his diagram but he leaves no doubt as to who did the operation. That's Dr Walker assisted by Dr Athanasiov.

Athanasiov?-- And the findings are quite specific: acute abdomen with likely perforated viscous. 56-year-old female. Six weeks history of upper abdominal pain and nausea. GGD today. Obstructed lesion in duodenum, developed acute peritonitis. Patient was quite sick actually on admission. Upper midline incision. No gas but free fluid in peritoneal cavity. Heavy adhesions between the duodenum, gall bladder, liver and pancreas. After desection, gall bladder perforation revealed with white plural and empyema. 3.5 to 4 centimetre craggy hard mass which appeared to be in the head of the pancreas. No obvious secondaries within the liver or peritoneal cavity. Stomach appeared to be normal. Cholecystectomy performed with an 18 gauge Foley catheter. That's the tube placed into the bed of the gall bladder and brought out through the abdominal wall to allow the pus to drain freely to the exterior. This catheter was secured with a purse string suture. A biopsy was taken of the omentum. A further drain tube was placed into the area of inflammation and the peritoneal cavity was washed with warm, normal saline

and closed in layers, and that's a further diagram of the findings. And that was on the 29th of June. The patient recuperated from this life-threatening situation, was quite toxic. Was discharged from hospital and the notes record the progress post-operatively. The histology confirms the diagnosis. But then the patient is brought back approximately a month later, or just over a one day more than a month later on the 30th of July, this time by Dr Patel to have the pancreatic tumour explored. He records the pancreatic cancer exploratory laparotomy biopsies of the necrotic mass and decides that the patient should best be treated not by resection but by a duodenal exclusion. As his diagram shows, the tumour in this area is blocking both the bile duct coming out of the liver but also the egress of food from the stomach into the intestine. So he puts a T tube into the bile duct to drain the bile. That's the third tube the patient now has in there. And performs this join with the bottom of the stomach to the first or an early loop of small intestine so that food can pass down the intestine in that fashion, by-passing the tumour. And he describes that in some detail and how he goes about the procedure. And so, I thought that was worth expanding in detail because it varies from previous accounts of events.

COMMISSIONER: I wonder if Mr Diehm might be kind enough - I don't see Dr Keating in the room but if Dr Keating would help us by explaining who Dr Walker is.

MR DIEHM: Yes.

COMMISSIONER: If you could get those instructions.

MR DIEHM: I'll endeavour to do so. It has just struck me that I think, from memory, from other evidence we have heard at the time of that earlier procedure that was just being described, Dr Patel was likely to have been on holidays and I wonder whether it was a locum surgeon but I'll get instructions if I can.

COMMISSIONER: From the notes it would seem to be a very competent surgeon who did the first operation?-- Indeed, yes, sir.

MR DEVLIN: What is it about what you've outlined that reflects on the professional competence of Dr Patel as a surgeon that causes you to classify this case the way you have?-- Can I just refresh my mind as to how I did classify this. Well, I don't believe Dr Patel did contribute to the adverse outcome. I believe that the operation that he did was appropriate. I believe the patient's management was appropriate. I believe that the occurrence of the toxicity that precipitated the transfer of the patient from the Friendly Society Hospital posed a challenge and I believe that Dr Walker dealt with that appropriately as well.

In your statement though you say at paragraph 5 (d), and I'll read it in full for you if you haven't got it there, "In respect of the remaining seven, in my opinion Dr Patel

significantly contributed to the adverse outcome of each of them", and you include P220 in that list?-- Which - which category was that again? Which table was that?

Page 5 - sorry, of your statement I was going off?-- Yes, which-----

COMMISSIONER: Page 5-----

MR DEVLIN: B3?-- B3. Well, you will see that I have - I was only given the statement of Dr Strahan and asked to comment on it last weekend, I think, or Friday or something of that nature, and subsequent to revisiting these case notes over the weekend, I have reclassified P220.

I see?-- I did - I did - on my initial appraisal, I wrongly attributed Dr Walker's operation to Dr Patel because the patient was transferred on the 29th of the 6th and the next operation was done on the 30th of the 7th and I overlooked - and in Dr Strahan's statement, he said he came in and Dr Patel incorrectly diagnosed a perforation and against his advice took the patient to theatre.

I see?-- Well, a month elapsed before Dr Patel took the patient to theatre and the patient did have a perforation. And so, that resulted in me reclassifying the situation when I re-visited it.

I think there may have been an earlier misunderstanding as well that P220 died when, in fact, that's not correct?-- Right.

Thank you for that clarification. Can I just summarise then in notetaking that in all the many notes you did see, there were but - several examples that you wished to query, but in general you found Patel's notes to be reliable?-- Correct.

Thank you. I have nothing further, Commissioner.

COMMISSIONER: Thank you. Who is next? Mr Allen.

CROSS-EXAMINATION:

MR ALLEN: Doctor, John Allen for the Queensland Nurses Union. Just two matters. The first one concerns your comments in relation to the Commission's discussion papers and simply one matter where you indicate that you believed the transfer of responsibility for regulatory issues to an independent health and standards Commission would be a good idea?-- Correct.

And in annexure A, the last document attached to your statement, you indicate that audit and review committees in the hospital would report directly to the health regulations and standards Commission?-- Correct.

Would there be any reason why such a body should not also have overview in relation to private hospitals?-- No.

And would there be good reason why, in fact, such a body would have oversight of private hospitals in that capacity?-- Yes.

And would you envisage that a body such as the Health Rights Commission could take on additional responsibilities of regulation of the type you envisage or would it be necessary in your view that there be a new body set up?-- I put these suggestions here to prompt further investigation and exploration of alternative models and I don't profess to have done sufficient work to have actually struck on the final model but I would make a plea that it's largely composed of clinicians, and by "clinician, I mean doctors and nurses.

Yes, thank you. The only other matter arises from some questions by my learned friend Mr Devlin concerning the underwater seal drainage in relation to Mr Bramich?-- Mmm-hmm.

Are you able to call up conveniently his progress notes in relation to the 27th of July?-- Affirmative.

It's clear from the notes that Mr Bramich was transferred from the ICU to the surgical ward on the 26th of July 2004?-- Correct.

And therefore the notes we see commencing perhaps with a nursing note in morning of the 27th of July 2004 in the surgical ward?-- Which date, the morning of?

27th of July. I am looking at a page which commences with the 26th of July '04 with 1410 hours?-- That's correct, that's the one that's on the screen now.

So we see that there's a transfer from ICU. That the, "right ICC is situ, swinging only. 200 mls blood drainage"?-- Correct.

Then 26 July '04, 2045 hours, obviously now in the surgical ward still?-- Correct, yes.

It's in situ, swinging but no bubbling, approximately 250 mls blood drainage?-- Correct.

Then if we go to the 27th of July in the morning there's a note that "no bubbling noted, approximately 260 mls in bottle"?-- Correct.

I should go back. "ICC remains in situ, swinging but no bubbling, 260 mls remains in bottle"?-- Correct.

Then on the same day, and it is apparent it's in the morning, he's seen by Dr Boyd, the surgical registrar?-- Correct.

And it's noted that, in relation to the chest drain, "patent draining well"?-- Correct. Patient eating, drinking well.

Excuse me?-- Feels much better. Breathing well.

Yes, yes, three lines down from that?-- Sorry, sorry, chest drain.

Chest drain patent?-- Draining well, correct, correct.

What does "patent" mean in that context?-- That means that it's still draining and not blocked.

Okay. And then over the next page there's an entry there for physiotherapy, 27th of July 2004, 11.20 a.m.?-- Correct.

And it's noted on the third line "ICC drain still swinging and draining"?-- Correct.

And the conclusion of that note includes as a plan, "Monitor drain"?-- Correct.

Now, it's apparent from other material that there's a plan in place from the 26th of July for two-hourly observations of the drain?-- I was unaware of that, but that - I accept that.

In any event, after the observations of the physiotherapist at 11.20 a.m., and you would have realised from the statements given to the Coroner that those observations are confirmed by a statement of the physiotherapist Simon Halloway, that there's less than two hours before there's a sudden collapse of the patient at about 12.55 a.m.?-- Correct.

So the observations up until that time, as they're recorded, don't seem to provide any indication to anyone that there is a blockage of the drain at that time?-- That - that is correct, but-----

No, you go ahead?-- The irrefutable fact is that the cause of death is three litres of blood in the chest. So by deduction and the fact that the pathologist excludes major vascular injury, the drain is not draining. It - whether it's recorded as been draining or not, it is not doing the job appropriately. It's three litres behind.

Yes, and we realise that from the results of autopsy?-- Mmm.

But at least at 11.20 a.m. on the 27th of July, the patient's condition is such that not only is there a note by the physiotherapist that the drain is still swinging and draining but there's a consideration of mobilising the patient with walking?-- Correct.

So there's obviously no physical condition of the patient manifesting at that time which would have warned anyone that there is this uncontrolled bleed in the thoracic cavity?-- Correct.

What we see at about 1 p.m. is a sudden deterioration, which would be consistent, I suggest, with Mr Bramich, up until that

time, compensating and then suddenly decompensating?-- Correct.

And it's at that time, according to the surgical note by Dr Boyd, that there's further bleeding noted from the chest drain site?-- Correct. And that, I believe, is an indication that the pressure is building sufficiently in the chest. It's not being released down the drain and it's now starting to express itself around the drain.

Yes. But the first note of that occurring is at about 1300?-- Correct.

And at that time there's urgent efforts towards resuscitation, and, of course, transfusion?-- Mmm-hmm, correct.

Is that so?-- Yes, correct.

And then, if you just go over to - past the pages which include the records of transfused bloods, you will see that there's another entry for the 27th of July which commences, "Patient attended in the ward being called by Dr James Boyd"?-- On the 28th, is this the date?

27th?-- What - do you have a page number?

Do you have the number down the bottom QHB, the barcode reference pages such as I have?-- Yes, yes.

This is 445?-- I'm not sure which barcode-----

COMMISSIONER: You're saying the last three digits are 445.

MR ALLEN: Yes, the last three digits are 445, sorry, Doctor?-- Are 445. Well, that page on the 28th I have on my barcoding are 193, 0193.

COMMISSIONER: Mr Allen, if it will shorten things, why don't you just have it put up on the projector so we can all see.

MR ALLEN: Yes, thank you, Commissioner. If we just go to the top of that page-----

COMMISSIONER: Doctor, if you look at the screen at your right, it should come up there.

MR ALLEN: This seems to be a note about someone attending the ICU after being called by Dr Boyd upon the patient deteriorating, being in respiratory distress, cardiovascular collapse. Do you see there's a highlighted line, "Test tube block", question, question?-- Yes.

I take it that's your annotation to the left?-- That's correct. And I might express some dismay, if I can, Commissioner. These case notes were given to me as my copy for the purposes of this event and I believe that they were mine and these are sort of the confidential file notes that I made before we went to the electronic system and they were

locked in a room in Queensland Health but they appear to be - well, they have been obviously copied and distributed to other people when I was given the assurance that that was my copy and would remain my copy. But I don't - you know, I wouldn't have written comments other than to myself on a record that I thought was going to be distributed to other people. I think it would be inappropriate for me to do that.

COMMISSIONER: Yes, of course.

MR ALLEN: I'm happy to ignore your comments, but in relation to the record made at the time, it's clear that the query is being raised at that time by Dr Boyd whether the test tube is blocked?-- Correct, correct.

Okay. Then the patient is shifted to ICU?-- Yes.

It's not clear whether the decision to put another chest tube in occurs before the shift to ICU or not. Were you able to ascertain the order of that?-- I believe the patient was - I would have to - I would have to - it's an important question. I'll have to look at the chart in a little more detail than I am able to at the moment but I - my recollection is that it was decided to incubate the patient and ventilate him before the transfer because he was deteriorating quite rapidly.

If we go the next flagged page, it might assist. There's a flag down the bottom. If we can see the top of the page just to try and ascertain where that comes from. Looks like it's from Boyd surgical. The note's been made on the 28th of July '04 but it includes an account of events?-- Correct.

And if we go down the page, we see it seems that after he attends, right chest drain reviewed and re-adjusted and then 700 ml blood loss?-- Correct.

So this is the right chest drain which you believe would have been blocked?-- That's correct.

And then we see, "Progressive deterioration in ICU, medical teams called, transfer to ICU, intubated about 1300, second tube inserted to right chest, 700 mls drained"?-- Correct.

Okay. So the patient records are consistent with there being a sudden decompensation and deterioration at about 1300, it's then ascertained that the chest tube is probably blocked and another tube is inserted?-- Correct.

Now, you were asked to look at a document which is an adverse event form which is Exhibit LTR9 to a statement of a Ms Raven, and I won't take you back to the form unless you need to, but it was pointed out to you that a person noted as being the reporter is a Ms Karen Fox, who's an ICU nurse?-- Mmm-hmm.

The witness is noted as being a D Atkin, who's also an ICU nurse. The place of the incident is noted as being - or the place of the adverse event is noted as being ICU and it's - the description of the adverse event is, "On doing checks, noted no water in underwater seal drain section of ICC drain and contributing factors? Busy, unstable patient." Now, and the form's signed off by the nurse unit manager of the ICU, Toni Hoffman. Now, is it clear from that then, that this adverse event report form concerning the absence of water in a drain had nothing whatsoever to do with the deterioration and collapse of the patient which had occurred earlier in the surgical ward?-- I'd have to - it's not clear to me, no, it's not clear to me, because I'm having trouble following the paper trail.

COMMISSIONER: I think, though, Mr Allen's question assumes, as seems to be the case on the documents, that the patient, in effect, deteriorated whilst he was in the surgical ward before he was transferred to ICU. The problem with the seal on the drain occurred in ICU, therefore, it must have occurred after the patient's deterioration; does that put it in a nutshell, Mr Allen?

MR ALLEN: Yes, and indeed, some of the patient statements you were provided, for example, a statement of Michelle Hunter, indicated that the transfer to ICU happened at 1420 hours, so there's the deterioration at 1300, the transfer at about 1420 to ICU, and it's only after that time that on the 27th of July Mr Bramich is in ICU?-- It's certainly commenced before he was taken back to ICU, the deterioration.

Yes?-- The clinical deterioration.

COMMISSIONER: That's your point, isn't it, Mr Allen?

MR ALLEN: Yes?-- Yes.

And it's not clear at all as to what time he was in ICU that was noted or for how long that might have been the case?-- This particular incident?

Yes?-- Correct.

And for all we know, the problem with the blocked chest tube had been corrected as from 1300?-- Well-----

And the subsequent problem with the lack of water in another drain may not have had anything to do with the outcome for the patient?-- I believe the patient either bled catastrophically due to what I'd said in the notation from a lesion somewhat like Princess Di's lesion, a major disruption of the pulmonary, major pulmonary vessel or he continued to bleed from his fractured ribs and sternum and contused lungs in a way that was compensated for by his resuscitation but not adequately described. So although the drain was draining, the fact that when it was repositioned, it suddenly yielded another - I've forgotten the figure, 200 or-----

COMMISSIONER: 700 mls?-- Or 700, it means that its drainage was deficient and inadequate, and that the - either the patient had a clear chest and had a catastrophic bleed, because something that was just being held by a little bit of clot or fibre had parted, or he was continuously oozing since the time of injury and, in effect, the draining was sufficiently deficient to fall behind and fall behind and the sudden deterioration was not from haemorrhage, it was from asphyxiation, and I've come to the conclusion that it was the latter.

MR ALLEN: Yes?-- Because the pathologist quite categorically addresses that issue and states that there was no major vascular injury and so - sorry, go ahead.

But to be fair to the medical staff involved in the surgical ward, there may have been no objective indication of a malfunctioning chest tube until the sudden decompensation of the patient at 1300?-- Superficially, yes, but I believe that appropriate management of underwater seal drains would determine where they were working effectively for a variety of reasons long before three litres of blood had accumulated in the chest.

So there would have to be some type of objective signs by which medical staff could reach an opinion that there is a massive internal bleed before they could reach any concern as to the chest tube not draining effectively?-- Not - they would have to - they would have to appreciate that there was an embarrassing collection of fluid in the chest or that the drains were not behaving appropriately or the drain or drains were not behaving appropriately, and it's very hard in looking at a piece of paper, particularly when you're confronted with the facts of the event, the fact of the event is the drains weren't working, that's how 300 litres finished up in the chest. From reading a piece of paper, I can't say how

effective or ineffective the management of the drains was, how glaringly obvious the physical signs were that were missed.

Or how hidden the physical signs were that were missed?-- Or how erroneous the observations pertaining to the functioning of the drains. I can't unravel that. We - what we do have is 300 litres of blood - 3,000 CCs of blood in the chest with a displaced medius sternum that asphyxiated a patient that had been slowly accumulating when it should have been drained.

Yes. And you - or you're unable to comment upon whether or not the physical signs of the patient prior to 1300 were such that a reasonably competent doctor should have reached an opinion that there was a significant bleed in the thoracic cavity which was obviously not being effectively drained?-- Once again, I believe the events speak for themselves. I mean, that - three litres of blood in your chest would produce symptoms and signs that should be apparent to anybody caring for that patient, and now, what was there and wasn't there and what was recorded and wasn't recorded, I can't determine from just reading the chart.

All right. And look, the only other matter is, if indeed it is the case that this absence of water in another drain was noted at some subsequent time in the ICU, you couldn't attribute that particular fact as contributing whatsoever to the outcome for the patient?-- Sorry, I missed the-----

Yes. If it is indeed the case?-- Yes.

That sometime after 1420 when the patient was transferred to ICU after the chest block - tube blockage had been noted and apparently rectified, the fact that at some point there may not have been water in the drain may not be connected to his outcome at all?-- That is correct. It's possible - I mean, it's all speculation - I think the second drain that was put in, and we both noted that it was recorded as going into the right chest, I believe it went into the left chest, can you help me with that? I mean, I don't have the detail.

Sorry?-- I think that's what the pathologist tells us at autopsy.

COMMISSIONER: Yes?-- So I think we're trying to read too much into this. You know, when a patient's transferred, often, or the - one of the mishaps that occurs in transferring patients or even walking them about the ward, with underwater seal drains is that the drains get disturbed and the water gets out of the tube, thereby breaking the vacuum that's responsible for removing the blood. So the points that I'd be looking at very carefully - and I did this and I can't answer them - is did the walk about the ward aggravate the situation? Did the absence of the water in the drain actually that was noted in the incident report actually exist for some time before the patient was observed to have that problem? I can't answer those questions. All I can say is that in the absence of a major bleed - I mean a catastrophic massive haemorrhage, the accumulation of three litres of blood has been going on

for some time, compensated for to a degree and has gone unnoticed.

Is it possible that the seal that was, as Mr Allen's suggesting, only discovered to be broken once the patient was in ICU, which is later in the afternoon, could that seal have been the same one as the drain in the patient in the surgical ward earlier in the day that was transferred with the patient to ICU?-- It could be.

D COMMISSIONER EDWARDS: Could you elaborate on the statement you said three litres of blood loss went unnoticed; over what period of time or have you a view on that because isn't that one of the most vital issues?-- I believe it is, and I gave a lot of thought to that and I've alluded to my concerns in that regard in the - in my own personal file note that I made before we went electronic, and in this particular file, I said the unanswered question, was he bleeding significantly all along unnoticed or concealed by resuscitation only to suddenly decompensate it becoming apparent at that time that efforts to appreciate and manage him had been woefully deficient or did he suddenly exsanguinate from a Princess Di type lesion that bled secondarily? And that took me to the pathology report, the final arbiter, and it's the former of those two scenarios. Now, when the drain became deficient and when it should have been noticed and wasn't noticed, I'm unable to answer.

COMMISSIONER: Yes?-- And I think in some ways, if we move into this culture of blame-free environment, and that's why I very carefully said earlier on that I believe this represented a team deficiency, I didn't want to point the finger at an intensive care nurse, a surgical ward nurse, Dr Boyd, Dr Patel, I believe everybody has a responsibility to - or the physiotherapist for that matter has a responsibility to ensure that drains are properly managed and not inappropriately disturbed or unsealed.

Thank you.

MR ALLEN: Just finally, in relation to that question asked by the Commissioner as to whether it's possible that this deficiency in the drains subsequently noted in ICU could have existed earlier in the surgical ward, it's clear from the notes, is it not, that after the patient deteriorates, the question is asked by Dr Boyd well, firstly, Dr Boyd notes that the chest tube is re-adjusted, and then the query is noted in the medical notes whether the chest tube is blocked. It would be unlikely, would it not, that the doctors wouldn't check the drainage system that they're concerned about?-- What I believe has happened - and there's a degree of supposition in this - but it's my opinion that the blood was accumulating in the drain from basically the time of injury - in the chest, I mean, and the drainage system fell well - proved inadequate and the blood was accumulating and part of it, the liquified part of the clot drained when the drain was re-adjusted but it had so far behind the game at that stage that a sizable clot had formed in the chest already, and with the resuscitation attempts with crystalloid, that's salt and water, that has an

effect of diluting the clotting factors and promoting further as from raw surfaces such as a contused lung, and I think that actually aggravated the bleeding. So I believe a clot occurred fairly early on, I think the drainage would probably was suboptimal from quite early on, when you played with them and re-adjusted them, you did - the tube itself wasn't totally blocked but it wasn't actually draining the blood from the chest and moving it did obtain some fluid, but the end result was that the accumulation became three litres positive for the chest and three litres negative for the drain.

Just finally, Dr Ashby was of the opinion that given the nature of the circumstances of the injury and the possibility of severe injury to the chest, which mightn't be readily apparent, that the patient should have been transferred to Brisbane at least by the morning of the 26th of July 2004 or for appropriate assessment by a thoracic surgeon; do you disagree with that opinion?-- I don't disagree with her opinion. I believe there are other equally tenable opinions. I've sought two opinions from two very senior thoracic surgeons and they both stated that they believe the management was appropriate supervision of underwater seal drains and they expect that they should be done in a hospital such as Bundaberg, and that it would - it is inappropriate to consider that everybody who needs to have an underwater seal drain managed has to be Medivacced to Brisbane to have that done, that is a real indictment on the system. It was not a surgical condition, it was a management of underwater seal drains, and - full stop.

Thank you.

COMMISSIONER: Mr Mullins?

MR MULLINS: Thank you Commissioner.

CROSS-EXAMINATION:

MR MULLINS: Doctor, after all that - sorry, my name is Gerry Mullins, I appear on behalf of the patients. After all that talk of Mr Bramich, you expressed the opinion yesterday the fact that the drains stopped working and were left in a non-working state at least while three litres of blood accumulated in the chest was the injury that produced his demise, and I think it is a team failure to appreciate that underwater seal drains are not functioning. Nothing's changed your view on that?-- No.

Doctor, I think you assessed more than 40,000 documents as part of this process, and you commented earlier today that some of the trends that you observed about Dr Patel didn't become apparent until you had the data appropriately tabulated and computerised to observe the trends?-- Correct.

Are you aware of the Otago audit system?-- I am.

We've heard evidence that Dr Patel dismantled the Otago audit system at the Bundaberg Base Hospital. Do you think that some of the trends that you have seen may have become apparent on that system had it been maintained at Bundaberg?-- Yes. Can I say we also dismantled the Otago system at the PA Hospital but it's infinitely better than what was non-existent in Bundaberg, but it's not as good as this system.

COMMISSIONER: Presumably, you dismantled it at the PA to replace it with something better?-- Yeah, something along these lines.

Rather than dismantling it, as Patel did, to have nothing?-- Yes sir, yes.

MR MULLINS: You also mentioned earlier on that if adequate supervision was in place, it is likely that that would have also detected these trends?-- Sorry, I missed the point of that question?

The adequate supervision of Dr Patel was in place if he was not appointed Director of Surgery and he was appointed as an SMO, that these trends may also have been revealed to the person supervising him?-- Which trends are you referring to now? His adverse outcomes?

Adverse outcomes?-- Yes, yes.

And lack of technique-----?-- Yes.

-----et cetera?-- Yes.

Doctor, yesterday, you highlighted in your evidence that there were some aspects of your clinical review that had some limitations, and I think at page 4270 of the transcript you mention that one of the problems or the limitations on your review was that you didn't have the opportunity to speak with the patients?-- Unquestioned limitation, Mmm.

Now, that would not be a limitation on the cases in which you have determined there was a problem or Dr Patel contributed to an adverse outcome; is that correct?-- It's a limitation of the process. The more dramatic the event that you're studying, the less of a limitation it becomes, but of course, there will be a grey area where this technique is insufficient to determine the truth.

COMMISSIONER: I think, doctor, Mr Mullins' point is that had you been able to speak with patients, the chances are that things would have got worse rather than better in the sense that you would have - speaking to the patients wouldn't have taken away your concerns about operations where you think Patel was responsible for an adverse outcome?-- Mmm.

But it might have added further examples?-- I would expect so.

MR MULLINS: The second aspect that you didn't have the benefit of - I must say this is not a criticism?-- No, no.

Just speaking about your report in general, was that some other surgeons, and Dr de Lacey has been mentioned, has had the opportunity to observe first hand the work of Dr Patel, and can I just read you this extract from his evidence at 3601 of the transcript? The question was asked by Mr Atkinson, "It has been suggested again by people who were in the operating theatre that he was quite rough, rusk in moving aside other organs while operating; are there any indicia from the surgical outcomes that you observed that would corroborate or reinforce that proposition?", and his answer was - Dr de Lacey's answer-----

COMMISSIONER: I don't think you can blame Mr Atkinson for that question, I think I'm solely to blame.

MR MULLINS: "Any number of them, any number of examples of that, injuries to the liver, spleen, rectum, bladder, ureter, pretty well every abdominal organ which were operative accidents and many of them, many of them. I can make the inference that he must have been a rough operator but it's, as I said, I never saw him operate apart from that one case." Now, you obviously haven't had the opportunity to have that sort of evidence as part of your review; that's correct?-- Correct.

But that sort of evidence would be very helpful to you in your assessment?-- No, I don't believe so. I mean, my assessment is based on a review of the case notes and I have identified in my review of the case notes and commented on them instances where he's torn the serosa by rough handling, inadequately performed an anastomosis, and I don't think I've spoken to it, but I've got written evidence of in my statement of damage to the spleen which would be indicative of rough handling, and in the case of one of his oesophagectomies, I mentioned that it was inevitable that trying to dissect the oesophagus from this diseased thoracic aorta would result in haemorrhage, so I've produced evidence expressed in a slightly different fashion from my colleague, but of rough handling.

COMMISSIONER: I think though the point here is that Dr de Lacey found numerous examples of rough handling which don't appear from the clinical notes, so in that sense he had a slight advantage over you, that he'd actually seen the patients and conducted examinations of them and could see the evidence that was missing from the notes?-- Yes, yes.

MR MULLINS: There is an added dimension of quality of assessment which is the observation or impression one gets from the patient at a particular time?-- Yes.

For example, when one looks at the case of P26, Drs Jenkins and Ray who were present at the time conducting the surgery, would have added benefit of observation and impression at the time from the surrounding circumstances as

to his prognosis, for example?-- They would be in a much better position to say how toxic he was. I identified that he was life-threateningly toxic and he did survive so he couldn't have been much worse from their observation than mine.

Have you had an opportunity to review the statements and the evidence of Dr Ray?-- No, I haven't seen them.

Can I ask you - I've got some copies of his statement and the transcript of his evidence. I'll just take it to you briefly. I have a number of copies of the document that I'm handing to the witness.

COMMISSIONER: What's the point of this, Mr Mullins? I mean, Dr Woodruff has been very candid in saying that for things that you naturally observe, Dr Ray would be in a better position to make the observations, but when it comes to reviewing things that happened a week before Dr Ray even saw the patient, why is he in any better position than Dr Woodruff. I mean, it's just too different opinions on the same material.

MR MULLINS: It is, except that Dr Woodruff has expressed an opinion about the likelihood that P26 would have lost his leg irrespective of what occurred.

COMMISSIONER: Yes.

MR MULLINS: And Dr Ray has expressed a different opinion.

COMMISSIONER: Yes, I'm well aware there's a different opinion, but what's the point? Do you want to challenge Dr Woodruff's opinion?

MR MULLINS: I want to ask Dr Woodruff whether he would change his view taking into account some observations of Dr Ray in his evidence?-- I'd actually appreciate the chance to answer that question.

COMMISSIONER: Yes?-- Well, I believe I'm in a better position to, having reviewed in detail an account of the admission, the findings, the events and the blood test results that weren't available at any time to Dr Ray. He hasn't seen this file and I believe that my comments that I gave this morning in relation to prognosis - I haven't read his - are unchallengeable. I'd be interested to hear what he has to say, he's my junior at the moment.

I'm sure you're glad you asked that question.

MR MULLINS: Well, your Honour, if I could just take it a little further? Doctor, can you look at paragraph 13? And you can see reference to the fasciotomies were extended to expose the muscle and the compartments?-- That's right.

And that muscle was clearly acrotic and there's an expression or statement, "The common femoral vein was absent, both ends had been suture ligated so really, the full segment common

femoral vein was missing. I subsequently saw the surgical notes for Bundaberg which suggested that the femoral vein had been repaired but I think that must have meant that it was ligated." Is that consistent with your understanding?-- That's correct.

All right. And the next passage, "At that stage the injury made more sense, the common femoral vein had not been reconstructed by the surgeon, that means that you lose most of the venous drainage from the limb and the limb subsequently swells and the pressure within the muscle compartments rise." That's consistent with your assessment?-- Correct.

Can you then just turn through five pages, it's to a different framed document, it's at the bottom of the page, page 3768, and can I ask you just to read - can you see the lines on the right-hand side - the numbers?-- Yes, yes.

About line 18, "But if he was transferred", through to line 50?-- 18 to 50. Uh-huh, I have read it.

Doctor, accepting this is all a matter of speculation?-- Yes.

It is impossible to say that P26 would definitely have lost his leg?-- Sorry to interrupt. I don't believe it is speculation. I believe for the reasons that I outlined this morning, I don't alter my view. That leg was, in essence, lost by somewhere between half past two and three o'clock for the reasons that the common femoral artery, the trunk artery before it had split into the superficial and profunda femoris was involved. The fact that the collateral beds through the gluteus and hamstring muscles were compromised by the fractured pelvis and the evidence of the compartmental syndrome and the sensory loss indicating the severity of the ischaemia. Plus the finding of myoglobin urea that I outlined this morning means that the leg was doomed by 2.30, 3 o'clock and I do not believe that this patient could have been gotten from the operating theatre after his lifesaving procedure into an operating theatre in Brisbane and revascularised in that time interval.

Thank you, nothing further.

COMMISSIONER: Thank you. Mr Diehm?

MS McMILLAN: Mr Commissioner, could I just ask your indulgence to clarify one thing from Mr Allen's cross-examination.

COMMISSIONER: Yes.

FURTHER CROSS-EXAMINATION:

MS McMILLAN: The question is, doctor, you gave evidence, as I understood it, that three litres of blood in Mr Bramich's chest would have produced signs that anyone caring for the patient would have noticed. Is that a correct note of what your evidence was?-- Yes.

What would those signs have been?-- Well, there would be absolutely no air entry in the right side of the thorax, that there would be a very dull percussion note, there would be no respiratory expansion on that side. There would be other more subtle change which may or may not be present but - you know, there are a whole list of subtle changes that one would be looking for.

All right, thank you. Thank you, Mr Commissioner.

COMMISSIONER: Mr Diehm?

MR DIEHM: Thank you, Commissioner.

CROSS-EXAMINATION:

MR DIEHM: Geoffrey Diehm for Dr Keating. Doctor, just before I ask you questions, with the assistance of Ms Hunt I am able to inform the Commission that Dr Walker is, I understand, an Australian qualified - Australian-trained general surgeon, member of the College who has done some stints at the Bundaberg Hospital from time to time including this occasion when Dr Patel was on leave as a locum.

COMMISSIONER: Thank you for that, Mr Diehm.

WITNESS: Which is consistent with the Commissioner's observation that that file that we looked at was obviously of an experienced surgeon.

COMMISSIONER: Yes.

MR DIEHM: Doctor, just because it is reasonably recent in terms of the questions others have asked, I will ask you briefly about patient P26, P26, you have been giving evidence about this afternoon. I wanted to firstly understand - it could be just my misunderstanding - do you identify - or do you have any criticism of Dr Patel's treatment of that patient?-- I do. He failed to reach the correct diagnosis in a timely fashion but, as I have stated this morning and again this afternoon, even if he had appreciated the diagnosis, it is still not certain that the leg would have been saved, although the operation Dr Patel subsequently did, in effect, did re-establish circulation. So it is possible that with an earlier diagnosis Patel himself could have saved the leg because he wouldn't have had to do any more than he did do in the third operation if he had done it by half past two or 3 o'clock.

Yes, all right. You are critical of the care, I take it, of that patient, though, in the sense that he should have been transferred at some time earlier than what he was?-- Certainly.

And certainly at a time from which it was thought the patient was stable?-- Correct.

Now, with respect to another patient who you gave some brief oral evidence about - he appears in D3 of your tables - that's Mr Grave - so that makes him a patient whose death was not perioperative, although where Dr Patel's involvement attributed to an adverse outcome. He is an oesophagectomy patient. If you go to your records regarding him, please?-- James Grave.

Yes. And Mr Grave was the patient who after the procedure in

Bundaberg was transferred to the Mater where he was held within intensive care there and, as you have noted, was discharged home on the 18th of August 2003. Now, from your examination of the records, are you able to tell us how it was - I am sorry, when it was that he died and how his death was related to Dr Patel's involvement?-- He died on the 8th of January 2004 and I believe Dr Patel did contribute significantly to the adverse outcome. I think there is a litany of events there that contributed to his protracted post-operative course, not the least being the paralysed vocal cord which would make the clearing of his airway and his breathing more difficult. The fact that he sustained two wound dehiscences, both of them requiring return to the operating theatre, once on the 12th of June and the other on the 16th, that would set him back. And the leakage from the jejunostomy site which was required to be oversewn in the operating theatre is a further major setback.

COMMISSIONER: Doctor, I want to be a bit careful about this: you don't say necessarily that any of those things was directly the cause of Mr Grave's death six months later?-- No.

What you do say is that those all contributed to a deterioration of his condition?-- Yeah, weakened him.

Weakened him. His cause of death might accurately be the underlying cancer for which he had the oesophagectomy?-- Correct, correct.

But these things made him more poorly and, therefore, reduced his ability to continue to live with that cancer?-- Correct. My review of this patient ceased on the 18th of August.

Yes?-- And I am really not able to comment on events between then and January '04.

Thank you.

MR DIEHM: Doctor, the evidence that we have before the Commission about events beyond then is also rather vague, and hence my question to see whether you could shed some further light on it, but what evidence we have got raises some suggestion about there being some metastasis in the liver or kidney, from recollection, having emerged. Is that something you have taken into account and would that fit in with what you have just said to the Commissioner about contribution to the death, or is it so uncertain as far as you are concerned that you can't really say?-- Well, the fact that nine of 14 lymph nodes were positive at the time of the original oesophagectomy almost allows you to anticipate that he died of his cancer. And one of the contraindications to this form of surgery is identifiable spread as being a contraindication for carrying out the surgery. Now, whether or not - and I would have to look at the CAT scan report, and I am happy to chase that up if you wish, but if there was evidence preoperatively on the CAT scan of disseminated disease, that would be another error of judgment in recommending this operation.

All right. Doctor, I don't want to be responsible for sending you away with homework, as some of us have been describing it, but if the Commissioner is interested in that, he can certainly ask you for such things. But, in short, is what you are saying is it wouldn't surprise you, given what you do know, that this man did develop a secondary cancer somewhere?-- Highly probable.

And that - but whether or not this procedure and its aftermath contributed to his demise is something that you would have to be speculating upon?-- Correct.

Thank you.

COMMISSIONER: I suppose hastened rather than contributed, might be the relevant-----?-- Yeah.

MR DIEHM: Thank you, Commissioner. You were present, I think, in the Commission when Dr Jeanette Young gave evidence a few weeks ago?-- I heard some of her evidence.

Some of her evidence. Do you recall her giving some evidence about the credentialing and privileges committee at the PA Hospital?-- I do.

One of the issues that has been the subject of some evidence before the Commission concerns the role of the colleges under Queensland Health policy in credentialing and privileges committees and the requirement under that policy for there to be a nominee of the relevant college on the committee considering a particular doctor at the time, and, indeed, some evidence has been adduced about apparent difficulties with getting representatives - sorry, I should say nominees of the colleges to participate in that process. Are you familiar with this topic?-- I am familiar with this topic, and since listening to that evidence I have sought to try and clarify the issue with the executive in Melbourne, the executive of the College of Surgeons, and there are some points that can be made in relation to this issue.

Yes. Well, please make them?-- One is that the nominee of the college is not indemnified by the insurance - the college insurance company and they are not really acting as a servant of the college in this circumstance, according to the insurers, and there is a question that a properly constituted privileging committee is indemnified anyhow as an agent of the employing authority, and, so, the process as it currently stands is that the college, usually the local State committee, is approached and asked to nominate generous-minded Fellows of some standing who are prepared to put their name forward or respond to requests from employing authorities. So it is an issue that I think needs to be firmed up. It is not any obstructionism on behalf of the college, and usually the State committee can put forward a number of names and usually an employing authority can find one or two of those to serve their purposes.

D COMMISSIONER VIDER: Dr Woodruff, could I ask you what's the situation in other States in relationship to that in the public sector?-- The relationship of the college doesn't alter but exactly how other States handle this, I can't answer.

MR DIEHM: Doctor, my questions aren't meant to be critical, aren't critical of any of the colleges. In fact, if there is a problem with indemnity, one might imagine that Queensland Health would fix that by indemnifying the surgeon or the college participating in the process. But are you aware historically there has been a problem with getting nominees from some of the colleges, including the College of Surgeons, to participate in some of these committees around Queensland?-- I was unaware of that because I have only seen the process from the college perspective, but I don't doubt - and I can understand from what you tell me that this has arisen, but I hadn't appreciated that it was a problem.

All right, thank you.

COMMISSIONER: Just as a matter for the future, it seems to me so obvious that it goes without saying that if Queensland Health wants to have an effective accreditation and privileges committee, Queensland Health will need to indemnify non-employees, people who aren't already employed by Queensland Health participating in that process. Do you agree with that?-- Sorry, I missed the point?

The point is that if Queensland Health wants outsiders to participate in accreditation privileging process, it is going to have to indemnify them for that involvement?-- Yes, yes.

I guess that wouldn't apply in your case because you're at present a staff specialist and therefore indemnified by Queensland Health anyway?-- Correct.

D COMMISSIONER VIDER: Doctor, could I turn that around another way for this getting college nominees on to credentialing and privileging committees, and say that for the outside metropolitan area hospitals, do you foresee it would be acceptable to the college if there was a local Fellow in the area, that if that person contacted the college and said, "I am prepared to sit on the credentialing committee of hospital Z", that would be acceptable to the college? Because we have heard a lot of evidence that there seems to be a time delay and it has been a problem?-- The college would have no objection to any Fellow of standing putting his name forward as long as he realises he is not being indemnified by the college insurers.

Yes.

MR DIEHM: Doctor, with respect to auditing processes, Mr Mullins asked you a question about Dr Patel's changes that he introduced to the morbidity and mortality process - or rather the audit process by abandoning the program - software program which supported it previously. Are you familiar with

the software system known as Transition 2 operated within Queensland Health?-- I am aware that such a software program exists. I am not very familiar with it but it did help us gather some of the data for this particular survey.

I appreciate the limitations that follow from your answer just then. If in a regional hospital such as Bundaberg that had been operating under the Otago system, a decision was made to change the audit process for the surgical unit so that it relied on the Transition 2 system as well as effective, honest and open morbidity and mortality meetings, would you think that that would provide an acceptable level of audit for a hospital?-- No. And this is quite a carefully constructed program in annexure A which I believe takes into account at each step a potential deficiency, and there is more to this annexure or the plan that it outlines than perhaps might be appreciated at first sight.

COMMISSIONER: Can I interrupt you? I think perhaps you have missed the point of Mr Diehm's question?-- Probably.

Bearing in mind Mr Diehm is here representing Dr Keating, I think what he is suggesting to you is that if a medical superintendent like Dr Keating understood, rightly or wrongly, that that was the system in place, would that be an acceptable system, just as good as the Otago one that was there before? Is that the point?

MR DIEHM: That is, Commissioner. It was my fault for the way I asked the question. And perhaps to put it in this context: not judging it against the model that you are putting forward as being the way forward in the future?-- Right.

But comparing it to other systems of audit that operate in hospitals or did operate in that time period in hospitals like Bundaberg, would it compare as being acceptable?-- I believe it would be - it would compare as being an example of what common practice deems acceptable but I think none of them are acceptable from a practical point of view.

Understood. I am not intending to challenge you about that, doctor. Commissioner, proceeding on the basis that it is neither necessary nor appropriate to cross-examine Dr Woodruff about the broader issues raised by the report of which he is a co-author, that's all I have.

COMMISSIONER: I understand your point. Doctor, am I right in thinking that your authorship of the report by the team comprising Dr Mattiuissi, Dr Wakefield, Professor Hobbs and yourself is really limited to the outcome of the clinical audit about which you have spoken?-- Yes.

And-----?-- As a generalisation.

Yes.

MR DIEHM: Thank you, Commissioner.

MR FARRELL: With the same qualification, I have no questions.

COMMISSIONER: Thank you. Mr Boddice, any re-examination?

MR BODDICE: Nothing in re-examination.

COMMISSIONER: Mr Andrews?

MR ANDREWS: No, Commissioner.

COMMISSIONER: Thank you. Doctor, we have reached the end of the road, you will be delighted to hear. I want to, while I think of it, both thank and commend Dr Price on his software which has obviously made your job a lot easier and ours as well. Indeed, I think if he is putting it on the commercial market he will have three customers up here before he goes any further, but more fundamentally to thank you for your time and your dedication to this extremely difficult and I am sure extremely wrenching task that you have been given. The outcome of this Commission of Inquiry will be hugely more valuable as a result of your input. We are deeply grateful and, if I may say, most of us in the room know your son-in-law, Dr Traves, and it is gratifying to see that his father-in-law is as much an ornament to the medical profession as Mr Traves is to the legal profession. Thank you so much for your assistance?-- Thank you very much for those kind words.

Ladies and gentlemen, we will now adjourn till 10 a.m. tomorrow in Bundaberg.

MS McMILLAN: What time Thursday for those of us who won't be-----

COMMISSIONER: Mr Andrews, 9.30, 10?

MR ANDREWS: 9.30, please, Commissioner.

COMMISSIONER: All right.

THE COMMISSION ADJOURNED AT 5.23 P.M. TILL 10.00 A.M. THE FOLLOWING DAY IN BUNDABERG