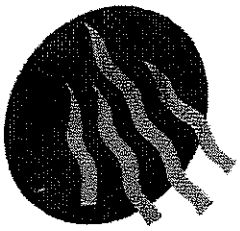


Queensland Government
Queensland Health

REVIEW OF CLINICAL SERVICES BUNDABERG BASE HOSPITAL

CONFIDENTIAL REVIEW REPORT

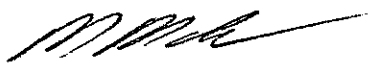
Bundaberg Review Team 28/6/2005

CONFIDENTIAL REVIEW REPORT

Investigation Team:

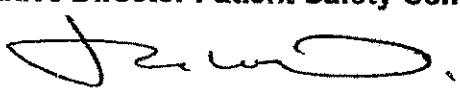
Team Leader **Name: Dr Mark Mattiussi**

Title: District Manager& District Director of Medical Services Logan & Beaudesert District Health Service District

Signature: 

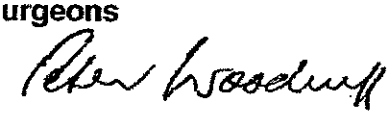
Member **Name: Dr John Wakefield**

Title: Executive Director Patient Safety Centre

Signature: 

Member **Name: Associate Professor Peter Woodruff**

Title: Chairman & Director of Vascular Surgery Princess Alexandra Hospital,
Vice President Royal Australasian College of Surgeons (Until May 9th 2005,)
President Elect Australian & New Zealand Society of Vascular Surgeons

Signature: 

Member **Name: Adjunct Associate Professor Leonie Hobbs**

Title: Acting Executive Director Women's & Newborn Services, Royal Brisbane & Women's Hospital

Signature: 

Date Review Commenced: Monday 18th April 2005

Date Review Completed: Thursday 30th June 2005

Controlled Document Number:

TABLE OF CONTENTS

EXECUTIVE SUMMARY

Introduction

Dr Patel was employed at the Bundaberg Hospital as the Director of Surgery from 1st April 2003 until the 31st March 2005 having been introduced to Queensland Health by Wavelength Consulting Ltd. During this time concerns were raised about his clinical competence and interpersonal skills. The Director General appointed a Review Team in April 2005 to investigate a number of serious allegations. The Review Team was requested to look at aspects of the appointment, credentialing and management of Dr Patel. The attached flow chart (Appendix A) provides a comprehensive chronological record of key facts identified by the Review Team during Dr Patel's tenure at Bundaberg Hospital. There are many key facts and each of these and others are examined in detail throughout the course of this report.

The Review Team was also requested to undertake an analysis of other clinical services within the Bundaberg Hospital and to review aspects of the safety and quality and risk management framework as it exists within the hospital. An analysis of the Clinical Services Capability Framework and its application to Bundaberg Hospital was also required.

The review was conducted from the 18th April 2005 to be completed by the 30th June 2005 and involved two (2) site visits, in excess of 50 interviews and review of substantial quantities of documentation including well in excess of 200 patient clinical records. The Review Team sought to validate information provided during interviews wherever possible and has elucidated numerous findings and provided recommendations for system improvement and further review where indicated.

The major findings of the Review Team are detailed below, though this summary is by no means exhaustive.

Findings & Analysis

1. Appointment, Credentialing and Management of Dr Patel

There were a number of critical events where opportunities for intervention to occur were possible. There are reasons as to why intervention may not have occurred at these times though potential solutions are provided as recommendations. Appendix A provides a comprehensive flow chart of the key events and times they occurred. Events where possible opportunity for intervention existed include:

- Dr Patel's initial appointment and Medical Board of Queensland registration
- The allocation of Clinical Privileges at initial appointment
- May 2003 when concerns were raised surrounding Dr Patel following the death of patient Phillips Ur 034546
- June 2003 when scope of practice issues and service capability concerns were raised
- February 2004 when Dr Miach provided a complication report for Tenkhoff catheters
- Wound dehiscence concerns investigated in July 2004
- Sentinel event report for patient P11 2nd August 2004
- Concerns raised formally by Ms Hoffman in October 2004.

2. Clinical Case Review

Dr Woodruff of the Review Team undertook analysis of two hundred and twenty-one (221) clinical records to formulate a view of the clinical management and competence of Dr Patel. Three questions in relation to each of those two hundred and twenty-one (221) patients were considered looking at whether; Dr Patel contributed to an adverse outcome, acted outside the scope of expertise of either himself or the hospital and whether the

patient's management was reasonable. Dr Woodruff concluded there were instances where Dr Patel exhibited an unacceptable level of care. In eight (8) cases this contributed to the deaths of patients. He may have exhibited an unacceptable level of care in another eight (8) patients who died. In the comfortable majority of cases examined, Dr Patel's outcomes were acceptable and in some instances, he retrieved patients from dangerous situations caused by other practitioners prior to his involvement in the patient's management.

Dr Woodruff found that Dr Patel lacked many of the attributes of a competent surgeon.

3. Analysis of Clinical Outcomes and Quality of Care

The Review Team undertook an analysis of available data sources for the purpose of identifying quality of care issues at Bundaberg Hospital that require further review. A number of areas are highlighted for further action including:

- Clinical Indicator reports are not embraced by clinicians.
- Human Resource Department oversight and support to medical services appears inadequate or non existent.
- Medical assessment of patients in the Emergency Department requires greater structure and needs to be more comprehensive.
- Junior doctor rostering and supervision after hours and on weekends does not support the clinical services provided.
- The 'flat' nursing structure and current duties of the Assistant Director of Nursing are not conducive to a well functioning nursing service.
- The After Hours Nurse Manager Bed Status report doesn't provided consistent and relevant information to the executive to assist in the management of issues which may have arisen after hours.

- The medical leadership and associated clinical practice within the Bundaberg Family Unit requires further detailed review.

4. Risk Management Framework

The Risk Management Framework at Bundaberg Hospital was examined. It was found that the Clinical Governance Committee Structure was complex and that there was no single committee delegated the responsibility for Safety and Quality issues. There was a lack of follow through and flow of information when incidents or concerns were raised and feedback to staff and ongoing evaluation required improvement.

Incident reporting systems were in place however there were difficulties with procedures as concerns were found relating to the available resources of safety and quality unit, the training and support that had been provided to staff, the failure to close the loop as detailed above and the lack of aggregated data reports available to the executive to monitor safety and quality. There was also no clear and consistent link with the complaints management process and incident reporting.

There was little evidence of hospital wide mortality audit and departmental clinical audits were variable, particularly in general surgery.

5. Clinical Services Capability Framework

The Clinical Service Capability Framework as currently written has been correctly applied to the Bundaberg Hospital. There are concerns with the framework as it stands though. These are:

- It is quite broad in its indicative range of procedures where significant and complex abdominal and thoracic surgery are grouped together with less major surgery such as caesarean section.

- There are some procedures detailed within the indicative surgery list which should not be performed in a facility such as Bundaberg Hospital and others which reasonably could be.

There are numerous opportunities to improve the functioning of Bundaberg Hospital and this has led to the development of recommendations.

Recommendations

Bundaberg Health Service District at a local level:

1. **Ensure that there is consistency with contemporary Queensland Health policy, awards and industrial agreements for Medical Staff Employment.**
2. **Ensure that all medical staff receive adequate orientation to the district on commencement.**
3. **Ensure that all medical staff are provided with written clinical privileges upon appointment, consistent with the Service Capability of the facility and their credentials.**
4. **Ensure one complete Personnel File is maintained in the Human Resources Department.**
5. **Ensure the anomaly of a medical officer with General Registration being employed as a staff specialist with right of private practice is corrected.**
6. **Provide training, support and supervision to ensure that the assessment of patients undertaken within the Emergency Department is thorough.**

7. Ensure structures are in place to provide adequate rostering and supervision of junior medical staff after hours and on weekends.

8. Ensure that the performance of clinical staff is effectively monitored and actioned by implementing effective supervision, ongoing performance assessment and development (PAD), and documented peer review processes.

9. Develop and implement a clinical governance framework which effectively tracks accountabilities for clinical performance, and is subject to regular compliance monitoring. Queensland Health should support this process by developing a state-wide clinical governance framework.

10. Ensure the Clinical Services Capability Framework is used only as a guide to decision making. There is a need for Management within a hospital to take a holistic view of the services when applying the current framework in specific instances.

11. Ensure decisions regarding service profile are clearly communicated to hospital staff so as to clearly define the scope of service.

12. Ensure the Measured Quality Indicators are followed up with the Measured Quality Program Team once 2004/5 data is available.

13. Ensure that safety and quality is afforded priority in funder/provider contracts. This will require Queensland Health to examine health funding incentives.

14. Ensure a plan to implement effective clinical incident and complaints management that is consistent with Queensland Health policy is developed. This should include

implementation of the incident management information system (PRIME) with consideration of designated consumer liaison and patient safety officers to support the district.

15. Ensure that all documents raising complaints or concerns are dated and signed by the staff member raising the complaint or concern or returned to them for signing and date at the time the document is first presented.

16. Establish a clear process for the multidisciplinary review and management of clinical incidents consistent with the Queensland Health Incident Management Policy.

17. Ensure that a process is established for coded data on clinical outcomes (particularly complication codes) to be audited with input from clinicians.

18. Ensure the format of the After Hours Nurse Managers' Bed Status Report is standardised so that all Nurse Managers provide accurate, pertinent and timely advice to the Executive in a consistent way.

19. Review the committee structure and their Terms of Reference to minimise duplication and to establish clear accountability.

20. Review the District Communications Strategy Map & Terms of Reference for committees to minimise duplication and to reduce the number of committees attended by individual staff.

21. Consider the establishment a single multidisciplinary committee to address patient safety and quality issues, monitor and evaluate actions and provide feedback to staff. District policies must clearly articulate the responsibilities and accountabilities of all clinical staff to report incidents.

22. Ensure that all minutes of meetings clearly document key points of discussion, agreed action, accountable officers and timeframes.

23. Ensure that items remain on meeting agendas until there is documented completion of agreed action by the accountable officer.

24. Ensure that feedback to referring committees or staff occurs in a meaningful format which assists in organisational improvement.

25. Consider a more comprehensive review of medical leadership and clinical practice, within the Bundaberg Family Unit.

26. Develop protocols to determine which patients are clinically appropriate to be admitted as outliers to the Bundaberg Family Unit.

27. Review reporting relationships for the Nursing Service to incorporate the existing Assistant Director of Nursing position and also to provide a reporting relationship for Clinical Nurses who are sole practitioners.

28. Review the Assistant Director of Nursing Position Description as a matter of priority.

29. Review the Pharmacy Department with a view to providing ward-based clinical pharmacy services.

Queensland Health at a broader level:

1. Ensure there are comprehensive processes for recruitment and assessment of Overseas Trained Doctors prior to their employment in Health Service Districts.

2. Develop a comprehensive strategy to address the serious medical workforce issues affecting safety and quality of health

services. This must deliver practical assistance to Health Service Districts. This will require comprehensive review of care models, conditions of employment and flexibility.

3. Develop and implement an orientation process for key executives.

4. Facilitate further review of the anomaly of a Medical Board of Queensland General (non specialist) Registrant with specialist level billing Provider Number.

5. Develop objective mechanisms for monitoring the ongoing clinical performance of medical practitioners to determine whether their practice is within acceptable standards. This may include periods of supervised practice or formative assessment.

6. Work with Bundaberg Health Service District to develop peer clinical networks with a focus on clinical performance, service improvement, benchmarking and shared learning.

7. Develop, implement and support statistical process control and 'cusum' methodologies, to assist with monitoring individual clinician performance and clinical services in key clinical areas of practice.

8. Review the indicative range of procedures described within the Surgical Complexity section of the Clinical Services Capability Framework document to ensure greater homogeneity of complexity of the listed procedures.

9. Provide input into the review processes of the Australian Council on HealthCare Standards (ACHS) specifically consideration to amend the current clinical indicator reporting and benchmarking to enhance validity and clinician acceptability.

10. **Further develop the Measured Quality Program to provide risk-adjusted and statistically valid performance data for outcomes of clinical services.**

11. **Provide comprehensive training and support in clinical incident and complaints management to Bundaberg Health Service District. This should include standardised Root Cause Analysis (RCA) methodology.**

12. **Ensure that the European style of date format or sets as 'long date' and removes the user definable characteristic of this field in GroupWise to reduce confusion in the future.**

1 Background & Relevant History

Bundaberg Hospital is situated within the Bundaberg Health Service District. The profile of the Bundaberg Hospital taken from the Facility Profile QHEPS updated 10/03/2005 shows that the Executive of this facility include:

- District Manager – Mr Peter Leck
- Director of Medical Services – Dr Darren Keating
- District Director of Nursing Services - Mrs Linda Mulligan
- Director of Allied & Community Health Services – Ms Tina Wallace
- Director of Corporate Services – Mr Peter Heath
- Director, Integrated Mental Health Service – Ms Judith McDonnell

The Hospital provides a wide range of general clinical services and some specialty areas including but not limited to renal and breast screen. The Facility Profile indicates that the hospital had 140 available beds with an occupancy rate of 78.3%. The Bundaberg Hospital is listed as being 350km away from its main referral hospitals of Royal Brisbane and Princess Alexandra Hospitals.

1.1 Emphasis on Elective Surgery

Many staff spoke of the emphasis on elective surgery stating that it was the major focus of the Health Service. Nurses stated that despite increasing Operating Room workloads, elective surgery was never cancelled with elective lists running over allocated time, after which the emergency cases would commence. This led to increased nursing overtime. There was a view amongst staff that in putting so much resource into meeting elective surgery targets other aspects of health service delivery were compromised. There was a perception amongst some that there is an inequitable budget allocation with an emphasis on reducing surgical waiting lists. Examples provided included inadequate allied health resources to meet both the current demand and the requirements of the Clinical Services Capability Framework (CSCF)

as it applied to Bundaberg Hospital. The definitions within the CSCF were inclusive of the allied health professions though they are very broad and neither outline the specific expertise required or numbers of staff.

1.2 History of Key Positions

In recent years Bundaberg Hospital has undergone some significant changes in senior management after having had a fairly long period of stability.

Following the resignation of the previous Director of Nursing in 2003, after sixteen (16) years service, it took six (6) months until the current incumbent was appointed and took up the position of District Director of Nursing Services. During this time there were a number of nurses acting in this role (including Ms Hoffmann). This was also at a time when there were two significant state wide nursing matters being progressed; the first being the restructure of Levels 3/4/5 and the second the Accelerated Advancement Qualification Allowance. There was a need for strong nursing leadership during this challenging period.

The Director of Medical Services was also a new appointment in 2003 having moved from Western Australia following the resignation of the previous incumbent who had been in the position for 2 years. The position was vacant for almost 3 years during which time the position was filled on a temporary basis. The position was primarily occupied by Dr Nydam during this time.

The District Manager commenced in the role in June 1998 and as such has been in the position for almost 7 years.

The Director of Surgery position was vacant from early 2002 and filled temporarily until Dr Patel commenced duties in April 2003. The position was advertised by Dr Nydam (Acting Director of Medical Services) in August-September 2002 and, again in November-December 2002. The details

surrounding this appointment are discussed in greater detail later in this report. Dr Patel, who was subsequently appointed to this position was described by many as a brash and rude American surgeon. Many described him as 'confident' and 'he seemed to know what he was talking about.' He was said by some to 'kiss up and kick down'. He has been described by several staff as a 'bully' who 'wouldn't listen to criticism' or 'admit his mistakes' and when questioned he would 'yell at people'. He is reported to have 'worked' with the Executive at Bundaberg Hospital to provide them with the confidence to bid for additional elective surgery activity and was said to have reduced waiting lists for elective surgery. He was described by some including his referees as a man with a 'can do' attitude. He was reported to have improved the functional management of the operating theatres at Bundaberg Hospital by reducing cancellations and improving throughput and utilisation. This could not be validated by the Review Team. Operating theatre utilisation data was not validated and was not considered reliable.

Throughout the review a number of those interviewed described the culture of Bundaberg Hospital as being 'generally a friendly place to work', 'a job for life'. Others were more critical of the culture with some of the more negative but common themes being:

- Strong focus on budget. Staff were continually struggling to maintain budget integrity and yet still provide quality of care and services
- Intimidating and bullying behaviours by staff at various levels (including union representatives) across Bundaberg Hospital
- Strong friendships and family linkages between staff which some staff believed led to some inappropriate behaviours being tolerated
- Lack of support from Executive akin to an 'us and them' mentality
- New people with fresh ideas often not welcomed
- Resistance to change

- District Manager described as the 'game breaker' – the person who made the final decision
- Expectation that managers will juggle multiple roles without adequate resourcing.

1.3 Nursing Services

The nursing structure at Bundaberg Hospital would be described within the profession as being flat. Nurse Managers, Nurse Unit Managers and Clinical Nurses that are heads of a unit (eg stomaltherapy) report directly to the District Director of Nursing (DDON). The Assistant Director of Nursing (ADON) has no line management as no nurses directly report to the position. This is unusual as it would be expected that nurses would report to the ADON for day to day line management issues.

The origin of such change appears to have begun in February 2001 when a review of the Nursing Structure of Levels 3, 4 and 5 within Bundaberg Hospital was undertaken. The reviewer was Ms Judy March, Executive Director of Nursing Services, Toowoomba Health Service District. The report documents that the purpose of the review was to 'identify a management structure within the nursing division that envelops the philosophy of clinician led management'.

A number of nurses made reference to the Judy March Review, predominantly to express an opinion about the change in structure, which in their view, has resulted in the loss of support for middle managers and incongruent reporting relationships. At the time there were two Assistant Directors of Nursing and a recommendation was to reduce the number to one upon the retirement of one of the incumbents. The Review Team could not identify the exact time the decision was made to remove the remaining ADON from line management and to implement the direct reporting to the District Director of Nursing. It appeared to follow the retirement of the former Director of Nursing, Mrs

Glennis Goodman in September 2003 but prior to Mrs Mulligan taking up the position in 2004.

A significant number of nurses were interviewed throughout the review either individually or as part of a group. It became apparent to the Review Team that many of these nurses expressed a sense of powerlessness. There were several examples provided of nurses not being given feedback from senior line managers including the District Quality and Decision Support Unit and therefore they had made an assumption that their information was not valued or acted upon. They were frequently asked to provide reasons for budget overruns even in areas for which they had no control such as pathology. Nurses described having every nursing hour scrutinised whereas the doctors reportedly did not plan leave and used locums at significant cost to cover shortfalls. Nurses saw this as unfair and an inconsistent standard being applied across the hospital. They held a view that whereas nurses were micro managed, doctors were not accountable for the management of their clinical service. This led to a strong sense of resentment between nursing and medical colleagues. There did not appear to be great respect for Dr Keating within the nursing service.

One of the relieving Directors of Nursing on secondment to Bundaberg, described the culture of the nursing service as one she was not used to, going on to explain that nurses appeared subservient and that she believed they were looking for a new leader. She described the nurses as competent with no obvious cause for concern in relation to the provision of quality nursing care.

Several of those nurses interviewed spoke of the differences between the previous Director of Nursing (Mrs Goodman) and the new District Director of Nursing Services (Mrs Mulligan). The overwhelming feeling was that with Mrs Mulligan they felt micro-managed and generally unsupported. They held a

belief that Mrs Mulligan's allegiance is more toward 'Executive' rather than with nursing. They describe that when they cannot progress issues with Mrs Mulligan they have nowhere else to go and they are powerless to do anything else.

It was clear to the Review Team that the Nursing Middle Managers as a group were generally supportive of each other, were keen to speak to the reviewers on issues and had a shared view on what they saw as management not responding to their issues effectively. This group, believe there is a lack of trust and supporting the view, they provided as an example an allegation that Executive had stated openly that 'there were no decent middle managers'.

The existing nursing structure within Bundaberg Hospital was highlighted as an issue of concern with nurses frustrated with the current reporting relationships. This will be discussed in detail under 3.4 Risk Management Framework.

1.4 Medical Services

The Division of Medical Services Structure had Directors in each of the Departments reporting directly to the Director of Medical Services. In addition, a variety of other positions reported directly to this position, including Director of Clinical Training and Elective Surgery Coordinator as two (2) examples. This structure was similar to that seen in many of the regional hospitals within Queensland Health. There were five (5) medical director positions reporting to the Director of Medical Services. These are listed below with their incumbent (or most recent incumbent):

- Medicine – Dr Miach
- Surgery – Dr Patel (recently completed contract)
- Emergency Medicine – Dr Keil
- Obstetrics and Gynaecology – Dr Stumer
- Anaesthetics and Intensive Care – Dr Carter

It was usual for these directors, in addition to managing administrative component of their own departments, to undertake leadership roles in other areas such as chairmanship of meetings and the management of service groups. It was also usual for these directors to be utilised by the Director of Medical Services as expert advisors in their specialty areas to assist with organisational decision making. It is the opinion of the Review Team that different directors displayed different level of leadership in the management of their departments and related services. It has been reported on many occasions to the Review Team that Dr Patel took an active role in the operating theatre management and drove the team to improved levels of efficiency. It was also been reported to the Review Team that some of these directors were consulted, in their expert advisory capacity, prior to some of the more complex cases being undertaken by Dr Patel and that they provided reassuring comment.

When considering the concerns related to Dr Patel it was clear to the Review Team that many members of the senior medical staff workforce, including many of the medical clinical directors were aware and had concerns regarding the care provided by Dr Patel or the complexity of cases he was undertaking. Some reported involvement or voicing of senior medical staff concerns as early as mid 2003. It is unclear what specific action these medical staff undertook in addressing their concerns from an organisation wide perspective. It is clear that some refused to allow Dr Patel to perform procedures on their patients, others raised questions surrounding specific individual patients and their procedures, whilst some passively continued with their duties even providing anaesthetics for patients as 'the patient was fit enough for the operation and the surgeon wants to do it' and 'ICU should be able to cope with these patients if the surgery is done well'. Others received critical feedback from other hospitals and don't appear to have acted upon this by escalating the concerns to the relevant people.

Generally the senior medical staff described Dr Patel as someone who was 'loud', 'confident', 'spoke as if he knew everything' and frequently 'yelled' at staff including his colleagues and junior medical staff. None of the medical staff were reported as willing to complain to him about his attitude. During the investigation, several staff provided glowing reports including one stating that 'Dr Patel is one of the finest doctors I have met and I would work with him again. He has more than reasonable skills'. In the opinion of the Review Team, there appeared to be a culture of avoidance of issues and acceptance of Dr Patel's behaviour. One doctor has stated that he wouldn't let Dr Patel operate on his family though he 'wouldn't let any of the surgeons in Bundaberg (public or private) operate on my (his) family'. It seems that, amongst the medical staff, there was general acceptance of mediocrity of performance.

1.5 Industrial Environment

The Review Team were advised that there was a strong industrial influence at Bundaberg Hospital and that unionism was entrenched. It has been suggested that change was difficult and protracted as some of the larger unions fought with the District over a number of issues. During the Review, the Team heard allegations of management bullying staff. There were also allegations of bullying by some union representatives who bully other staff to ensure the views of the few union delegates and organisers are adhered to. The Review Team were advised that a number of union representatives hold positions as middle managers and this, at times, produced a conflict of interest.

Within the minutes of the District Consultative Forum, whilst there was reference to workload management issues, there was little or no reference to issues pertaining to a culture of bullying and intimidation, service capability or other matters arising relevant to this Review.

1.6 Allegations of Failure of Executive to Manage Concerns

Whilst the following matter pertaining to allegations of sexual assault falls outside the scope of this review, the Review Team has included some comments as the matter was raised during interviews with staff. There is a perception amongst some staff that the Executive of Bundaberg Hospital did not take sufficient action against Dr Tariq Qureshi, a doctor who fled Australia following charges of sexual assault against patients of Bundaberg Hospital. Nurses report that they were told to observe his behaviour and to ensure he was not left alone with any patient. An allegation was also made that 'he was to be allocated to Operating Rooms where he could be kept an eye on'. The staff raising these concerns did so in the context of explaining that in their view, Executive Management did not respond to serious complaints against doctors in a timely way.

The file pertaining to this matter was reviewed and it appears that reasonable action was taken in accordance with relevant legislation and policy and indeed principles of natural justice. It could be argued though, that intervention such as suspension or other disciplinary action should have been taken at an earlier stage.

The issue of lack of feedback and support from senior managers to staff is one that will be dealt with in more detail within the report.

2 Methodology

On the 18th April 2005 the Director-General Queensland Health appointed investigators (the Review Team) under Part 6 of the Health Services Act 1991 to conduct an investigation pursuant to specified terms of reference. This occurred on a background of a previous clinical audit which was undertaken by the Chief Health Officer (CHO) Dr Gerry Fitzgerald with the assistance of Mrs Susan Jenkins of the Office of the CHO.

This review is purported to have revealed four broad issues of concern (taken from the background contained within the terms of reference).

a. That Dr Patel appeared to practice outside the scope of practice of Bundaberg Hospital. Specifically he undertook operations which the hospital was not in a position to support. Some of these patients did not survive. In addition he appeared to retain patients whose condition deteriorated when they would best be transferred to a hospital with higher capacity

b. That Dr Patel appeared to have a higher complication rate that other hospital of similar standing.

c. That there appeared to be a lack or failure of systems and structures that would support the quality and safety of health care.

d. That as a result of these issues, there is considerable disharmony at the Bundaberg Hospital.

The Terms of Reference specify that the Review Team needed to:

1. Examine the circumstances surrounding the appointment, credentialing and management of Dr Patel.

2. Review the clinical cases of Dr Patel where there has been an identified adverse outcome or where issues related to his clinical practice have been raised.

3. Analyse the clinical outcomes and quality of care across all services at Bundaberg Hospital. Compare with benchmarks from other states or other like hospitals and identify areas requiring further review or improvement.
4. Review the Risk Management framework as it relates to the provision of direct services at Bundaberg Hospital to determine its effectiveness. Make recommendations in relation to improvements to these systems.
5. Examine the way in which the Service Capability Framework has been applied at Bundaberg Hospital to determine that the scope of practice is appropriately supported by clinical services.
6. Consider any other matters concerning clinical services at Bundaberg that may be referred to the review by the Director-General.
7. Should the Review Team identify other areas of concern outside the scope of these Terms of Reference, the Director-General is to be consulted to extend the Terms of Reference if considered appropriate.

In order to undertake the review to comply with these Terms of Reference the Review Team first reviewed the Clinical Audit Report undertaken by the Office of the Chief Health Officer. This report highlighted a number of areas of concern from both staff interviews and within the data sources identified. The Clinical Audit Report highlighted areas for further review around complication of procedure codes from data provided by the Client Services Unit (CSU) of the Queensland Health Information Centre (HIC), provided some interpretation of relevant ACHS clinical indicators and made some conclusions and recommendations primarily around system modification. There were no conclusive statements made about the clinical competence of Dr Patel though attention was drawn to complication rates which the report advises required further in-depth statistical analysis and if indicated, a review of the clinical records in those cases. The Clinical Audit Report doesn't appear to cover this analysis. The Review Team having read the report and believing that CSU

HIC complication code data is typically not validated by clinicians in some districts, decided to conduct their own independent review from the outset to ensure integrity of the review. It is worth noting that following discussion with the Health Information Unit at Bundaberg Hospital it was confirmed that there was no process in place wherein clinicians in Bundaberg Hospital regularly validate complication codes.

The Review Team conducted two (2) site visits as part of this review. These occurred from the 19th April to 22nd April 2005 and from the 9th May to 13th May 2005. Key people or groups of people for interview were identified, and as the investigation revealed further people who may be able to assist with information, more were added to the interview schedule. An interview schedule is attached (Appendix B) to assist with details of those who were interviewed and when. Some of those to be interviewed were not available at the requested times, consequently some of the interviews were conducted in an order which was not that preferred by the Review Team.

During the first site visit an open staff forum was conducted to advise staff of the mechanism to confidentially communicate with the Review Team so that those who wished to provide information confidentially to the team could do so. This was also aimed to capture those who had not been included on the interview schedule who felt they had information to contribute to the investigation. All staff at the forum were issued with notification forms and confidentiality information. They were invited to circulate the information and photocopy the forms for colleagues who were interested in submitting their concerns. A locked box was used to collect these forms and was provided outside the rooms which the Review Team were using. The Review Team were located away from the Executive Suite and were not in a main thoroughfare, so that staff would feel comfortable to post their concerns. Sixteen (16) Confidential Staff Notification forms were received.

As the terms of reference specify that the Review Team were to 'review the clinical cases of Dr Patel where there has been an identified adverse outcome or where issues related to his clinical practice have been raised', it was decided that an initial process to screen for adverse events was to review the Dr Patel patients from Hospital Based Clinical Information System (HBCIS). The Review Team considered that a reasonable screening tool would be to look at a sample of deceased and transferred patients. A report was requested to be generated from the Health Information Unit of Bundaberg Hospital which included all patients who were discharged during Dr Patel's tenure and had an admission or discharge consultant or surgeon with the consultant code for Dr Patel who had either a discharge code of transfer or deceased. There were some difficulties experienced by the Review Team in obtaining this information as an initial report which was produced by the Transition II team at Bundaberg Hospital only included those patients with a principal surgeon code for Dr Patel. Once it was realised that there may be other patients operated on by Dr Patel who were not listed under the Principal Surgeon category a further report was generated by the Transition II team.

Further updated lists were provided during the course of the Review as the Transition II team found other potential ways of identifying patients that Dr Patel had seen as an outpatient. A schedule of the final list of patient records that were reviewed by the Review Team is attached (Appendix C). It should be realised that there was never an intention to review all deceased or transferred patients who may have come into contact with Dr Patel. This was only a screening tool to gather information on the clinical practice of Dr Patel. Further, in accordance with Term of Reference No. 2, the Review Team assembled a list of patients of Dr Patel where there was an identified adverse outcome. These cases were identified by staff or from incident report forms or as a result of the interview and investigative process. This process was also utilised to identify other cases of potential adverse outcomes in services other than the Dr Patel surgical services, in response to Term of Reference No. 3.

An appendix (Appendix D) identifies the names of patients that were mentioned during interviews.

The Review Team also formed a link with the recently formed Patient Liaison Service and the temporary Medical Services Executive and District Manager to obtain patient details that, in their opinion, the Review Team should have been aware of. This link was also utilised by the Review Team to ensure that any patients, identified during the course of the investigation by team members, who needed ongoing clinical care, could be appropriately referred. All the additional patients are included in the attached lists.

During an interview with Ms Hoffman, the Review Team were advised that there were some surgical patients that were admitted under other consultants to apparently 'hide' them from Dr Patel. These patients apparently had their admitting consultant changed to Dr Patel following transfer. As no specific patient names were provided as examples by Ms Hoffman, this could not be verified and therefore has the potential, if this in fact the case, to hide some patient records from review.

In order to gather further data about the functions of the Bundaberg Hospital the Review Team utilised the Bundaberg Health District Communications Strategies Map to identify which committees might have records relevant to the scope of the investigation. The Review Team identified the following committees:

- Clinical Services Forums (Paediatrics, Medicine, ASPIC, Family Unit)
- Continuum of Care
- DDON, ADON, AHNM & Bed Management Meeting
- DDON/ADON/NMs
- District Consultative Forum
- District Health Council
- Erromed meetings

- Executive Council
- Improving Performance
- Infection Control
- Leadership and Management
- Local Consultative Forum
- Medical Staff Advisory Committee
- Nursing 3,5,6 Nursing Services Committee
- Nursing HOD
- Safe Practice and the Environment
- Theatre Management Group
- Workload Management Committee.

The Review Team requested and reviewed documents dating back two (2) years, for relevant information. In addition the Review Team compiled a list of other relevant documents, some of which were brought to the attention of team members including:

- Adverse and sentinel event forms
- Complaint forms
- Emails
- File Notes
- Letters
- Memorandum
- Other Documents provided to the Review Team during interviews.
- Personnel Files

The Review Team experienced difficulties with some of these documents as there were many loose leaf documents from staff raising concerns and some containing crucial information which were undated and some even unsigned. This included many of the statements reportedly attached to the letter of complaint dated 22nd October 2004. In these circumstances, it was virtually impossible for the Review Team to absolutely verify when these documents

were created, and, at times, by whom. In addition, it became apparent that printed copies of emails contain dates that are reported in both European and American format (default American though user definable). Depending on the settings of the individual, and at times, the computer from which they are printed the date 05/10/03 could be the 5th October or the 10th May 2003. It was impossible to determine from the printed document or profile of the individual GroupWise account which date it was. The Review Team where possible used other collateral information to validate dates where ambiguity occurred. However this anomaly has the potential to affect the chronology of reported events.

Dr Patel has had contact with a significant number of outpatients and other hospital inpatients. It is clear that he provided care to some 1,457 patients during the 1,824 admissions. He operated on approximately 1,000 patients and conducted some 400 endoscopic procedures on outpatients during his tenure at Bundaberg Hospital. As the Review was to 'review the clinical cases of Dr Patel where there has been an identified adverse outcome or where issues related to his clinical practice have been raised'; a case review of all these patients and other inpatients of Dr Patel, where issues were not raised was out of scope of this review. There was never an intention, or requirement, to review all cases involving Dr Patel.

This report is a compilation of all of the above information and the interpretation of the Review Team as to the facts and matters as they occurred. It is based on a combination of documents and information provided during interview with witnesses. As much as possible, the events reported by staff and community members have been verified with documentation. However, there was no compulsion on those interviewed to tell the truth and the Review Team had no powers to compel witnesses to provide information. This should be remembered when considering the information contained within this report.

There will be three (3) recommendations pertaining to the issues identified within the methodology as part of the Executive Summary of this report.

3 Findings & Analysis

3.1 Credentialing & Privileges

Examine the circumstances surrounding the appointment, credentialing and management of Dr Patel.

The Review Team approached the investigation of the management of Dr Patel using a systems-orientated approach. This is consistent with contemporary analysis techniques used in the investigation of major incidents in high risk industries, and recently increasingly used in the healthcare setting. This technique has three main aims:

- To determine **'what happened'**: Collection and verification of facts and chronology of events.
- To analyse **'why it happened'**: This involves repeatedly asking 'why' until root causes or significant contributing factors could be identified. It was also useful during this process to consider ***'what usually happens'*** and ***'what should have happened'*** based on the information available to the staff at the time of the event (i.e. avoiding hindsight bias).
- Determine **'How this could be prevented'**: Recommend corrective actions.

The attached flow chart (Appendix A) provides a comprehensive chronological record of ***key facts*** identified by the Review Team during Dr Patel's tenure at Bundaberg Hospital. This document provides for simple cross-checking of witness statements and summary evidence obtained during the review process. It is not practical to address all these events in the body of this Report.

3.1.1 Dr Patel Appointment Process:

What happened? The Director of Surgery position had previously been occupied by Dr Nankivell, who resigned the post in January 2002 and then Dr Baker, who acted in the position until he resigned on 30th November 2002. The position of Director had been advertised on two (2) occasions closing in September 2002 and, after the successful applicant apparently declined the position, again in December 2002 when no applications were received.

From the information contained within Dr Jayant Patel's Bundaberg Hospital Personnel Files and interviews with relevant persons, it appears his Curriculum Vitae (CV) was presented by Wavelength Consulting to the Bundaberg Hospital A/Director of Medical Services, Dr Nydam on the 13th December 2002. Dr Nydam was looking to fill a current and impending vacant staff surgeon positions.

Dr Patel's initial CV indicated that he was most recently employed as a Staff Surgeon at Kaiser Permanente, from October 1989 to September 2001 and Clinical Associate Professor, Department of Surgery, Oregon Health Science University 1992 to present (December 2002). A subsequent (presumably updated in 2002) copy of his CV listed his employment as Staff Surgeon at Kaiser Permanente, Portland Oregon from October 1989 to September 2002. A copy of an application for Temporary Residency completed in March 2005 by Dr Patel indicates that he was employed at Kaiser Hospital from September 1989 until February 2003. References, that appear to have been provided in December 2002 with this updated CV, included the following on Kaiser Permanente letterhead which were faxed:-

- 4th May 2001 from Edward Ariniello M.D. Northwest Permanente, P.C., Diplomate of the American Board of Surgery, Chief of Surgery (retired as Chief 2000
- 18th May 2001 from Peter Feldman, F.A.C.S., F.R.C.S.(C)

- 4th June 2001 from Bhawar Singh, MD, DABA, FACA, Department of Anesthesiology N.W.P., P.C.
- 4th June 2001 from J.T. Leimert, MD, Chief, Department of Hematology-Medical Oncology, Portland OR.

There were other references provided with these which included:-

- 30th May 2001 from Wayne F Gilbert, MD
- 2nd May 2001 from Leonora B Dantas M.D., Northwest Permanente, Dept of Internal Medicine.

Subsequent supportive telephone reference checks were obtained by Wavelength Consulting on the 20th December 2002 from Dr Bharwar Singh Dir of Anaesthesia and Peter Feldman, both from Kaiser Permanente. These conversations were documented and copies were available in the Personnel File.

From the interview with Dr Nydam, the Review Team were advised that no further checks were undertaken of Dr Patel by the hospital management at that time as Dr Nydam felt he could rely on the information provided by Wavelength Consulting. In December 2002 Dr Patel was offered the position of Senior Medical Officer, Bundaberg Hospital for twelve (12) months, on a Temporary Full Time basis, subject to Medical Board of Queensland (MBQ) and Immigration Department approval. Wavelength Consulting undertook the liaison with the MBQ and Department of Immigration (DIMIA) on behalf of Bundaberg Hospital to ensure deadlines were met and that the hospital administration was updated of progress. Dr Patel was subsequently registered under Section 135 of the Medical Practitioners Registration Act 2001 from 1st April 2003 to 31st March 2004, registration number 1030450 by the Medical Board of Queensland. There were was no reference made by MBQ to any concerns raised with previous registration in other countries. Dr Patel was subsequently appointed as the Director of Surgery by Dr Nydam as

the position remained unfilled and out of the two (2) Full Time Surgeons, Dr Nydam felt Dr Patel would be the most suitable.

Dr Patel commenced employment with the Bundaberg Health Service District at Bundaberg Hospital on the 1st April 2003.

Opportunity for intervention: Though not within the scope of this review, identification of past registration restrictions may have altered the decision regarding the employment and subsequent clinical privileges of Dr Patel by Bundaberg Hospital.

3.1.2 Dr Patel Credentials and Clinical Privileges:

What happened? There is no evidence that on appointment Dr Patel was granted specific clinical privileges consistent with his credentials and the Clinical Service Capability of Bundaberg Hospital. Dr Kees Nydam was the acting Director of Medical Services when Dr Patel commenced work in Bundaberg. Dr Nydam reported that short term locums were usually not formally credentialed and allocated privileges. Formal clinical privileges were first mentioned as being sought in June 2003. This was recorded in the letter of 29th July 2004 from Dr Keating to Dr Patel. On the 29th July 2004 the Director of Medical Services, Dr Keating wrote to Dr Patel following up on the previous correspondence of November 6th 2003 regarding the allocation of clinical privileges. This correspondence advises that 'the colleges have been unable to provide the appropriate nominations and this has significantly slowed down the process of formal approval of clinical privileges' and that in the interim 'the District Manager has approved interim privileges'.

Opportunity for intervention: It is usual practice for the District Manager or their delegate (eg. Director of Medical Services) to determine clinical privileges for temporary medical staff. It is important to note that it would not be usual to specify specific procedures for inclusion or exclusion. Typically, privileges would have been 'general surgery', which would not exclude the

complex surgical procedures such as oesophagectomy which have raised concerns in this case.

3.1.3 Management of Dr Patel:

The following section of the Report will address several key decision points identified by the Review Team, and provide an analysis of each, followed by a summary.

a) Concerns first raised with management about Dr Patel:

What happened? On 19th May 2003, Mrs Glennis Goodman (former DDON) and Ms Hoffman met with Dr Darren Keating regarding a patient Phillips UR 034546. This patient had died following an oesophagectomy, and concerns were raised about three issues.

These were:

- Dr Patel had allegedly written that the patient was stable when in fact they were on maximum inotrope therapy and support.
- Dr Patel was rude, loud and allegedly did not work collaboratively with the ICU medical and nursing staff.
- That the ICU in Bundaberg was Level 1 and as such was not capable of providing the level of care that was required to support such surgery.

Dr Keating advised that he had agreed to speak to Dr Patel and Dr Carter in response to the complaint. Dr Keating raised the issue with Dr Carter who had indicated that the ICU should have been able to cope with this surgery with appropriate patient choice. Dr Carter had also indicated that the patient had not been a good candidate for surgery and had been refused surgery in Brisbane. Dr Keating advised the Review Team that he further discussed the issue with Dr Patel. No file notes could be located by the Review Team to confirm these discussions.

Opportunity for intervention: A multidisciplinary meeting chaired by the DMS, with Director of Surgery, Director of ICU and Nurse Unit Manager of

ICU in attendance would have been an appropriate forum to discuss the issues and document a decision regarding the surgical capability of the Intensive Care Unit. Communication of such decision or outcomes to the staff who initially raised concerns would have been appropriate.

b) Further concerns raised about Dr Patel by Dr Joiner:

What happened? Around the 5th June 2003, Dr Joiner met with Dr Keating to raise concerns regarding the care of patient Mr P18 This patient was the second oesophagectomy performed by Dr Patel and had suffered complications requiring prolonged ICU stay. Dr Joiner questioned Dr Keating about whether these cases should be done in Bundaberg Hospital. Dr Joiner had suggested transfer of the patient to Brisbane but Dr Patel had refused. Dr Carter, Director of ICU had been away and Dr Keating reports that he had asked the acting Director, Dr Yunus, to see the patient. Dr Keating reported Dr Yunus had indicated that the patient could stay in Bundaberg Hospital. Two days later, the patient had been transferred to the Mater Hospital, Brisbane due to complications. On Dr Carter's return, Dr Keating had met with him to discuss concerns raised by Ms Hoffman that the Bundaberg Hospital ICU should only electively ventilate patients for 24 to 48 hours. Dr Carter had indicated that this was flexible and could be extended for 3 to 5 days depending on circumstances. No specific outcomes had been documented from the complaint.

Opportunity for intervention: As above a (Multidisciplinary meeting) to address the concerns raised and decision regarding clinical privileges for Dr Patel in line with Service Capability of ICU. Communication and feedback of such decision to staff who initially raised concerns.

c) Further concerns raised about Dr Patel by Dr Miach:

What happened? On 6th February 2004, Dr Miach had provided to Mr Martin (Acting DDON) and Dr Keating, an unsigned and undated complication report. The report had been compiled by Dr Miach and had

outlined a 100% complication rate (six out of six patients), that had undergone Tenkhoff catheter insertion by Dr Patel. Mr Leck had found the complication report on his desk and requested Dr Keating to follow up. As a result of the high complication rate, Dr Miach had refused to have Dr Patel operate on his patients and Dr Patel had refused to visit the renal unit. Dr Miach had arranged for this access surgery to be provided under an outsourced contract arrangement in private facilities at no cost to the hospital, through Baxter. Mr Leck had requested advice from Dr Keating regarding this arrangement. This contract was signed by Mr Leck.

Opportunity for intervention: Given that several senior clinicians had expressed concerns regarding the patient outcomes from Dr Patel's surgery, consideration could have been given at this stage to obtaining formal external peer review.

d) Concerns raised regarding wound dehiscence rates:

What happened? On the 2nd July 2004, the ASPIC minutes had suggested that wound dehiscence rates were high. This had also been reported to the Executive Council. This had been followed up by Dr Patel and the Infection Control Nurse. It had been reported back to the committee that this had been a definitional issue and, as a result of further review, the Infection Control nurse had indicated that she was satisfied with the results of the audit.

Opportunity for intervention: This information in addition to the previous concerns would have suggested external peer review of the cases and consideration of restriction of clinical privileges of Dr Patel.

e) Sentinel Event Report from Ms Hoffman to Dr Keating, Mrs Mulligan and Mr Leck:

What happened? On 2nd August 2004, Ms Hoffman had reported the death of Mr P11 as a Sentinel Event. Ms Hoffman had

considered the incident to consistent with 'unexpected death' which appeared in the Queensland Health Sentinel Event list. This had been delivered to Mr Leck, Mrs Mulligan and Dr Keating. The allegations of the staff against Dr Patel in this case had included delayed transfer, verbal abuse of Mrs P11 in the ICU and grossly inappropriate attempts at pericardial drainage when the patient had been in extremis. The ICU staff had been so shocked by this event that they had attempted to access the hospital Employee Assistance Service for counselling. This had not been available and several staff accessed counselling services external to the hospital. The staff had 'heard' that the sentinel event had not been reported to the Director General as per the Queensland Health policy of June 2004. It was alleged that Dr Keating had not considered the death to be a sentinel event. The sentinel event had not been reported to the Director General as was the new procedure under the Incident Management Policy. Dr Keating had commenced an investigation process into the incident. It was alleged that no feedback had been given to the ICU staff regarding the handling of the incident report, or the result of any investigation.

Ms Hoffman had met with Mrs Mulligan on the 26th August 2004 to discuss several issues. These included the fact that Dr Patel had been planning a thoracotomy operation for the following Friday, and she had been concerned that this was beyond their capability to manage in ICU. Secondly that she had been concerned that there had been no action or feedback on the Mr P11 incident. Ms Hoffman, was concerned at the apparent lack of management action and proceeded to raise the issue with the Queensland Nurses Union in August 2004. Ms Barry from the QNU had met with Ms Hoffman on 3rd September 2004. On 20th September 2004, Bundaberg Hospital had received a Ministerial complaint about the Mr P11 case and a Section 9A PIPA Notice was also served on Queensland Health, at which point Dr Keating's investigation ceased. At a meeting between Mrs Mulligan and Ms Barry on 6th

October 2004, the possibility of mediation had been discussed for Dr Patel and Ms Hoffman.

Some Nurse Managers had reported that, during nursing meetings, their attempts to have sensitive issues discussed had been stopped by the Chair (District Director of Nursing). When questioned, these nurses had maintained that their attempt to raise issues relating to Dr Patel had been stopped. They had been advised that such a forum was an inappropriate venue to raise specific clinical practice concerns. They had maintained that confidentiality had been given as a reason for this stance. Mrs Mulligan has denied that issues concerning Dr Patel were raised at any nursing meeting although she had recalled on one occasion where nurses had raised an issue re lack of support from Medical staff (DDON, ADON, AHNM and Bed Manager 9th August 2004 Minute No 08/04-6). The minutes indicate there had been no agreed action or outcome and the agenda item was closed.

Opportunity for intervention: A multidisciplinary team review of the death would have been appropriate. Once again, given the previous issues, external peer review of Dr Patel, would have been appropriate given the serious concerns raised about the clinical care.

f) Serious concerns regarding the competence of Dr Patel were formally raised by Ms Hoffman with Mr Leck and subsequent events:

What happened? After a meeting between Ms Hoffman and Mrs Mulligan on 20th October 2004 regarding Dr Patel, they had immediately gone to meet with Mr Leck. He had requested that Ms Hoffman put her concerns in writing. This had been detailed in a letter dated 22nd October 2004. Following this, Mr Leck had arranged to meet with Dr Keating and three other medical staff to assess the allegations made by Ms Hoffman. He subsequently met with Drs Berens, Risson and Strahan around 29th October 2004. Following these three (3) meetings, Mr Leck had made a decision to obtain formal external peer review of Dr Patel. During interviews with the Review Team, Mr Leck had indicated that he did not believe there was sufficient evidence to

remove Dr Patel or to limit his clinical privileges. Over the next few days, he had attempted to secure a reviewer.

The Tilt Train derailment occurred on 16th November 2004 and this had created two weeks of major disruption and the issue had not been further addressed during this period. Dr Patel had contributed significantly to local efforts in treating the injured.

After contacting a number of colleagues for the names of potential reviewers, Mr Leck was subsequently advised that he should consider progressing the matter with the assistance of the Audit Branch. He had sent a fascimile on 16th December 2004. He was subsequently advised in writing, via email, the next day that this had been judged as a clinical matter and had not appeared to constitute misconduct. The recommendation had been to contact the Chief Health Officer, Dr Fitzgerald where a copy of the email had also been sent. Mr Leck contacted his office and had been advised that he was going on leave and would not be able to attend to this matter until he had returned in January 2005.

On the 24th December 2004, the Director of Medical Services, Dr Keating had written to Dr Patel to offer a further extension of his contract from 1st April 2005 until 31st March 2009 under the terms and conditions of the previous extension. The Review Team have been unable to find any documentation of a merit based process to support such an extended period of contract extension for Dr Patel. Dr Patel had advised in correspondence dated the 14th January 2005 that he was 'not renewing my (his) contract as Director of Surgery with Bundaberg Hospital beginning April 1 2005'. This had been acknowledged by Dr Keating on the 18th January 2005. Further discussion ensued and correspondence from Dr Keating dated 2nd February 2005 had confirmed an offer under the provisions of the District Health Services – Senior Medical Officers' and Resident Medical Officers' Award – State 2003

for a salary of $1,150.00 per day (includes all call ins) and weekends were also to be paid at the above rate when he was placed on call for weekends. This correspondence had also detailed that it was Dr Patel's responsibility to obtain an ABN number and to submit an account to Accounts Payable for payment upon completion of the locum appointment. The Review Team are not aware of any provision under the District Health Services – Senior Medical Officers' and Resident Medical Officers' Award – State 2003 which allows for locums to be employed in this way. Dr Patel had written to accept this locum position on the 7th February 2005.

It should be noted that on 21st December 2004, Dr Patel had undertaken another oesophagectomy (Mr I P21) who died, and had allegedly grossly mismanaged a young trauma victim (P26 3) on the 23rd December 2004. In January 2005, letters of concern regarding these patients had been written by staff working in Theatre and Intensive Care Unit.

On the 2nd February 2005 the Director of Medical Services, Dr Keating had completed a Special Purpose Registrants – Section 135 Area of Need – Qld assessment for Dr Patel for the period December 2003 – January 2005 and rated Dr Patel's performance primarily 'better than expected'. He had also rated emergency skills, procedural skills and teamwork and colleagues as 'consistent with level of experience' and professional responsibility and teaching as 'performance exceptional'.

Dr Fitzgerald and Ms Jenkins had arrived in Bundaberg on 14th February 2005 to commence a review of Dr Patel. On 22nd March 2005, the letter from Ms Hoffman had been read in parliament and the Review Team were advised that on the 24th March 2005, Dr Fitzgerald released preliminary findings of his review in a press conference.

Dr Patel had subsequently left at the end of his contract in March 2005 before taking up the locum position.

Opportunity for intervention: Given the significant and ongoing nature of the allegations of patient harm associated with Dr Patel, and the potential risk to patient safety, there was an opportunity to limit or remove clinical privileges in late October 2004 pending formal review.

g) Other relevant management details:

The Review Team were unable to find evidence that the Human Resource Department had reviewed the offered extension and locum contracts. From interviews and the documentation it appears that the Director of Medical Services operated outside of standard Queensland Health Human Resource accepted practices and that there had been little if any Human Resource Department oversight for Dr Patel's extension and subsequent contracts. Also, the lack of one complete Personnel File indicates that there had been disconnect between the filing systems within the Human Resources Department and the Office of the Director of Medical Services.

On the 25th November 2003 Dr Patel's contract of employment had been extended for a further 12 months from 1st April, 2004 until 31st March 2005. The Review Team noted in his extension of employment that the rental subsidy which was initially $150 per week for the first 12 month period had been increased to $300 per week. On the 2nd December 2003 the Director of Medical Services, Dr Keating, had completed a Special Purpose Registrants – Section 135 Area of Need – Queensland assessment on Dr Patel for the period April – November 2003 indicating that his performance was 'better than expected' for most of the criteria and 'consistent with level of experience' for the others (emergency skills and medical records/clinical documentation).

On the 5th January 2004, Dr Patel had been appointed as the Surgery Academic Coordinator (0.5 FTE) in the Rural Clinical Division – Central

Queensland (RCD-CQ), School of Medicine, University of Queensland. Dr Patel had continued to be employed by Bundaberg Hospital and part of his position had been funded by the RCD-CQ under this appointment.

h) Employee of the Month awards

There had been widespread discontent with the awarding of the 'Employee of the Month' in November 2004 to Dr Patel. This award had been in recognition of his contribution following the tilt train disaster. Given that the investigation into concerns raised by Ms Hoffman had commenced, many staff felt strongly that this recognition had been offensive. Documentation sourced by the Review Team indicates that the award was not an individual award but was in fact a multidisciplinary team award for outstanding achievement for nine staff involved in the train disaster of which Dr Patel was but one recipient.

i) Sexual Harassment

The Review Team was provided with information surrounding allegations of sexual harassment involving Dr Patel and a number of nursing and medical staff. Whilst some of the information was hearsay, one female staff member who made serious allegations against Dr Patel did speak with the Review Team. The staff member concerned had accessed support and advice in accordance with the Sexual Harassment Policy and had been in the process of pursuing her complaint further when Dr Patel left Queensland. Given the confidential nature of the allegation and the inability to speak with Dr Patel, the issues raised and actions taken have not been documented within this report. However there is clear indication from the statements made by the complainant that this matter would have required immediate investigation.

Statements made by other staff members in relation to this incident contain the following allegations:

- Dr Patel had asked interns to perform surgical procedures beyond their level of expertise;
- Dr Patel had paid more attention to females than males;

- The performance assessment of the staff member concerned had been used as a tool for personal favours. When the staff member had refused, the performance assessment was graded as unsatisfactory.

j) Lack of feedback from tertiary facilities

A number of staff raised the issue of lack of feedback from tertiary and other hospitals following transfer of patients. Staff believed that had information been provided, especially where there was a view that Bundaberg Hospital was potentially working outside of their service capability, then perhaps this may have been opportunity for earlier intervention.

The Review Team had a discussion with the Medical Superintendent Royal Flying Doctor Service who confirmed that in July 2004, there had been some discussion with Bundaberg Hospital staff – Ms Hoffman and Dr Keating. This discussion included:

- The number of transfers from Bundaberg Hospital to Brisbane Hospitals
- The practice of hospital handovers rather than the preferred tarmac handovers
- The suggestion that Bundaberg Hospital may be performing procedures outside the CSCF.

At no time had Dr Patel's competency been raised as an issue. This was confirmed by Dr Rashford, Clinical Coordinator who had also spoken with staff at Royal Brisbane & Women's Hospital to ascertain whether they had experienced any particular issues with transfers from Bundaberg Hospital.

3.1.4 Why Did This Happen?

This section summarises the key underlying system issues identified by the Review Team believed to have contributed to the events as they unfolded in relation to Dr Patel.

The major contributing factors were:

Organisation level:

- There appears to be a single point weakness in the registration process for Area of Need temporary resident doctors that allowed for a doctor to be registered without independent checks to verify the veracity of the application. *(It is not within scope of this Review to comment further on this matter).*
- The severe medical workforce shortages in Queensland and challenges faced by provincial/rural practice, has led to a situation where services are under constant threat, which leads to recruitment of overseas trained medical staff that are often not suited to the local culture, practice and expectations or have the necessary skills. This has potential to decrease safety and quality of care.
- There is an emphasis on production within health service delivery. Some of the hospital funding is linked to activity and waiting list performance which leads to a focus on finance. Such focus and increase on workloads can impinge adversely on safety and quality.
- The Queensland Health Clinical Service Capability Framework (CSCF) discussed within this report, lacks clarity in relation to specific surgical procedures. The Credentials and Privileges process would require significant change to allow for specific procedures to be defined based on Clinical Service Capability.
- There is no Queensland Health orientation process for executives particularly for interstate appointments. This leads to a situation where executives are often unfamiliar with organisational legislation, policy, procedure and practice and further, they often lack the necessary networks and contacts to ensure compliance with requirements.
- There is no objective mechanism for monitoring the ongoing technical ability of a medical practitioner to determine whether their practice is

within acceptable standards. The absence of any formal guidance to help senior clinical staff and executives determine the appropriate process when concerns are raised about a clinician's performance, causes confusion and uncertainty in dealing with this situation.

Health Service District (Workplace) level:

- The local committee structure is complex and lacks clear accountability systems for the reporting and management of patient safety and quality issues.
- There appears to be insufficient resources and expertise to adequately support the safety and quality requirements of the hospital.
- The performance assessment of local management was based heavily upon budget integrity and ability to keep services going, with safety and quality of services receiving lesser emphasis.
- The changing medical workforce over recent years has led to a predominance of locums and temporary overseas trained doctors that has diminished cohesion, peer review/support and collegiate focus of the medical community at the hospital.
- There appears to be a culture at the Bundaberg Hospital which does not support the open reporting and analysis of clinical incidents.

Team level:

- There was no established process for the multidisciplinary review and management of clinical incidents. The executive are charged with investigating events and the process lacks openness and transparency, which has led to a lack of trust between staff and management.
- There was no standard process and support of multidisciplinary peer review, audit and quality improvement at clinical unit level (paediatric Erromed was a notable exception).

- There was a perception that executive management did not listen to concerns raised by clinicians. This was made worse as they were reportedly rarely seen in the clinical areas.

Individual level:

- Dr Keating was an interstate appointee and was unfamiliar with the Queensland legislative, policy and administrative processes.
- Dr Patel's behaviour gave rise to fear and polarised staff groups. There was no minimal commitment to facilitate the multidisciplinary review of patient care and adverse events. This resulted in a focus on interpersonal issues rather than what was best for patient care.
- There appeared to be a medical culture of tolerating problems rather than addressing them. Several doctors withdrew, some did nothing, others hid patients, or arranged alternative surgical support rather than providing clinical leadership to address the problem together with their nursing colleagues.
- Dr Patel was not provided with written advice regarding his clinical privileges.

How could this be prevented?

Recommendations:

Bundaberg Health Service District at a local level:

1. **Ensure that there is consistency with contemporary Queensland Health policy, awards and industrial agreements for Medical Staff Employment.**
2. **Ensure that all medical staff receive adequate orientation to the district on commencement.**

3. Ensure that all medical staff are provided with written clinical privileges upon appointment, consistent with the service capability and credentials.

4. Ensure one complete Personnel File is maintained in the Human Resources Department.

5. Develop and implement a clinical governance framework which effectively tracks accountabilities for clinical performance, and is subject to regular compliance monitoring. Queensland Health should support this process by developing a state-wide clinical governance framework.

6. Ensure that safety and quality is afforded priority in funder/provider contracts. This will require Queensland Health to examine health funding incentives.

7. Develop a plan to implement effective clinical incident and complaints management that is consistent with Queensland Health policy. This should include implementation of the incident management information system (PRIME) with consideration of designated consumer liaison and patient safety officers to support the district.

8. Establish a clear process for the multidisciplinary review and management of clinical incidents, consistent with the Queensland Health Incident Management Policy.

9. Review the committee structure and Terms of Reference to minimise duplication and to establish clear accountability.

10. Consider the establishment a single multidisciplinary committee to address patient safety and quality issues, monitor and evaluate actions and provide feedback to staff. District policies must clearly articulate the responsibilities and accountabilities of all clinical staff to report incidents.

Queensland Health at a broader level:

1. **Ensure there are comprehensive processes for recruitment and assessment of Overseas Trained Doctors prior to their employment in Health Service Districts.**
2. **Develop a comprehensive strategy to address the serious medical workforce issues affecting safety and quality of health services. This must deliver practical assistance to Health Service Districts. This will require comprehensive review of care models, conditions of employment and flexibility.**
3. **Develop and implement an orientation process for key executives.**
4. **Develop objective mechanisms for monitoring the ongoing clinical performance of medical practitioners to determine whether their practice is within acceptable standards. This may include periods of supervised practice or formative assessment.**
5. **Work with Bundaberg Health Service District to develop peer clinical networks with a focus on clinical performance, service improvement, benchmarking and shared learning.**

3.2 Clinical Case Review

Review the clinical cases of Dr Patel where there has been an identified adverse outcome or where issues related to his clinical practice have been raised

3.2.1 Clinical Case Chart Review

a) Scope of chart review

'HBCIS' and 'Transition II' data processed through 'Crystal Reports' was used to derive a dataset where Dr Patel had been involved in the management of patients. Data was imported into 'Surgical Director' software for analysis.

Dr Patel was involved in the care one thousand, four hundred and fifty seven (1457) in-patients undergoing one thousand, eight hundred and twenty-four (1824) admissions between March 2003 and April 2005. Dr Patel performed one thousand, one hundred and seventy-seven (1177) operations on one thousand and sixteen (1016) of these patients. Data was gathered from two hundred and twenty-one charts reviews (221) or fifteen per cent (15%) identified as falling within the Terms of Reference of this review. Data was not gathered from one thousand, two hundred and sixty patient charts (1260) or eighty-five per cent (85%) as they were outside the Terms of Reference of the Review of Clinical Services Bundaberg Base Hospital.

b) Methodology

Of those one thousand, four hundred and fifty-seven (1457), there were two hundred and twenty-one (221) patients who:

a. Died
b. Were transferred to another institution
c. Had an outcome which was identified as 'adverse' and brought to the attention of the Review Team.

In respect of each of those two hundred and twenty-one (221) patients, Dr Woodruff:

a. Examined their case notes
b. Examined any other related significant documents (eg. Coroner's reports or Infection Control reports)
c. Examined statements of complainants or informants.

Dr Woodruff considered three questions in relation to each of those two hundred and twenty-one (221) patients:

a. Did Dr Patel contribute to an adverse outcome?
b. Was Dr Patel acting outside the scope of expertise of either himself or the hospital?
c. Was the patient's management reasonable?

Each of these three questions was answered in relation to each case as 'yes', 'maybe' or 'no'. Dr Woodruff identified in the tables below in relation to each question those in respect of whom a 'yes' answer or a 'maybe' answer was reached. In each case the 'No' category are those cases remaining.

The conclusions Dr Woodruff reached are his own, acting in good faith expressing what Dr Woodruff believes to be an objective and dispassionate interpretation.

Table: Patients in respect of whom Dr Patel contributed or may have contributed to adverse outcomes

Selection Value	Count
Total	221
Maybe	24
No	175
Yes	22

Table: Patients in respect of whom Dr Patel operated/may have operated outside his scope of expertise or outside/maybe outside that of the hospital

Selection Value	Count
Total	221
Maybe	5
No	213
Yes	3

Table: Patients in respect of whom management was considered reasonable

Selection Value	Count
Total	221
Maybe	20
No	15
Yes	186

The following are attached as Appendix E:

1. List of the 221 patients referred to above.
2. Notes concerning patients with adverse outcomes considered **to have** been contributed to by Dr Patel.
3. Notes concerning patients with adverse outcomes which **may** have been contributed to by Dr Patel.
4. Notes concerning patients operated on by Dr Patel considered to be **outside** his expertise or scope of practice or that of the hospital.
5. Notes concerning patients operated on by Dr Patel where this **may** have been outside his expertise or scope of practice or that of the hospital.
6. Notes concerning patients where Dr Patel's management was considered reasonable.

c) Deaths

The eighty-eight (88) deaths were analysed in greater depth using an extended survey. The following questions were included in the extended survey:

1. Was the patient's condition terminal?

2. Was the wound
    - satisfactory
    - abnormal
    - dehisced?
3. Was operation class
    - major abdominal
    - thoracic
    - peripheral
    - vascular
    - other?
4. Was the operation type
    - curative
    - palliative
    - diagnostic?
5. Was the patient immunocompromised
    - yes
    - no
    - maybe?
6. Was the patient transferred to another institution
    - not transferred
    - appropriate
    - morbid transfer?
7. Was death
    - perioperative
    - remote
    - unrelated?
8. Was secondary surgeon responsible for:
    - iatrogenic injury
    - wound problem
    - anastomotic leak
    - other?

Table: Analysis of Deaths

88	**Total Deaths** (including P11	
64	**Terminal Deaths**	
	Dr Patel Contributed to Adverse Outcome	
4	YES	P19, P236, P21, Nagle
5	MAYBE	P200, P161, P224, P259 P48
55	NO	
24	**Non Terminal Patients**	
	Dr Patel Contributed to Adverse Outcome	
4	YES	P11, P180, P238, P34
3	MAYBE	P28, P273, P297
17	NO	
5	**Death Contributed to by other Doctors**	P217, P243, P253, P266, P326
11	**Remote or unrelated deaths**	P166, P176, P177, P164, P172, P192, P242, P244, P292, P313, P322
1	**Perioperative Death**	P276

The death analysis review shows in Dr Woodruff's opinion that sixteen (16) deaths were or may have been contributed to by Dr Patel. On the other hand, seventy-two (72) were not related to any unacceptable clinical performance of Dr Patel.

Of the fifty-five (55) terminal patients where there was no identified contribution to the death from Dr Patel, the outcome would reasonably have followed if these patients had been managed elsewhere in the health care system. Of particular concern is the death of twenty-four (24) patients considered to be non terminal. In seven (7) of these, further investigation of the clinical performance of Dr Patel is indicated.

In seventeen (17) of the twenty-four (24) considered by Dr Woodruff not related to Dr Patel's clinical management, there were five (5) patients whose deaths were significantly contributed to by doctors other than Dr Patel. Of the remaining twelve (12) deaths in this group, eleven (11) were remote or unrelated.

Although Dr Patel is considered to have contributed to four (4) deaths in non terminal patients, he rescued or attempted to rescue five (5) patients from major iatrogenic injury caused by other medical practitioners during this time.

d) Competence

It is difficult and in many senses risky to attempt to express a short view of Dr Patel's competence. Dr Woodruff has never witnessed Dr Patel operate. Dr Woodruff's analysis can only be limited to his review of the case notes and other material identified.

Having said that, these are Dr Woodruff's views:

a. In the cases identified, Dr Patel contributed or may have contributed to adverse outcomes; or operated beyond his scope of practice or the hospitals' scope of practice.

b. Dr Patel exhibited an unacceptable level of care in some cases

c. Dr Patel's unacceptable level of care contributed to eight (8) deaths:

P11
P180
P21
P30

Phillips Ur 034546

P236
P18
P238

There may have been an unacceptable level of care which contributed to a further eight (8) deaths:

P200
P215
P224
P259
P28
P273
P297
P98

d. There are other patients upon whom Dr Patel operated who subsequently died. In Dr Woodruff's opinion, however, their deaths were not related to an unacceptable level of care on Dr Patel's part and were a consequence of the underlying pathology.

e. It is difficult without an empirical denominator to quantify (in relative terms) Dr Patel's adverse outcomes, however concern was raised by recurrent reports of:

    1. Wound dehiscence
    2. Anastomotic leakage
    3. Failure of dialysis access.

f. In the comfortable majority of cases examined, Dr Patel's outcomes were acceptable and in some instances, he retrieved patients from dangerous situations caused by other practitioners prior to his involvement in the patient's management.

g. Dr Patel's case notes were legible and full and his clinical decisions generally well reasoned.

h. The case notes do not show that Dr Patel intentionally caused harm to any patient.

Effective patient care is a team effort. Each member of the team plays his or her part. The team works most effectively when communication between each member is encouraged, uninhibited and constructive. There were serious deficiencies at the Bundaberg Hospital in this respect. This is also evident within the clinical record case review.

In particular:

a. There was an absence of contemporary interaction between members of the clinical team;

b. There was no system of contemporary review of the patient's care particularly those involving adverse outcomes. Constructive and contemporary review among those involved in a patient's care, if necessary with input from other experienced senior clinicians, would go a long way towards improving outcomes. Ideally from the perspective of healthcare outcomes alone, such a review would be confidential and conducted within a culture which encouraged the open disclosure, discussion and analysis of adverse outcomes, clinical events and near misses. Feedback of such formative data to the multidisciplinary team (nurses, doctors and allied health) should be resourced and supported.

In Doctor Woodruff's opinion, there is no doubt that the hospital and the surgeons would also benefit from regular review by surgeons of the appropriate speciality and experience. Inadequate skills are more likely to fester in regional hospitals where the level of informal peer influence is likely to be less. It would be worthwhile, for example, for there to be regular validation of surgical skills in surgical skills laboratories, and mobile review by senior experienced surgical colleagues would permit a prompt, rapid and focussed response to complaints about particular problems or surgical outcomes.

3.2.2 Interview Feedback Relating to Dr Patel Clinical Performance

During the interviews many staff provided comments on the surgical technique and performance of Dr Patel including the following:

- Infection control practices:
  - 'Coughed and wiped his nose with a gloved hand'
  - 'Operated with active dermatitis of his arms'
- Anastomosis techniques
  - 'sutured too tight'
  - 'sutures spaced too far apart'
- Wound closure techniques
  - 'opted for mass closure'

He was reported to be a fast surgeon and have reasonable technique although, not as meticulous in his dissection of vital structures or as protective of bowel as other surgeons. Some considered him 'better than others'.

It was reported that Dr Patel was not receptive to feedback regarding his performance and denied responsibility for complications. Others reported instances when during teaching he allowed very junior staff to operate under his supervision. In one instance he supervised a new intern performing a bowel anastomosis. A number of the more senior resident medical officer staff found this very unusual. He allegedly taught 'at people' and was reported to use 'his own curriculum rather than that of the university'. He reportedly 'often yelled' when things weren't as he would like.

It was not possible on the basis of a clinical case chart review to form a confident opinion on the reported concerns regarding Dr Patel's surgical technique. It would only be possible to do this if all data including his total operative workload were analysed with the rigour applied to the analysis of his

deaths, transfers and reported adverse outcomes. To draw conclusions on his level of wound infection or dehiscence rate based on 15% of data, highly selected, would be statistically unsound and prone to misinterpretation.

In defining surgical competence, the Royal Australasian College of Surgeons (RACS) recognizes the following attributes:

- Medical Expertise
- Technical Expertise
- Judgement-Clinical Decision Maker
- Communication
- Collaboration
- Management and Leadership
- Health Advocacy
- Scholar and Teacher
- Professionalism.

RACS expects these attributes to be demonstrated through clinical skills, patient care and professional judgement. Dr Woodruff formed the opinion that Dr Patel did not meet this test of competence.

3.3 Analysis of Clinical Outcomes & Quality of Care

Analyse the clinical outcomes and quality of care across all services at Bundaberg Hospital. Compare with benchmarks from other states or other like hospitals and identify areas requiring further review or improvement

The Review Team undertook an analysis of available data sources for the purpose of identifying quality of care issues at Bundaberg Hospital that require further review.

The major data sources analysed were:

- Health Information Centre, Queensland Health
- CHRISP Infection surveillance reports
- ACHS Clinical Indicator Reports
- Measured Quality Report
- Surgical Access Team Reports (now called Health Systems Development)
- Incident Reports

It was evident to the Review Team that there are significant limitations on the validity of the various reports that track clinical indicators. Small sample sizes render statistical analysis useless. As a result, it is rarely possible to obtain useful 'information' that can assist management decision-making. In addition, data is sourced from medical record coding which, at Bundaberg Hospital the Review Team were advised, has not received clinical validation. Furthermore, comparison between Bundaberg Hospital and other facilities is really only possible when providing risk-adjusted data, such as the Measured Quality Report, which is currently subject to cabinet confidentiality provisions.

3.3.1 Surgery

The surgical service includes general surgery, including management of emergencies and trauma, general orthopaedics, and urology performed by a visiting general surgeon. Public vascular surgery has now ceased due to the resignation of Dr Theile, a previous Director of Medical Services. Upper and lower GI endoscopy are provided by both surgeons and physicians.

Total performance against elective surgery waiting time benchmarks during Dr Patel's tenure did improve. However, this can not be solely attributed to Dr Patel nor to General Surgery.

Despite the collection of clinical indicators for surgery, it is not possible to identify statistically significant variation from benchmark for the service, or Dr Patel as an individual.

The indicators that were assessed included:

ACHS Indicator	Definition
4.1	Unplanned patient admission to ICU within 24 hours of a procedure
1.3	Cancellation of procedure after arrival due to acute medical condition
3.1	Unplanned overnight admission
3.4	Haematemesis and/or malaena with blood transfusion with operation during same admission

It is not clear that these anomalies were adequately investigated and explained.

Adverse event reporting was reported in trended graphs. These reports were produced by the DQDSU and were not well developed, having only been

recently commenced. It is notable that the surgical ward reported much higher numbers of incidents than other clinical areas and the medical ward (with the exception of mental health). This could be either due to a better reporting culture in the area, heightened awareness due to concerns about Dr Patel, or more actual incidents. It is not possible to draw valid conclusions from comparison of *reported incident numbers*.

Infection rates are reported through the CHRISP eICAT surgical site infection process. This provides for 6 monthly reports across a range of indicators. Discussion with Dr Whitby, Medical Director of CHRISP suggested that there was no significant change in the infection rates collected and reported through CHRISP for Bundaberg Hospital. General surgical data (surgical site infection surveillance) is not collected from Bundaberg Hospital or from many hospitals due to the short length of stay for common surgery. Long stay operations are usually complex, such as abdomino-perineal resection, and are classified 'dirty' within the surveillance rankings. As a result, inpatient Surgical Site Infection Surveillance is not collected in either of these general surgical groups. Due to the small numbers and the problems with post-discharge surveillance, it is not possible to make any conclusions.

Current reporting of clinical indicators is not embraced by clinicians, has little statistical validity and does not appear to assist decision-making.

3.3.2 Intensive Care Unit

Intensive care was reviewed as part of the Critical Care Review of 2002 commissioned by the Central Zone. No further analysis of this data was undertaken.

3.3.3 Integrated Mental Health Service

This service has been the subject of a recent comprehensive review and was considered outside the scope of the current review. The Review Team were advised by Ms McDonnell that apart from recommendations regarding the

nursing NO4 position and some capital works which were progressing, the other recommendations had been implemented.

3.3.4 Paediatrics

The paediatric service comes under the Director of Medicine. The paediatric service is consultant led, has excellent supervision and teaching and has embraced incident analysis and improvement through the Erromed group. As a service, they appear to be functioning effectively.

3.3.5 Emergency Department

Performance benchmarking in the Emergency Department is against the average waiting times in the National Emergency Triage Categories 1 – 5 (ACHS Criteria 1.1-1.5). Bundaberg Hospital consistently meets or exceeds benchmark for percentage of patients seen within the required time for each category.

The percentage of eligible patients that receive thrombolysis within 1 hour of presentation to the Emergency Department also consistently exceeds benchmark performance.

No further review of Emergency Department data was made by the Review Team. However, a recent Review of Critical Care Services in February 2002 (which included a section on ED issues) identified significant medical staff shortfalls, lack of medical leadership and quality systems and problems with the layout and design of the area. It is not clear what actions were taken to address the recommendations in this Review.

3.3.6 Internal Medicine

The Medical Department at Bundaberg Hospital consists of general medicine, nephrology, visiting gastroenterology and non-invasive cardiology services. Case-mix data indicates that Renal dialysis is the highest volume DRG for Bundaberg Health Service District.

There are two clinical indicators that are of concern in relation to Medicine as identified by the Measured Quality Report, 5th May 2003 (Cabinet In Confidence).

These are:

Indicator	Definition	2003/4 Rate	2003/4Peer Group Mean
CI01.1	In-hospital mortality acute myocardial infarction (AMI)	25.5	14.2
CI03.1	In-hospital mortality stroke	30.9	19.4

These results are risk-adjusted (based on age, sex and selected co-morbidities) and statistically significant. Work has been done to analyse and address these issues, with Bundaberg Hospital staff reviewing local care paths and joining the state collaboratives. The impact of this will be evident from the 2004/5 data once available.

The patient safety culture survey conducted in Bundaberg Health Service District in March 2004 by DQDSU identified that the senior management support for safety in the Medical Department was below that in other areas.

3.3.7 Obstetrics and Gynaecology

Bundaberg Hospital provides obstetric and gynaecology services for the Bundaberg District delivering approximately 800 babies and admitting some 660 gynaecology patients for the 2004 year. The Bundaberg Family Unit (BFU) was recently refurbished and currently comprises a 16 bed unit with 3 Birthing Suites and four (4) designated Special Care Nursery cots.

Two (2) Staff Specialists are employed Dr Stumer and Dr Wijeratne. Dr Stumer, who is a long standing staff member of Bundaberg Hospital is the Director and has been employed in this capacity since the 1st July 1997. The

Bundaberg Family Unit has had stable nursing leadership with the Nurse Unit Manager having been in the position for a number of years.

When considering the clinical outcomes of the obstetric service, data was obtained from the Health Information Centre, Queensland Health. The most recent data provided was for 2003. This data demonstrates that Bundaberg Hospital performs favourably against peer Qld Hospitals. There was a 21.3% Lower Segment Caesarean Section rate which compares favourably to Rockhampton and Mackay Hospitals with 30% and 27.5% respectively. There was a 74.6% Spontaneous Vertex Delivery rate which, compares to 63.7% at Rockhampton and 65.3% at Mackay. High Apgar scores and low admission rates to Special Care Nursery when compared to peer group would suggest that generally the obstetric and neonatal outcomes do not raise concerns. The percentage of women being provided with an epidural for management of labour was lower than the peer group and may be suggestive of an inability to access anaesthetists in a timely way or as a consequence of the clinical practices and management within the delivery suite.

The Review Team was made aware of a number of concerns regarding the Obstetrics and Gynaecology service. Specifically, there were a significant number of complaints, seven (7) over a two (2) year period relating to the communication and treatment of patients by Dr Wijeratne. It was noted by some staff, even in a letter to the A/Director of Medical Services, Dr Nydam in March 2002 that there was reportedly up to one (1) patient a clinic complaining about his communication manner. These complaints span the last three (3) years of Dr Wijeratne's appointment. Dr Wijeratne's abrupt management of patients has been attributed by some to Dr Stumer's inability to make decisions. It has been reported to the Review Team that it was not unusual for him (Dr Stumer) to take one and a half (1½) hours to see one patient in an outpatient setting. This results in significant patient delays with

Dr Wijeratne seeing the majority of patients for which he reportedly becomes resentful.

It was reported to the Review Team that one of the specialists was regularly off site when rostered on duty and this has raised concerns regarding the supervision of other medical staff. In addition concerns were raised that the other senior medical staff member often deliberated far too long when called upon for clinical management decision and reportedly requested junior staff provide advice on these decisions. The Review Team formed the view that the senior registrar in 2004 was seen by many as the informal medical leader of the service.

There was also significant and ongoing conflict between the Director of Obstetrics and Gynaecology and midwives surrounding clinical practice protocols, the reported obsessive and repetitious behaviours of the Director and the responsibility for the management of the unit. The last of these, relating to the lack of engagement of the Medical Directors in issues such as the management of service budgets and quality agenda, was not only relevant to the Family Care Unit and is dealt with in other areas of the report.

There were instances where clinical practice guidelines produced by the Director such as those for urinalysis on antenatal patients, dated 16th January 2005 are referenced to outdated sources or letters in response such as:

- Mayes, B.T. (1959), A Text Book of Obstetrics
- Murphy D.J. & Redman, C.W. (2003), The clinical utility of routine urinalysis in pregnancy MJA:178(10) Letter in Response.

Further, within an email from Dr Stumer supporting his clinical decision making he makes reference to his of texts from the '60's and '70s, for example, 'Professor Townsend's Textbook of Obstetrics'.

Other guidelines are internally inconsistent, such as that for the Management of Mono-Amniotic Twins revised on 26th February 2005 which details that 'the delivery of mono-amniotic twins should be by Caesarean section at 32-34 weeks and except for emergencies should be undertaken at the Royal Women's Hospital or Mater Mothers' Hospital Brisbane'. In the next paragraph the guidelines advise that 'At Bundaberg Hospital, elective Caesarean section for mono-amniotic twins should be delayed at least until 36 weeks completed gestation'.

During interviews, the Director was described by some as 'peculiar' with 'challenging' behaviours. In the opinion of the Review Team, from behaviours observed during interview he seems to be quite fixated, almost to a point of concern, on issues of the placement of delivery suites to the operating theatre complex, the testing of urine for protein antenatally and outpatient clinic arrangements.

During review of relevant documentation, the Review Team identified a number of Incident Report forms completed by Dr Stumer. These were dated and submitted in January 2005 but relate to events which occurred in mid to late 2004. Of note, these reports highlight clinical practise issues which were within the control of the Director to manage and it was unclear to the Review Team whether this had in fact occurred. When considering the previously noted behaviours, the details contained within these incident reports further confirm the ongoing theme of urinalysis for antenatal patients.

Following interviews and reviewing the After Hours Nurse Manager Bed Status reports, the Review Team became aware of a number of patients, including those with undifferentiated chest pain, being admitted to BFU and, to a lesser extent, the paediatric unit. This raised concerns about the appropriateness of admissions to these areas considering the skill set of the staff and resources available. In the instance of BFU the geographic

dislocation from the acute wards poses additional potential risk. It is not unusual to outlie patients in these areas though parameters need to be agreed upon to ensure only appropriate patients are admitted to these areas.

3.3.8 Other Medical Issues

Upon review of the multiple personnel files of all of the senior medical staff, it is very apparent that there are primarily two (2) discrete records maintained, one within the Office of the Director of Medical Services and the other within the Human Resources Department. Personnel files within the office of the Director of Medical Service hold information on performance management issues for senior medical staff including issues which have been referred to the Audit Branch for consideration of the Criminal Justice Commission (refer Personnel File from Director of Medical Services Office for Dr Anderson). There is certainly a need to consolidate the Personnel Files of the senior medical staff and for the Human Resource Management Department to ensure appropriate storage of performance management and disciplinary information.

Other Medical Officers have been appointed to permanent Full Time positions seemingly without any merit based process. Also Option A contracts have been offered for a period of 5 years which is contrary to IRM 2.7-12 seemingly without any Human Resources Department oversight.

Another anomaly which was identified whilst reviewing the Personnel Files of the Senior Medical Staff was that one of the specialists, the Director of Medicine, Dr Miach holds General Registration, Reg No. 924595 in the State of Queensland. He was, and the Review Team believes currently is, employed as a specialist with right of private practice by Queensland Health and appears to hold the relevant qualifications (MB BS Melbourne 1968 and FRACP, MRACP Australia). At the time of the Review he did not hold Specialist Medical Registration in Queensland. Upon enquiry with the Medical

Board of Queensland, the Review Team were advised that Dr Miach only applied for General Registration in Queensland on the prescribed General Registration application form. The Review Team were advised that Dr Miach had never applied for specialist registration in Queensland. It appeared from Dr Miach's Personnel File that he was previously registered as a specialist in Victoria prior to taking up his appointment at Bundaberg Hospital. Further, even though Dr Miach didn't hold Specialist Registration with the Medical Board of Queensland he was in possession of a provider number for specialist billing No 0222115X for the Bundaberg Hospital in Queensland.

Rostering of medical staff was also raised as a concern. There was a change to the overnight on-call cover from 14th July 2003. This change placed an additional Principal House Officer (PHO) in the emergency department overnight, and allowed the on-call senior doctors for medicine and surgery to cease call at 10pm. After hours management of ICU, as reported by a previous PHO, was not adequately supported with clinical knowledge or direction with this change. This change was introduced to curb fatigue payments and fatigue leave to on-call staff. It was opposed by the medical staff due to ongoing concerns about patients admitted overnight without appropriate diagnosis and management.

Review of concerns raised by staff and patients/relatives led to a review of other clinical records. Some of the common themes which have arisen from these include:

- Poor structure to the ED assessment of many of the patients reviewed. Some patients had significant pathology which appeared to be missed at initial presentation because a thorough assessment was not undertaken at initial presentation and admission in the Emergency Department or on the ward when the patient was admitted.
- There was evidence that the supervision of junior doctors during business hours was appropriate. After hours and on weekends, this

was not necessarily the case, with inexperienced junior doctors required to provide unsupervised care. This was hard to avoid given the difficulties in recruiting suitably trained medical staff. In addition, junior medical staff are not as well supported by consultants as they could be. There was an instance of a patient who was transferred from one of the local private hospitals because they needed Intensive Care. This patient was admitted publicly under the same consultant they were cared for privately and was quite unwell. One of the junior staff was left to care for this deteriorating patient after hours and even though the consultant was informed of the criticality of the case they did not attend the hospital to care directly for their patient. This patient was subsequently transferred to a Brisbane Intensive Care Unit the following day.

3.3.9 Other Nursing Issues

A number of nurses interviewed raised the issue surrounding line management, stating that they are no longer clear as to the role of the ADON and further that the current reporting relationship is most unsatisfactory. Reasons for their dissatisfaction are primarily that with so many nurse managers reporting to the District Director of Nursing there is difficulty accessing her in a timely manner. Some nursing middle managers report that whilst the District Director of Nursing espouses an 'open door' policy that in fact this is not the case and at times had to wait weeks to get an appointment to see her.

In discussion with the current District Director of Nursing, Mrs Mulligan agrees that the number of staff reporting to her is significant and does impact on her workload. However, the matter had been raised with the District Manager when she commenced in the role and it was determined that the current arrangement would stay in place for 12 months to enable her to assess the

skills of her middle managers and to provide an opportunity to develop these staff further.

Mrs Mulligan maintains that when any of her middle managers requested to see her to discuss an urgent matter she was always available and/ or communicated via email. Certainly there is evidence that email is a common form of communication with many issues and decisions provided within these communiqués.

The Bed Manager/After Hours Nurse Managers are required to provide a written report to the Executive which is completed three times a day at 0700, 1500 and 2300 hours. This report is intended to communicate staffing issues, ward occupancies and activity within Peri-operative Services and the Department of Emergency Medicine. There is also a section to report significant events that have occurred and that may be of interest to the Executive. The Review Team requested and reviewed these reports from 2003-2005. On reviewing this large number of reports it became obvious that these reports do not always provide key information. Significant events such as the sentinel events (P11) and another after-hours adverse event P21) were not documented. If the purpose of the report is to inform Executive of significant issues that may prompt further investigation then the report needs to be completed accurately and comprehensively.

It could be argued that within the current environment the flat nursing structure does not support the nurse middle managers at Bundaberg Hospital. Some nurses have reported a reluctance to report issues knowing that they are reporting to 'Executive' whilst others say 'there is no feedback so why bother'. It was commonly reported that the District Director of Nursing 'micro-manages'. Some showed concern for the Assistant Director of Nursing

(ADON) who they believe has been sidelined, with key responsibilities also removed.

The Assistant Director of Nursing reported that prior to Ms Mulligan taking up duties she reviewed all incidents. Her current role tends to focus on specific projects such as the Asthma Trial. This would be inconsistent with other Assistant Director of Nursing positions around the state where they would have direct line management and would be accountable for nursing leadership and professional practice at a senior level. A number of nurses reported that the Position Description for the Assistant Director of Nursing was to be reviewed but had not progressed. Lack of role clarity and a perceived lack of support for the position by Executive were expressed by some of those staff interviewed.

One of the risks in having such a flat structure is in relation to the escalation of issues or grievances. Within the current arrangement, if any of the nurses who directly report to the District Director of Nursing have an issue with a decision or want to take out a two stage grievance against their line manager then any such grievance would need to be directed to the next level above. In this instance this person would be the District Manager (Stage One). This would be a significant disincentive to report matters especially those relating to clinical issues. It would be unlikely that Nurse Managers would take such action and even less likely that Nursing Officer Level 2 (Clinical Nurses) would take such action. This would be particularly so if the matter remained unresolved or perceived to be unresolved at District Manager level. At this point the matter would require escalation to the Zonal Manager (Stage Two).

As a consequence, when staff are reluctant to report upward they may tend to opt toward the seeking of support from their union i.e. Queensland Nursing Union (QNU). It has been suggested that the QNU have a strong presence and are very active within Bundaberg Hospital. This is not an unusual

phenomenon and is common practice in many hospitals especially those where flat structures exist and wherein nurses may seek industrial advocacy rather than a more direct and less threatening approach with senior management.

Recommendations

Bundaberg Health Service District at a local level:

1. **Ensure that there is consistency with contemporary Queensland Health policy, awards and industrial agreements for Medical Staff Employment.**
2. **Ensure one complete Personnel File is maintained in the Human Resources Department.**
3. **Ensure the anomaly of a medical officer with General Registration being employed as a staff specialist with right of private practice is corrected.**
4. **Provide training, support and supervision should be provided to ensure that the assessment of patients undertaken within the Emergency Department is thorough.**
5. **Ensure structures are in place to provide adequate rostering and supervision of junior medical staff after hours and on weekends.**
6. **Ensure the Measured Quality Indicators are followed up with the Measured Quality Program Team once 2004/5 data is available.**
7. **Ensure the format of the After Hours Nurse Managers' Bed Status Report is standardised so that all Nurse Managers provide accurate, pertinent and timely advice to the Executive in a consistent way.**

8. Consider a more comprehensive review of medical leadership and clinical practice, within the Bundaberg Family Unit.
9. Develop protocols to determine which patients are clinically appropriate to be admitted as outliers to the Bundaberg Family Unit.
10. Review reporting relationships for the Nursing Service to incorporate the existing Assistant Director of Nursing position and also to provide a reporting relationship for Clinical Nurses who are sole practitioners.
11. Review the Assistant Director of Nursing Position Description a matter of priority.
12. Develop a plan to implement effective clinical incident and complaints management that is consistent with Queensland Health policy. This should include implementation of the incident management information system (PRIME) with consideration of designated consumer liaison and patient safety officers to support the district.

Queensland Health at a broader level:

1. Facilitate further review of the anomaly of a Medical Board of Queensland general (non specialist) registrant with specialist level billing Provider Number.
2. Develop, implement and support statistical process control and cusum methodologies to assist with monitoring individual clinician performance and clinical services in key clinical areas of practice.
3. Provide input into the review process of the Australian Council on HealthCare Standards (ACHS) regarding the consideration to amend the current clinical indicator

reporting and benchmarking to enhance validity and clinician acceptability.

4. Further develop Measured Quality Program to provide risk-adjusted and statistically valid performance data for key clinical outcomes.

3.4 Risk Management Framework

Review the Risk Management Framework as it relates to the provision of direct services at Bundaberg Hospital to determine its effectiveness. Make recommendations in relation to improvements to these systems

3.4.1 Risk Management:

Risk Management is the 'systematic application of management policies, procedures and practices to the task of identifying, analysing, assessing, treating and monitoring risk' (Management Advisory Board's Management Improvement Advisory Committee, 1996).

Clinical risk management is a systematic approach by health services to improve patient safety through the identification, prioritisation and treatment of risks.

3.4.2 Queensland Health Risk Management Policy Framework:

Queensland Health has had a state-wide policy in Integrated Risk Management since 2002. This Policy was followed by the Incident Management Policy and the Complaints Management Policy.

3.4.3 Bundaberg Health Service District Implementation of Clinical Risk Management:

Limited training had been provided in 2003 by the Queensland Health Risk Management Coordinator to Bundaberg Health Service District to assist Bundaberg staff comply with the risk management policies. However, no formal training in Root Cause Analysis methodology was provided. No additional human or fiscal resources were allocated to support the work required to effectively implement and sustain these policies. The District Manager for Bundaberg Health Service District was responsible for ensuring that the Risk Management Policy was implemented. The District Quality and Decision Support Unit (DQDSU) in conjunction with the Director of Medical Services (DMS), was delegated the responsibility of leading the implementation and providing ongoing support for clinical risk management

systems in Bundaberg Hospital. Staff in this office raised concerns with District Executive that they did not have sufficient resources to effectively support these activities. A business case was submitted for additional staff, but no extra resources were provided.

3.4.4 Bundaberg Health Service District Clinical Governance committee Structure:

The major district committees are named according to the six EQuIP functions. The district has comprehensive terms of reference for the committees and has maintained documentation of meeting proceedings. The attached diagram represents the committee structure in the Bundaberg Health Service District. Whilst the Communication Strategies Map provided in April 2005 (Appendix F) indicates communication between the committees, it does not clearly identify the accountability and reporting relationships of the various committees. The total number of committees recorded on the map is twenty one (21). On the follow up visit in May 2005, an updated map (Appendix F) was provided by Ms McDonnell advising that the map had been reviewed within the last two weeks. This has reduced the number of major committees on the map to thirteen (13), with some new committees added and others deleted. It is not clear what precipitated this review.

The peak decision-making and accountability committee in the district is the Leadership and Management Committee (L&M). All of the Bundaberg Health Service District executives are members of this committee. All information in the form of committee minutes is filtered through to the Leadership and Management committee. There is no single committee that has been delegated responsibility for clinical safety and quality issues. These issues are covered in the terms of reference of the following committees directly reporting to L&M: Safe Practice and Environment; Improving Performance; Executive Council; Improving Performance; Continuum of Care. Subcommittees included the Clinical Service Forums, Workplace Health and Safety, Infection Control, Falls, Pressure Ulcers and Erromed, which all

reported through separate committees. The Medical Staff Advisory Committee was not represented on the Communication Map, despite also being a forum where safety and quality issues were raised.

It is of note that many staff including the Executive members sit on a number of committees and further, that similar information, if not the same, is discussed within the various committees. For example, the District Manager and the Director Medical Services sit on three (3) of the larger committees that feed to the Leadership & Management Committee which the District Manager chairs.

There was evidence that the Paediatric Erromed group under the leadership of the staff paediatrician was taking a contemporary approach to clinical incident analysis and system improvement.

It was reported by many staff that there were too many committees, significant overlap in functions and potential for issues to 'fall through the cracks'. It was also reported, and evident from reviewing the minutes, that when safety and quality issues were raised, that there was rarely feedback of decisions and documented actions. When reviewing committee minutes it was not always evident what the key points were from the issue raised on the agenda. Further there was little evidence of any outcome of the preceding discussion or of any decisions made. The Agreed Action column frequently has 'Nil' recorded. This is unusual particularly given that the membership of some of these committees has executive representation.

The Review Team was also provided with a list that documented all of the committees on which the Nurse Unit Managers (NUMs) were participants. There were 63 committees on this list alone. This list did not include all of the committees existing within Bundaberg Hospital and it could be reasonably expected that middle managers from other disciplines also attended these

meetings and indeed others. The significant impact on the workload of staff through middle manager attendance at multiple meetings must be recognised. From the information provided some Nurse Unit Managers (NUMs) are sitting on as many as fifteen (15) separate committees with an average of average 7.6 per NUM. As outlined in the methodology, minutes or outcomes of all of these meetings were not scrutinised by the Review Team, only those thought to be relevant.

The minutes presumably were sent to the next (higher) committee for noting but again there was little documentary evidence that the issue was further discussed and a resolution made at the next level meeting. Examples of this can be seen most clearly within the ASPIC and Executive Council minutes. The following table outlines an example of an issue raised at ASPIC, (Wound Dehiscence), reported to Executive Council where the matter is closed whilst the lower level meeting is still progressing the issue. In addition, the issue is not recorded in subsequent Leadership & Management minutes.

Table: Example of gaps in follow through and documentation

Meeting	Minute Number	Issue	Action
ASPIC 19th May 2004 9th June 2004 14th July 2004 18th August 2004 13th October 2004	04/04-6	Wound Dehiscence	NUM to check on definition and collect data Ongoing- still defining terminology Report tabled. M Carter, J Patel to meet to discuss indicators No discussion. Wards to report as Adverse Event. **Item closed**
Exec Council 2nd July 2004 4th August 2004 3rd Sept 2004	0704-1.1	Wound Dehiscence	Nil Action documented Report by next mtg ASPIC will continue to progress. **Item closed.**

Meeting	Minute Number	Issue	Action
Leadership & Management Jun 7th, 15th, 21st and 28th 2004 Jul 5th, 19th and 26th 2004 Aug 9th, 16th, 23rd, and 30th 2004 Sept 6th, 13thand 27th 2004 October 4th, 11th and 18th 2004	**No record on minutes that Executive Council have referred the minutes or discussed items raised**		

This example demonstrates the lack of follow through despite common committee membership and the existence of a communication strategies map that outlines the flow of information. There is also no evidence of feedback to staff or ongoing evaluation, such as further reported cases of wound dehiscence identified through Adverse Event Forms; even though a further episode of wound dehiscence was reported on 20th August 2004 after release of the initial wound dehiscence report.

From the lack of documentary evidence, which was further confirmed at staff interviews, the Review Team formed a view that where actions were identified there was often no documented or clear evidence of follow up to ensure that the action had been achieved or further evaluated to ensure that the strategies put in place had been successful.

3.4.5 Local Clinical Risk Management Procedures:

a) Incident reporting systems:

Bundaberg Health Service District had local procedures in place for incident management and sentinel event reporting. These were initially approved in November 2004. Risk management procedures were initially approved in February 2002 and revised in November 2004 to be consistent with changes to the Queensland Health policy. The complaints handling procedure that the

Review Team obtained was approved in March 2000 and apparently had been changed by the incumbent District Director of Nursing (DDON) shortly after commencing at Bundaberg Hospital. These procedures were consistent with the Queensland Health policy, and outlined:

- Procedures for reporting, reviewing and responding to clinical incidents
- Accountability for investigations
- Feedback to staff on the outcome of investigations.

These procedures were new and were not in place in Bundaberg Hospital when Dr Patel arrived. However, it was clear that Bundaberg Health Service District had responded promptly to develop and promulgate local procedures in response to the Queensland Health policy directives. The Review Team were informed that the DQDSU in conjunction with the Director of Medical Services had provided education to clinical staff on the procedures and made them readily available. A patient safety cultural survey of clinical staff had been conducted by DQDSU to identify current perceptions of attitudes and behaviours which affect patient safety in Bundaberg Hospital. The documented review date for the procedures was November 2005 and so no formal evaluation was evident at the time of Review. However, the DQDSU noted that they had encountered the following difficulties with implementing the new procedures:

- Workload issues – They were unable to maintain effective support for the process due to inadequate staff. They had been unable to get approval for further support until concern was raised about possible failure of the ACHS mandatory criteria.
- Inadequate training and support – Training provided to support roll-out of the Queensland Health Incident Management Policy did not include standardised Root Cause Analysis (RCA) methodology, which is a component of the Incident Management Policy.

- Failure to close the loop – Referral of high, very high and extreme risks to the relevant Executive Director rarely led to a report which documented investigation findings, approved actions or feedback to DQDSU or reporting staff.
- Executive and clinical directors did not provide clear advice on what aggregated data reports they required to monitor safety and quality performance.
- There was a tendency to have an individual and punitive approach to staff that reported incidents, rather than a system-focussed approach which encouraged reporting and used incidents as an opportunity to learn.
- Reluctance to report incidents – It was reported by many staff that there was no point in reporting incidents as nothing happened and the culture did not support reporting.

b) Clinical incident information system:
DQDSU utilises an Excel spreadsheet for the recording of clinical incident data. Various aggregated incident reports are produced for key committees and services in the Bundaberg Health Service District. These reports are of limited management value at present.

The Bundaberg Health Service District is in the process of implementing the state-wide, web-based incident information system (PRIME). This will assist in addressing a number of issues already outlined including standardised incident taxonomy, risk rating, reporting functions and management decision support.

3.4.6 The Effectiveness of Bundaberg Health Service District Clinical Risk Management Procedures:

a) Identification of clinical incidents when they occur:
There appeared to be varied understanding of what was a reportable clinical incident amongst staff. The Bundaberg Health Service District procedure was

titled *Adverse Event Management Policy* (QHEPS No. 21906: 1st June 2004) and did not provide clear definitions for incident, near-miss, adverse event and sentinel event. This was highlighted in relation to an unexpected death of a surgical patient. A sentinel event report had been submitted to the Executive by the NUM of Intensive Care. However, this was not reported to the Director General. Under the Queensland Health Incident Management Policy, sentinel events are subject to mandatory reporting to the Director General and require a Root Cause Analysis (RCA) to be conducted into the event.

b) Barriers to reporting clinical incidents:
Numerous staff at Bundaberg reported barriers to reporting clinical incidents. The barriers can be summarised as follows:

- 'Little point reporting as nothing changed'
- Leadership not actively encouraging reporting for 'learning'
- Lack of feedback of outcome to reporting person/unit
- Culture of blame and history of punitive approach to reporter
- Fear of reprisal
- Seen as nursing business
- Multiple forms

3.4.7 Other Methods Used to Identify Clinical Incidents:

There was no evidence of adverse event screening activities which may provide an alternative method of identifying adverse events. Examples of these could include systematic multi-disciplinary chart review for: all in-hospital deaths, all cardiac arrests, unplanned return to ICU, unplanned return to operating theatre.

a) Complaints management process:
There appeared to be no link between the complaints and clinical incident management processes. The complaints procedure at Bundaberg Hospital had been changed with the District Director of Nursing assuming responsibility for complaints management since her arrival. It was not clear to the Review

Team that the complaints process was adequately resourced, and consistent with the principles of 'open disclosure'.

There were many examples of patient complaints which were later shown to incidents that had not been reported through the incident management system, including an instance of incorrect surgery by Dr Patel. This should have been reported as sentinel events.

b) Mortality and morbidity reviews and clinical audits:
There was no evidence of a hospital-wide death audit process. Though there was a history of clinical audit occurring within some clinical units at Bundaberg Hospital and documentation around these activities was variable. Whilst this can be a very useful way to share information and learning, it is unclear how clinical incidents identified at these forums led to improvement.

It was noted that prior to the arrival of Dr Patel, there had been an electronic information system to support surgical audit data collection and reporting (Otago). Dr Patel ceased using this system and indicated to the Director of Medical Services that this was no longer required. Dr Patel conducted monthly clinical audits with junior medical staff. Surgical consultant colleagues did not attend and there was little opportunity for peer review. It was reported that Dr Patel went to great lengths to prevent his patients and clinical management being reviewed by peers. Examples included directing junior staff not to refer patients to other medical staff for review, refusing to transfer patients even when this was clearly indicated, and refusal to co-manage surgical patients in the ICU with the intensivist.

3.4.8 Risk Assessment and Investigation of Clinical Incidents:

Reported incidents are centrally risk-rated by the DQDSU using the Queensland Health risk matrix which is based on the Australian Standard AS4360. Incidents with a risk rating of high, very high or extreme, including sentinel events were reported to the relevant executive for investigation.

a) Investigation of high, very high and extreme clinical incidents:
There was no evidence that a transparent, multidisciplinary analysis was undertaken for events reported to the Executive. It is important to note that at the time of the review, there was no Queensland Health endorsed methodology for Root Cause Analysis (RCA). A generic system-based analysis tool (HEAPS) had been provided as part of the state-wide implementation of the integrated risk management policy.

The only evidence that such incidents had been actioned by Executive was brief notes in some of the spreadsheet held in DQDSU. No evidence of reporting findings through a committee or feedback of outcomes to the reporting person was found.

b) Management of lower risk clinical incidents:
There was no consistent approach to managing lower risk incidents. These incident reports were generally viewed and signed off by the NUM and data aggregated by the DQDSU. Erromed groups had commenced and were best developed in paediatrics, with strong clinical leadership.

c) Evidence that changes were implemented following incident investigation:
In the absence of any formal investigation process of high risk incidents, there is no opportunity to develop and approve action plans, and monitor effectiveness of interventions.

3.4.9 Pro-active Clinical Risk Management Strategies at Bundaberg Hospital

In addition to the clinical risk management systems aimed at responding to and learning from incidents *after they occur*, clinical risk management incorporates pro-active strategies. These include:

a) Recruitment, retention, credentialing and privileges, performance management
The Review Team noted that there were significant medical workforce shortages in Bundaberg which are consistent with state and national

shortages. Seventy per cent (70%) of the medical staff were Overseas Trained Doctors (BBH Medical Staff Establishment).

The junior medical staff profile has changed significantly over the past five years from a mix of Australian trained and overseas trained doctors from the UK and South Africa, to a predominance of medical staff from non English speaking backgrounds and cultures. This has also been reflected in the senior medical staff with 53% being overseas trained. It was noted that this change was in part due to a lack of competitiveness in remuneration and conditions and the increasing globalisation of the medical workforce. It was alleged that Queensland has fallen behind in this area when compared with other Australian states and the UK, which have been actively recruiting Australian doctors. In addition, expectations of medical staff have changed in line with generational changes, and this has also impacted on the willingness of medical staff to work in provincial and rural towns. There were reports of cultural, language and competency issues associated with Bundaberg Hospital doctors. Maintenance of appropriate basic secondary level specialist services was a constant challenge for administration.

The Human Resource Department at Bundaberg Health Service District was not involved in the appointment process for doctors and this had led to a number of anomalies in the appointment processes of doctors. The loss of the 'corporate knowledge' of the previous Director of Medical Services' Executive Support Officer created significant issues for the new Director of Medical Services in the registration and immigration processes for doctors.

The credentialing system for senior medical staff was being reviewed at the time of the appointment of Dr Patel. Privileges for temporary consultant staff were not outlined at appointment. It has been reported that there had been problems encountered in getting the involvement of the Royal Australasian College of Surgeons representative (qualified surgeon) in the credentialing process.

There was no formal performance assessment and development process in place for medical staff at Bundaberg Hospital. This reduced the opportunity for earlier identification of performance and development needs for individual clinicians.

Orientation for new medical staff was limited and many staff identified this as a serious deficit.

It is important to note that the Director of Medical Services was recruited after almost two years of the position being vacant. Dr Keating was from interstate and reported receiving no formal orientation either to the Hospital or Queensland Health. The significant medical workforce shortages created an environment where recruiting and retaining appropriately trained medical staff was a major problem.

b) Clinical pharmacy services:

Following discussion with the Director of Pharmacy at Bundaberg Hospital and from information provided on Staff Notification Form, the Review Team were advised that ward based clinical pharmacy services were not provided at Bundaberg Hospital. Provision of clinical pharmacy services to ward areas provides significant benefits in risk reduction from medication related adverse events. The Review Team did not look in detail at the Pharmacy Services at Bundaberg Hospital aside from noting this concern.

Recommendations:

Bundaberg Health Service District at a local level:

1. **Ensure that all medical staff receive adequate orientation to the district on commencement.**
2. **Ensure that all medical staff are provided with written clinical privileges upon appointment, consistent with the Service Capability of the facility and their credentials.**

3. Ensure that the performance of clinical staff is effectively monitored and actioned by implementing effective supervision, ongoing performance assessment and development (PAD), and documented peer review processes.

4. Develop and implement a clinical governance framework which effectively tracks accountabilities for clinical performance, and is subject to regular compliance monitoring. Queensland Health should support this process by developing a state-wide clinical governance framework.

5. Ensure that safety and quality is afforded priority in funder/provider contracts. This will require Queensland Health to examine health funding incentives.

6. Develop a plan to implement effective clinical incident and complaints management that is consistent with Queensland Health policy. This should include implementation of the incident management information system (PRIME) with consideration of designated consumer liaison and patient safety officers to support the district.

7. Review the District Communications Strategy Map & Terms of Reference for committees to minimise duplication and to reduce the number of committees attended by individual staff.

8. Ensure that all minutes of meetings clearly document key points of discussion, agreed action, accountable officers and timeframes.

9. Ensure that items remain on meeting agendas until there is documented completion of agreed action by the accountable officer.

10. Ensures that feedback to referring committees or staff occurs in a meaningly format which assist in organisational improvement.
11. Review the Pharmacy Department with a view to providing ward-based clinical pharmacy services.

Queensland Health at a broader level:

1. Ensure there are comprehensive processes for recruitment and assessment of Overseas Trained Doctors prior to their employment in Health Service Districts.
2. Develop a comprehensive strategy to address the serious medical workforce issues affecting safety and quality of health services. This must deliver practical assistance to Health Service Districts. This will require comprehensive review of care models, conditions of employment and flexibility.
3. Develop and implement an orientation process for district executives.
4. Develop objective mechanisms for monitoring the ongoing clinical performance of medical practitioners to determine whether their practice is within acceptable standards. This may include periods of supervised practice or formative assessment.
5. Provide comprehensive training and support in clinical incident and complaints management to Bundaberg Health Service District. This should include standardised Root Cause Analysis (RCA) methodology.

3.5 Clinical Service Capability Framework

Examine the way in which the Service Capability Framework has been applied at Bundaberg Hospital to determine that the scope of practice is appropriately supported by clinical services

Clinical Services Capability Framework

Queensland Health developed the Clinical Services Capability Framework (CSCF) for Public and Licensed Private Health facilities in 2004. As detailed within the document, this framework outlines the minimum support services, staffing, safety standards and other requirements required in both public and private health facilities to ensure safe and appropriately supported clinical services (Queensland Health 2004). When the members of the Bundaberg Health Service District Executive applied this framework to their service they produced a document, a copy of which is included as Appendix G. The following table is a summary of the key services.

Summary - Clinical Service Capability Framework – Bundaberg Hospital

	CSCF Level	Potential Gaps Identified
Core Clinical Services		
Emergency Services	Level 3	
Endoscopy Services	Level 2	
General Surgery	Level 3	Anaesthetic Level 3 Pharmacy Level 3
Internal Medicine	Level 3	Pharmacy Level 3
Maternity Services	Level 3	Anaesthetic Level 3
Supporting Clinical Services		
Anaesthetic Services	Level 2	
Coronary Care Units	Level 2	
Diagnostic Imaging	Level 2	
Intensive Care Units (Adult)	Level 2	Anaesthetic Level 3 Endoscopy Level 3 Pharmacy Level 3
Interventional Radiology	Level 2	
Neonatal Services	Level 2	
Nuclear Medicine	Level 1	
Operating Suite Services	Level 3	Anaesthetic Level 3
Pathology	Level 2	
Pharmacy	Level 2	

Further discussion during an interview with the Director of Medical Services, Dr Keating revealed that the Health Service District Executive had subsequently reviewed the scoring and had decided that the anaesthetic service at Bundaberg Hospital should have been scored as a Level 3 service when considering the proper application of the Clinical Services Capability Framework.

When reviewing the Clinical Services Capability Framework as it applies to the Bundaberg Hospital it is the opinion of the Review Team that the scores provided by the Bundaberg Health Service District Executive fit within the framework. The score for Anaesthetic Services should be three (3) as the hospital with the current specialist registered medical director and staff should be able to undertake some of the complex surgical procedures as defined in the document on medium anaesthetic risk (class III) patients. The Intensive Care Unit falls between a Level 1 and 2 service as the Director of Anaesthetics and Intensive Care is specialist registered in anaesthetics and not in intensive care and further the unit has traditionally managed patients who are ventilated for a period of up to 48 hours. The level of General Surgical Services also fits reasonably within the area of complex surgery as Bundaberg Hospital has the capacity to undertake some of the procedures detailed as indicative procedures within that category such as joint replacement, abdominal hysterectomy, limb amputations, caesarean section and mastectomy to name a few. In fact prior to 1st April 2004 there were isolated, reported and documented instances of complex elective surgery being undertaken such as oesophagectomies and abdominal aortic aneurysm repair which the Review Team have identified through reports or from staff interviews.

Regardless of whether the Intensive Care Unit is Level 1 or 2, the framework details that provided Anaesthetics is at Level 3, Pharmacy at Level 2 will be the only gap for a Level 3 Surgical Service at Bundaberg Hospital.

When considering the Clinical Services Capability Framework the Review Team is of the opinion that:

- It is quite broad in its indicative range of procedures where quite significant and complex abdominal and thoracic surgery are grouped together with less major surgery such as caesarean section.
- There are some procedures detailed within the indicative surgery list which should not be done in a facility such as Bundaberg Hospital and others which reasonably could be.
- The issues identified above will have broader relevance than just Bundaberg Hospital.
- As a consequence, decisions about which procedures are suitable to be performed in a hospital such as Bundaberg cannot be made simply by broadly applying the Clinical Services Capability Framework, rather they should be made on a case by case basis using the framework as a guide to decision making and this needs to be clearly communicated to the clinicians by the District Executive.

In addition, the Review Team believes that the indicative procedures within the Surgical Services section of the Clinical Services Capability Framework require review to attempt to provide greater homogeneity of complexity of the procedures listed to aid in the decision making.

Recommendation

Bundaberg Health Service District at a local level:

1. **Ensure the Clinical Services Capability Framework is used only as a guide to decision making. There is a need for Management within a hospital to take a holistic view of the services when applying the current framework in specific instances.**
2. **Ensure decisions regarding service profile are clearly communicated to hospital Staff so as to clearly define scope of service.**

Queensland Health at a broader level:

1. **Review the indicative range of procedures described within the Surgical Complexity section of the Clinical Services Capability Framework document to ensure greater homogeneity of complexity of the listed procedures.**

3.6 Other Clinical Service Matters Referred

Consider any other matters concerning clinical services at Bundaberg that may be referred to the review by the Director-General

There were no other matters concerning clinical services at Bundaberg Hospital that were referred to the Review Team by the Director-General for consideration that were not covered by the original Terms of Reference.

3.7 Other Areas of Concern Outside of Scope

Should the Review Team identify other areas of concern outside the scope of these Terms of Reference, the Director-General is to be consulted to extend the Terms of Reference if considered appropriate

There was one (1) issue which was identified to the Review Team which involved a practitioner within the Bundaberg Health Service District. This was raised during interviews with staff and appeared to have been investigated and acted on in the past. There was some concern about whether the issue had been completely resolved. It was outside of the initial Terms of Reference as it didn't involve Bundaberg Hospital and as a consequence no detailed investigation was conducted by the Review Team. Following discussion between the Team Leader of the Review Team, Dr Mattiussi and the Director-General it did not consider it appropriate to extend the Terms of Reference on this occasion for this isolated concern. It was decided that the most appropriate course of action was to exclude this from the Review and for the concern which had been raised about this practitioner to be investigated and managed by the acting management of the Bundaberg Health Service District. This concern was referred for follow up by the acting District Manager/Director of Medical Services for ongoing follow up to occur locally.

There were no other areas of concern identified which were outside the scope of the Terms of Reference provided.

4 References

Queensland Health 2002 *Complaints Management Policy* No.15184: 23rd July 2002

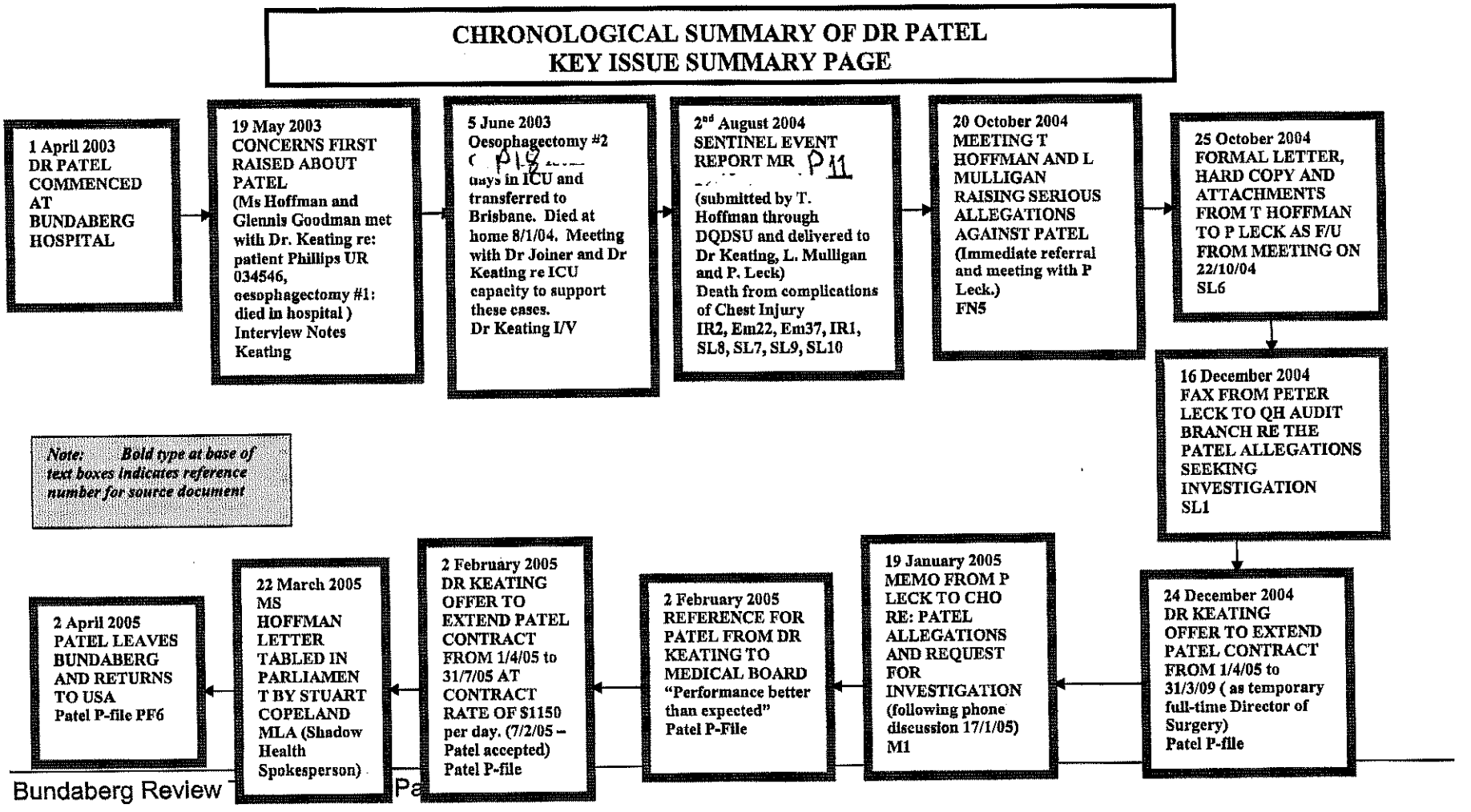
Queensland Health 2004 *Incident Management Policy* No. 23360: 10th June 2004

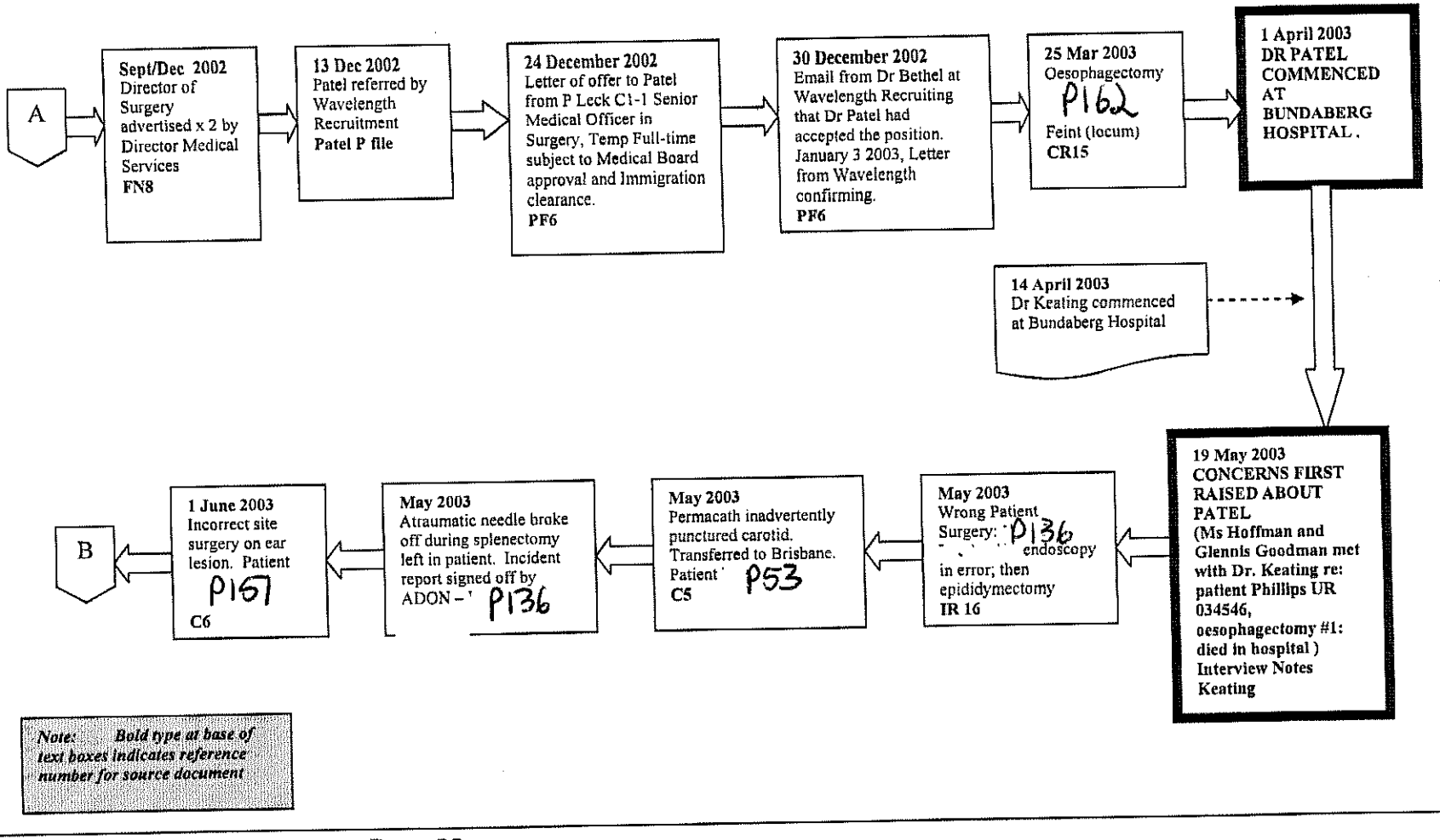
Queensland Health 2002 *Integrated Risk Management Policy* No: 13355, February 2002; superseded by No 13355, June 2004.

Management Advisory Board's Management Improvement Advisory Committee (MAB/MAC) 1996 *Guidelines for Managing Risk in the Australian Public Service*, Report No. 22, Canberra, October 1996, p.3.

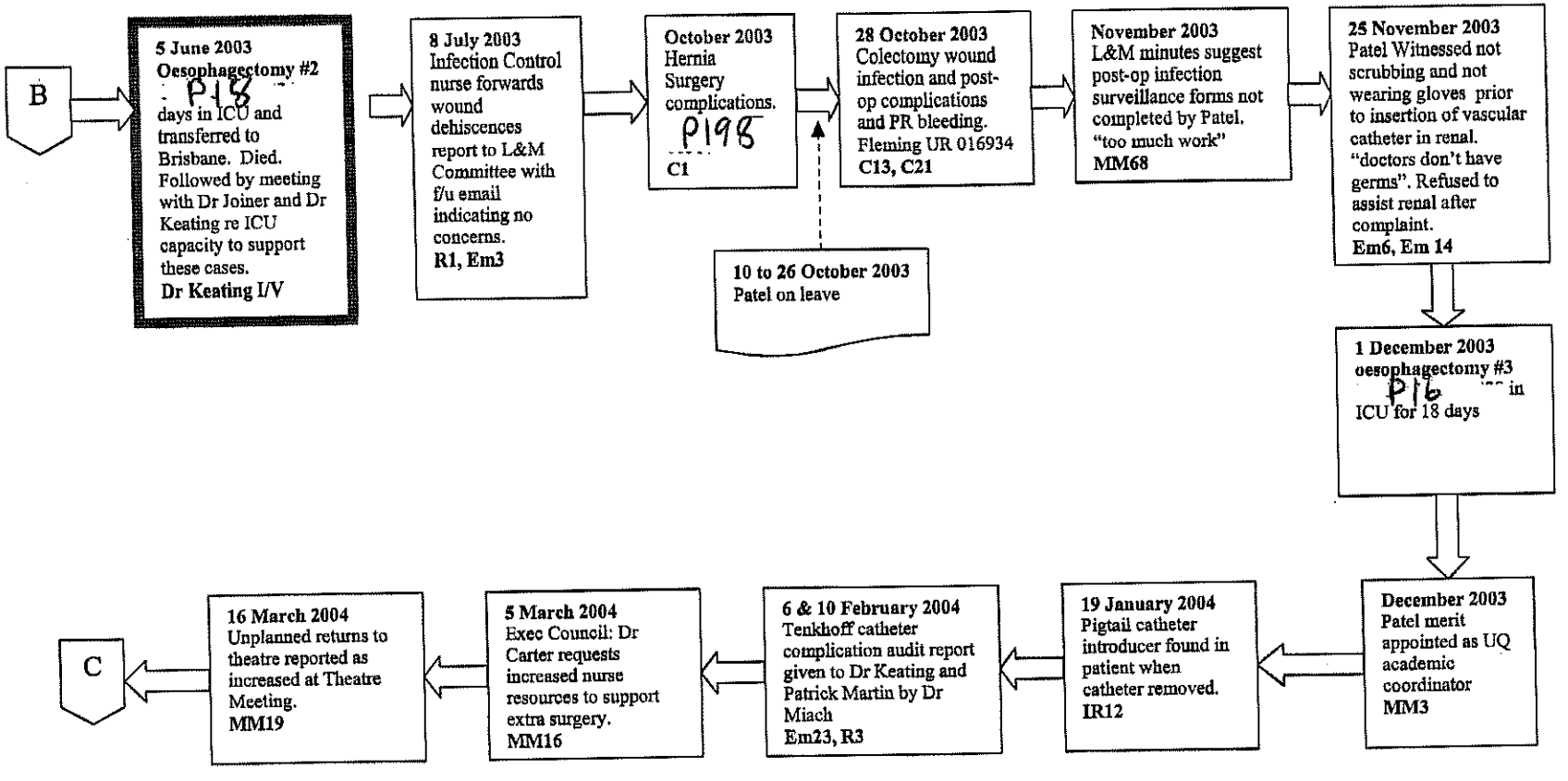
5 APPENDICES

APPENDIX A FLOWCHART OF EVENTS

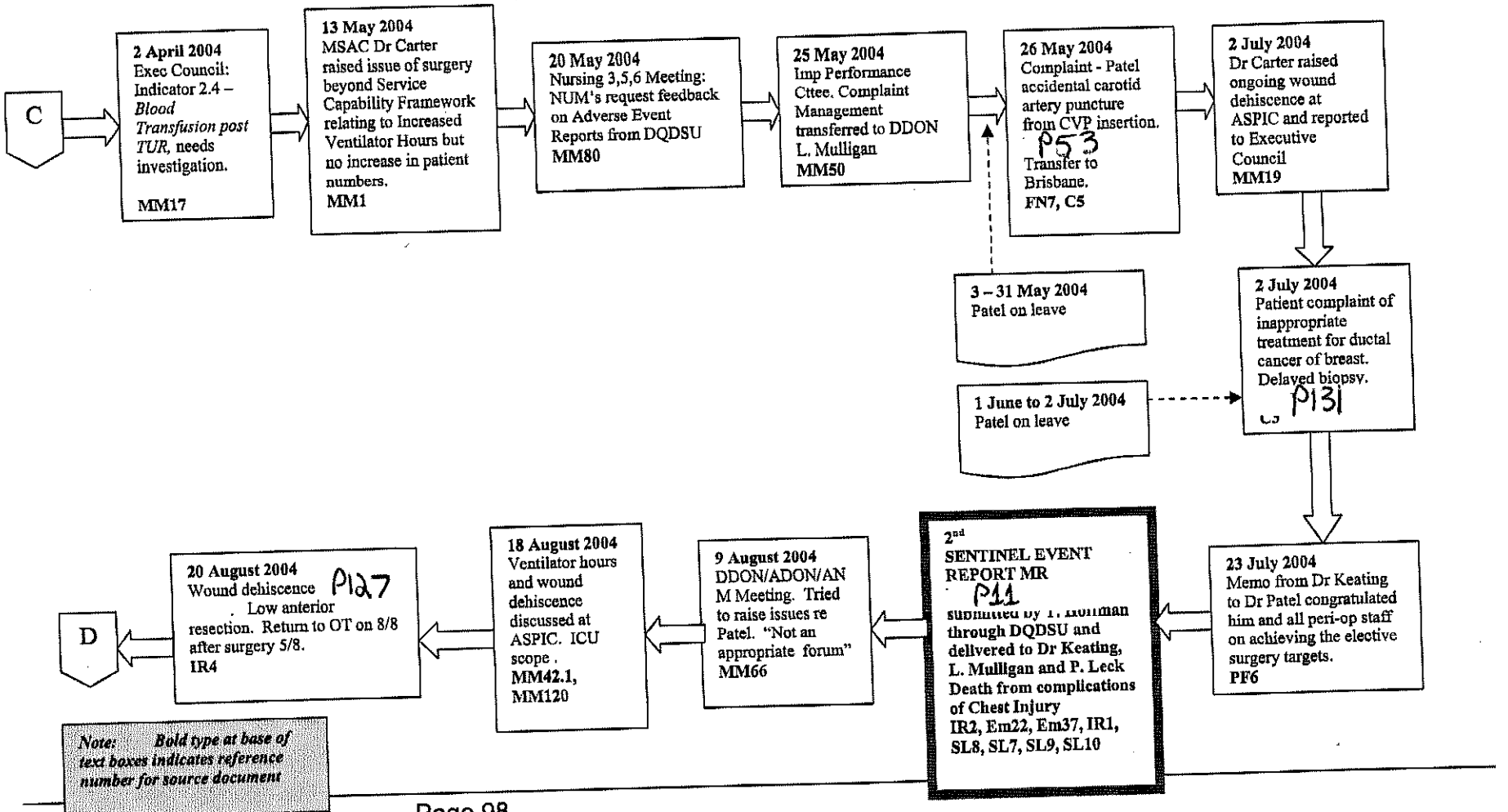




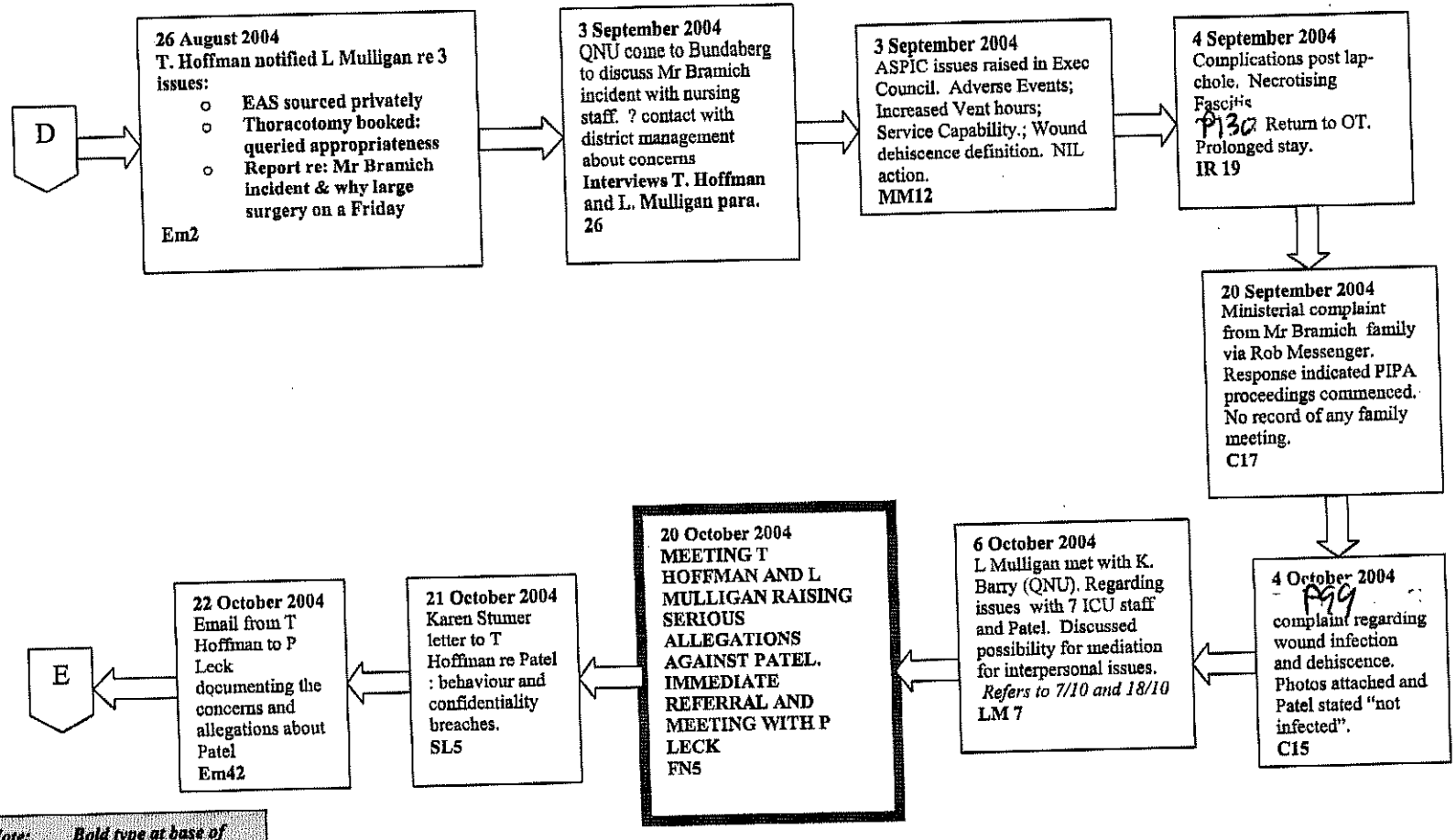
Note: Bold type at base of text boxes indicates reference number for source document



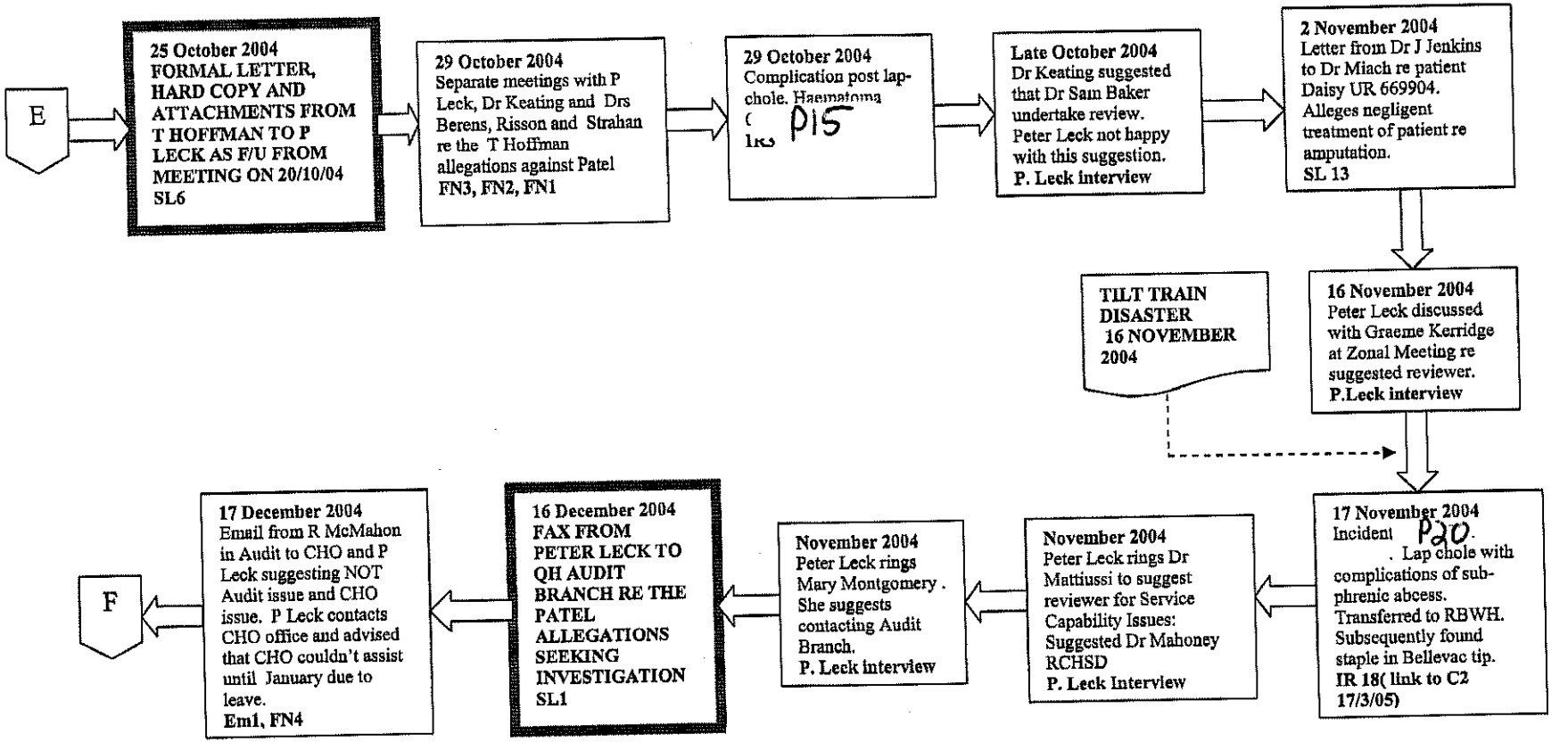
Note: Bold type at base of text boxes indicates reference number for source document



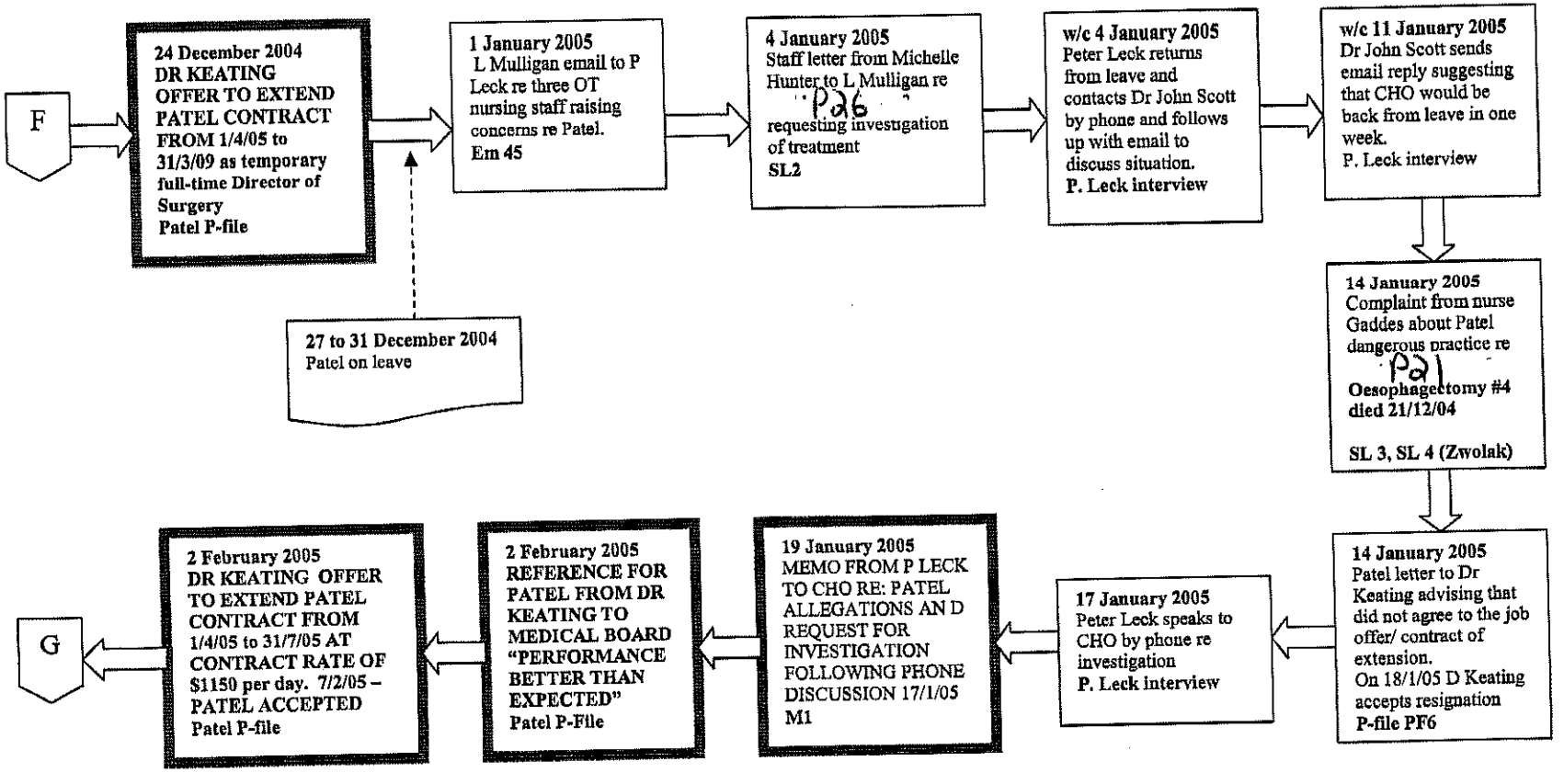
Note: Bold type at base of text boxes indicates reference number for source document



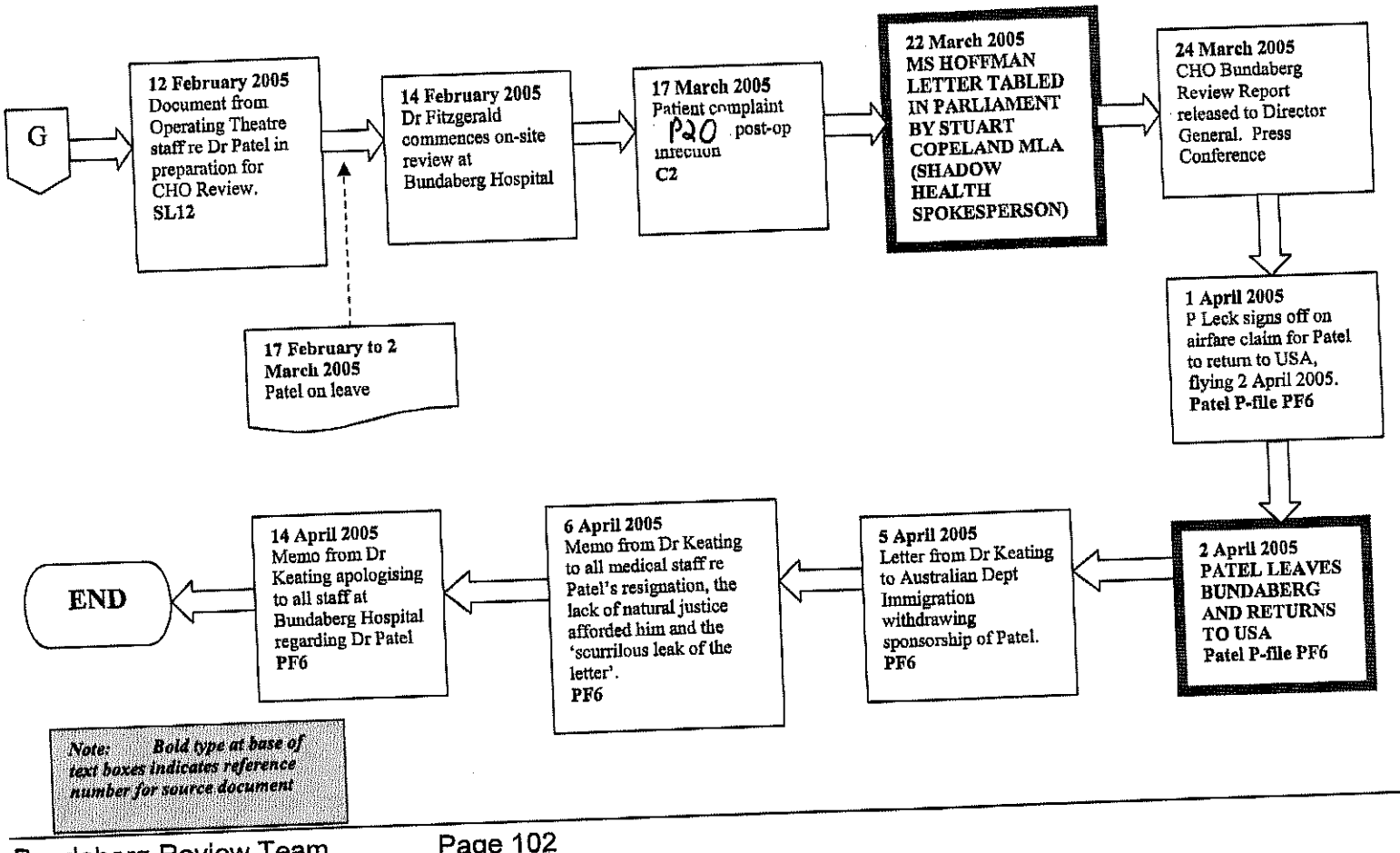
Note: Bold type at base of text boxes indicates reference number for source document



Note: Bold type at base of text boxes indicates reference number for source document



Note: Bold type at base of text boxes indicates reference number for source document


G
12 February 2005
Document from Operating Theatre staff re Dr Patel in preparation for CHO Review.
SL12
14 February 2005
Dr Fitzgerald commences on-site review at Bundaberg Hospital
17 March 2005
Patient complaint
P20
post-op infection
C2
22 March 2005
MS HOFFMAN LETTER TABLED IN PARLIAMENT BY STUART COPELAND MLA (SHADOW HEALTH SPOKESPERSON)
24 March 2005
CHO Bundaberg Review Report released to Director General. Press Conference
17 February to 2 March 2005
Patel on leave
1 April 2005
P Leck signs off on airfare claim for Patel to return to USA, flying 2 April 2005.
Patel P-file PF6
2 April 2005
PATEL LEAVES BUNDABERG AND RETURNS TO USA
Patel P-file PF6
5 April 2005
Letter from Dr Keating to Australian Dept Immigration withdrawing sponsorship of Patel.
PF6
6 April 2005
Memo from Dr Keating to all medical staff re Patel's resignation, the lack of natural justice afforded him and the 'scurrilous leak of the letter'.
PF6
14 April 2005
Memo from Dr Keating apologising to all staff at Bundaberg Hospital regarding Dr Patel
PF6
END
Note: Bold type at base of text boxes indicates reference number for source document

APPENDIX B. INTERVIEW SCHEDULE

INTERVIEWEES	Date	Time	Interviewers
Mr Peter Leck	18/04/2005		MM, JW, LH
Dr Kees Nydam	19/04/2005	1500-1530	MM, PW
District Health Council	19/04/2005	1600-1700	All
Ms Toni Hoffman & QNU Rep	20/04/2005	1015-1200	All
Bundaberg Hospital All Staff Forum	20/04/2005	1200-1300	All
Allied Health Heads of Department	20/04/2005	1300-1400	LH
QLD Police Services- Mr Graham Walker, Mr David Nicoll, Mr Terry Borland	20/04/2005	1315-1345	MM
ICU Staff	20/04/2005	1400-1500	LH, JW
Theatre Nursing Staff	20/04/2005	1500-1600	LH, PW, JW
Director of Anaesthetics, Dr Martin Carter	20/04/2005	1600-1700	MM, PW, JW
Senior Medical Staff	20/04/2005	1700-1800	MM, PW, JW
Brian Johnston ACHS Phone Call	20/04/2005		LH
SMOs- Dr Malcolm Stumer, Dr Naldo Kiel & Dr Scott Jenkins	21/04/2005	0800-0900	MM, PW
Dr Darren Keating DMS	21/04/2005	0900-1030	All
Directors of Nursing, A/DDON & ADON	21/04/2005	1030-1130	LH, MM
Mrs Di Jenkins, NUM Surgical Ward	21/04/2005	1030-1130	PW, JW
Dr Peter Miach, Director of Medicine	21/04/2005	1330-1430	PW, MM, JW
Other Nurse Managers	21/04/2005	1430-1530	LH, MM
Mr Damien Gaddes, Theatre RN	21/04/2005	1530-1600	LH, JW
Dr Ben Davidson, PHO	21/04/2005	1500-1600	PW, MM
Dr Dieter Berens	21/04/2005	1600-1700	JW PW
Ms Jenny White, ex-NUM Theatre (Theatre CN)	21/04/2005	1630-1730	LH, MM
Phone Call to Dr Gerry Costello, Medical Director RFDS	21/04/2005	1230	LH
Phone Call to Dr Steve Rashford, Clinical Coordinator	21/04/2005		LP
Email from Dr Steve Rashford re phone call	21/04/2005		LP
Dr Denise Powell Local Medical Association	22/04/2005	0830-0930	JW, MM
Ms Gail Aylmer Infection Control CN; Ms Lindsey Druce Renal, Ms V. Smythe QNU	22/04/2005	0930-1030	PW, LH
Ms Lyn McKean, Administration Officer	22/04/2005	0930-1030	MM
Ms Sue Hutchins, Administration Officer, Specialists Secretary/Med Ed	22/04/2005	1030-1000	JW
Mr [illegible] (patient & husband of)	22/04/2005	1100-1200	MM, LH
Ms Judy O'Connor, Medical Education	22/04/2005	1100-1200	PW
Mr David Nicoll & others QLD Police Service	22/04/2005	1230-1345	MM, PW
Ms Karen Smith, Elective Surgery Coordinator & Ms Gail Doherty A/NUM Theatre	22/04/2005	1400-1500	MM, LH
Phone Call to Dr Michael Whitby, Director CHRISP Re Bundaberg CHRISP data	22/04/2005	1200	MM
Email via Ms Kim Howe from Dr Michael Whitby in relation to phone call	22/04/2005	1500	LP

INTERVIEWEES	Date	Time	Interviewers
Dr Heike Kath- previous JHO BBH	29/04/2005	1045-1145	JW
Dr Ayesha Curtis-previous Intern BBH	3/05/2005	1300-1400	LH, JW
LALU	3/05/2005	1600	All
Mr Peter Leck Phone Call	3/05/2005	1800	MM
Dr Andrew Chang- Registrar - previously at BBH	5/05/2005	0800-0900	LH, JW
Dr David Risson Phone Interview from Dalby	6/05/2005	1230-1330	PW, JW
Ms Jenny Kirby & Ms Leonie Raven DSU & DQDSU	9/05/2005	1030-1130	JW, LH
Phone Call to Coroner's Office- Mr Michael Barnes	9/05/2005		MM
Ms Ann Robinson, NUM Family Services	9/05/2005	1200-1300	MM, LH
Dr Stumer	9/05/2005	1330-1500	MM, LH
Dr Wimal Wijeratne	9/05/2005	1530-1700	MM, LH
After Hours NUMs & QNU	10/05/2005	0800-0900	LH, MM
Mrs Linda Parsons -Patient with infection & dehiscence problems	10/05/2005	1030-1130	LH, MM
Dr Colin Lye, PHO	10/05/2005	1330-1430	MM, LH
Ms Judith McDonnell, Director of Mental Health	10/05/2005	1430-1530	MM, JW
Mr & Mrs P38 Mrs P38 patient)	10/05/2005	1600-1700	MM, JW
Ms Margie Mears, Pre-Admission Clinic Coordinator	11/05/2005	0830-0900	LH, MM
Ms Carol McMullen, NUM Nursing Informatics	11/05/2005	0915-1015	MM, LH
Ms Jane Truscott, Cancer Care Project Officer	11/05/2005	1100-1200	MM, JW
Ms Sue Hutchins, AO Medical Specialists Secretary/Med Education	11/05/2005	1400-1500	JW
Dr Darren Keating, Director of Medical Services	11/05/2005	1500-1530	MM, JW
Ms Judy Rayner- daughter of deceased patient Mr P335	11/05/2005	1600-1700	JW, MM
Mr Paddy Martin ex A/DDON Project Manager Community Health	12/05/2005	0900-1000	MM, LH
Mrs Beryl Crosby & Mr Ian Fleming (Patient Support Group)	12/05/2005	1030-1130	MM, JW, LH
Ms Cathy Fritz, HRM Manager BHSD	12/05/2005	1430-1530	JW, MM
Dr Jim Gaffield Phone Interview to Sydney with Solicitor	13/05/2005	0830-0930	JW, MM
Commission of Inquiry Solicitors Mr Damien Atkinson & Mr Angus Scott	13/05/2005	0930-1030	JW, MM, LH
Ms Rita Haines Radiology	13/05/2005	1030-1130	MM
Ms Judy O'Connor, Medical Education	13/05/2005	1130-1200	JW
Mr Peter Leck, District Manager BHSD	16/05/2005	1300-1500	JW, MM, LH, PW
Dr Michael Beckmann, O&G Registrar (now at QEII Hospital)	16/05/2005	1600-1700	MM, LH
Mrs Linda Mulligan, DDON BHSD	17/05/2005	1300-1500	JW,MM,LH, PW
Ms Beryl Callanan ex A/DDON BHSD	18/05/2005	0900-1000	LH, MM
Mrs Glennis Goodman, ex DDON BHSD Phone Interview	20/05/2002	0900-1000	LH, MM

APPENDIX C. DR PATEL PATIENTS LISTS – DECEASED &TRANSFERRED

Deceased Patients - not in Bundaberg Hospital/whilst under care of Dr Patel

UR	Name DECEASED	DOB	ADMIT	SURG	ADMIT DATE	STATUS	D/C DATE	DOD	Comment
P166		12/10/1964	MCAR	PAT	18/09/2003	01 - HOME/USUAL RESIDENCE	23/09/2003	23/02/2004	
P169		09/09/1919	PAT		2/07/2003	01 - HOME/USUAL RESIDENCE	8/07/2003	29/08/2003	
P172		09/04/1984	PAT	PAT	19/04/2003	01 - HOME/USUAL RESIDENCE	20/04/2003	30/05/2003	
P177		24/04/1919	PAT	PAT	29/12/2003	01 - HOME/USUAL RESIDENCE	29/12/2003	15/03/2004	
P176		27/07/1965	PAT	PAT	27/11/2003	01 - HOME/USUAL RESIDENCE	27/11/2003	15/08/2004	
P180		22/02/1927	PAT	PAT	8/06/2003	01 - HOME/USUAL RESIDENCE	15/06/2003		
P182		08/10/1932	MIA	PAT	18/06/2003	01 - HOME/USUAL RESIDENCE	26/08/2003	27/09/2003	
P184		28/06/2003	RYA	PAT	6/10/2004	01 - HOME/USUAL RESIDENCE	9/10/2004	6/11/2004	
P192		08/06/1925	PAT	PAT	14/01/2004	01 - HOME/USUAL RESIDENCE	19/01/2004	8/10/2004	
P195		02/12/1944	PAT	PAT	07/10/2003	01 - HOME/USUAL RESIDENCE	07/10/2003		CR11 Complaint
P199		27/02/1956	PAT		4/03/2004	01 - HOME/USUAL RESIDENCE	4/03/2004	31/03/2004	
P202		25/09/1934	STR		14/11/2003	01 - HOME/USUAL RESIDENCE	15/12/2003	23/04/2004	
P204		20/11/1931	KNAPP		15/06/2003	01 - HOME/USUAL RESIDENCE	20/06/2003	13/09/2003	
P205		14/04/1947	PAT	PAT	24/04/2004	01 - HOME/USUAL RESIDENCE	30/04/2004	9/06/2004	
P210		05/07/1959	PAT	PAT	8/09/2004	01 - HOME/USUAL RESIDENCE	11/09/2004	11/01/2005	
P217		20/04/1927	PAT	PAT	03/04/2003	02-OTHER HOSPITAL	3/04/2003	1/05/2003	
P218		18/10/1947	MIA	PAT	17/11/2003	01 - HOME/USUAL RESIDENCE	21/11/2003	6/12/2003	
P220		11/12/1947	PAT	PAT	30/07/2004	16 - TRANSFER TO ANOTHER HOSP	18/08/2004	25/08/2004	BIGGENDEN HOSPITAL C7
P18		22/12/1939	PAT		7/08/2003	01 - HOME/USUAL RESIDENCE	18/08/2003	8/01/2004	R1-dehiscence,Em5,R6
P224		28/08/1936	PAT	PAT	26/05/2003	01 - HOME/USUAL RESIDENCE	27/05/2003	1/07/2003	
P227		19/03/1944	PAT		9/03/2004	01 - HOME/USUAL RESIDENCE	9/03/2004	28/03/2004	
P229		17/10/1930		PAT	13/12/2004	01 - HOME/USUAL RESIDENCE	16/12/2004	21/02/2005	
P19		13/08/1927	MIA	PAT	12/12/2003	01 - HOME/USUAL RESIDENCE	12/12/2003	25/01/2004	R3, R7-Peritoneal catheter
P234		01/11/1945	STR	PAT	23/03/2004	EPISODE OF CARE CHANGE	24/03/2004	1/05/2004	

UR	Name DECEASED	DOB	ADMIT	SURG	ADMIT DATE	STATUS	D/C DATE	DOD	
P234		03/07/1927	PAT	PAT	20/05/2003	01 - HOME/USUAL RESIDENCE	23/05/2003	4/06/2003	
P241		17/11/1956	PAT	PAT	23/05/2003	01 - HOME/USUAL RESIDENCE	23/05/2003	24/10/2003	
P242		26/04/1924	PAT		17/02/2004	01 - HOME/USUAL RESIDENCE	19/02/2004	22/11/2004	
P243		30/11/1930	PAT	PAT	30/10/2004	16 - TRANSFER TO ANOTHER HOSP	1/11/2004	22/12/2004	WESLEY HOSP-A'FLOWR
P244		08/02/1978	WIJE	PAT	30/06/2003	01 - HOME/USUAL RESIDENCE	6/07/2003	10/04/2004	
P246		07/02/1962	PAT	PAT	22/11/2004	01 - HOME/USUAL RESIDENCE	22/11/2004	21/02/2005	
P248		04/07/1942	PAT		10/08/2004	01 - HOME/USUAL RESIDENCE	22/08/2004	14/09/2004	
P251		25/12/1926	PAT	PAT	9/12/2004	06 - EPISODE CHANGE	16/12/2004		
P253		10/10/1927	MCAR	PAT	8/07/2003	16 - TRANSFER TO ANOTHER HOSP	8/07/2003	6/08/2003	ST ANDREWS WAR MEM
P333		13/09/1938	PAT		3/11/2004	01 - HOME/USUAL RESIDENCE	8/11/2004	18/12/2004	
P256		18/08/1933	MCAR	PAT	25/04/2004	16 - TRANSFER TO ANOTHER HOSP	10/05/2004	30/05/2004	REDCLIFFE HOSPITAL
P260		09/12/1921	PAT		9/10/2003	01 - HOME/USUAL RESIDENCE	29/10/2003	17/01/2004	
P266		12/03/1905	PAT	PAT	22/12/2004	01 - HOME/USUAL RESIDENCE	18/01/2005	1/02/2005	
P272		15/07/1953	PAT	PAT	23/06/2003	01 - HOME/USUAL RESIDENCE	23/06/2003	14/02/2004	
P273		13/08/1923	PAT	PAT	16/04/2003	01 - HOME/USUAL RESIDENCE	16/04/2003	8/08/2003	
P278		04/07/1950	PAT		3/03/2004	01 - HOME/USUAL RESIDENCE	22/03/2004	10/06/2004	
P279		01/02/1942	PAT	PAT	21/04/2004	01 - HOME/USUAL RESIDENCE	26/04/2004	28/11/2004	
P291		03/02/1926	PAT	PAT	10/09/2003	01 - HOME/USUAL RESIDENCE	17/09/2003	6/12/2003	
P292		13/12/1941	PAT	KARS	04/11/2004	01 - HOME/USUAL RESIDENCE	10/11/2004	13/01/2005	
P294		29/11/1921	SML	PAT/AND	2/12/2003	01 - HOME/USUAL RESIDENCE	2/01/2004	26/01/2004	
P295		25/02/1993	PAT	PAT	8/02/2004	01 - HOME/USUAL RESIDENCE	13/02/2004	7/01/2005	
P296		07/04/1938	PAT	PAT	11/12/2003	01 - HOME/USUAL RESIDENCE	11/12/2003	31/08/2004	
P334		27/07/1934	PAT	PAT	17/01/2004	01 - HOME/USUAL RESIDENCE	20/01/2004	27/02/2004	
P302		26/07/1936	PAT	PAT	4/06/2003	01 - HOME/USUAL RESIDENCE	4/06/2003	18/01/2004	
P308		30/06/1941	PAT	PAT	24/08/2004	01 - HOME/USUAL RESIDENCE	3/09/2004	20/12/2004	
P53		10/02/1945	MIA	PAT	10/12/2003	16 - TRANSFER TO ANO HOSP	12/12/2003		

UR	Name DECEASED	DOB	ADMIT	SURG	ADMIT DATE	STATUS	D/C DATE	DOD	
	P322	27/12/1925	PAT	PAT	8/07/2003	01 - HOME/USUAL RESIDENCE	22/07/2003	26/01/2004	
	P325	23/04/1926	PAT	PAT	28/08/2004	01 - HOME/USUAL RESIDENCE	24/09/2004	21/10/2004	
	P327	24/09/1920	PAT	PAT	20/09/2003	16 - TRANSFER TO ANOTHER HOSP	23/09/2003	18/11/2003	
	P329	15/03/1927	PAT	PAT	8/12/2003	01 - HOME/USUAL RESIDENCE	12/12/2003	4/08/2004	
	P331	09/10/1931	PAT	PAT	9/05/2003	01 - HOME/USUAL RESIDENCE	9/05/2003	25/06/2004	
55 patients									

Patients NON-Patel Deceased					RAISED AS ADVERSE OUTCOMES	
NAME	UR	DOB	ADMIT	DOD	COMMENT	Review Code
P11		15/04/1948	25/07/2004	28/07/2004	legal file SL 1, 6,7,9,10,14,25 IR2 Em22,35,39	C17, IR1
P48		27/07/1928		21/03/2005	Patel R/V	Staff Interview
P335		24/09/1927	25/07/2004	27/07/2004	medical WS15 Em12	
P47		26/04/1980	9/11/2003	11/11/2003	Carter/Patel ICU no surg -chart not copied	JW-? Breach T&A Act CR4
P336		1/9/1914	18/2/2003	21/3/2003	Family complaint- previously Inv by police	
P337		14/07/1940	11/12/2003	12/12/2003	01 - HOME/USUAL RESIDENCE	CR5 nil issues Id.
6 Patients						

Deceased in Bundaberg Hospital		PATEL ONLY PATIENTS						
UR	NAME	DOB	ADMIT	SURG	ADMIT DATE	STATUS	DC DATE	COMMENT
	P164	19/09/1936	MCAR	PAT	1/05/2003	05 - DIED IN HOSPITAL		
	P189	15/08/1942	PAT		19/04/2003	05 - DIED IN HOSPITAL	25/04/2003	
	P187	06/08/1924	PAT	PAT	27/06/2003	05 - DIED IN HOSPITAL	27/06/2003	
	P200	15/11/1942	GAF	PAT	13/09/2004	05 - DIED IN HOSPITAL	14/09/2004	
	P207	09/07/1925	PAT	KIN	19/08/2003	05 - DIED IN HOSPITAL	19/08/2003	
	P208	09/03/1965	MIA	PAT	20/09/2003	05 - DIED IN HOSPITAL	21/09/2003	
	P215	07/07/1928	PAT	PAT	8/09/2004	05 - DIED IN HOSPITAL	22/09/2004	CR10 MM SL1
	P236	08/09/1946	PAT	PAT	22/09/2003	05 - DIED IN HOSPITAL	1/10/2003	
	P238	20/12/1949	PAT	PAT	30/06/2003	05 - DIED IN HOSPITAL	2/07/2003	
	P21	14/08/1927	PAT	PAT	19/12/2004	05 - DIED IN HOSPITAL	21/12/2004	Em51, C9, SL2,3,4
	P22	18/06/1910	PAT	PAT	31/07/2004	05 - DIED IN HOSPITAL	17/08/2004	SL1-TH
	P247	06/04/1920	MCAR	PAT	21/04/2003	05 - DIED IN HOSPITAL	22/04/2003	
	P259	11/09/1931	MCAR	PAT	29/09/2003	05 - DIED IN HOSPITAL	7/10/2003	
	P264	14/08/1909	PAT	PAT	23/03/2004	05-DIED IN HOSPITAL	23/03/2004	
	P268	14/03/1925	MIA	PAT	11/09/2003	05 - DIED IN HOSP	16/09/2003	
	P28	30/10/1927	MCAR	PAT	20/05/2003	05 - DIED IN HOSPITAL	14/06/2003	R1- deh, IR10, Em5, R6
	P30	22/11/1938	MIA	PAT	16/12/2003	05 - DIED HOSP	17/12/2003	R3-Perl Catheter, R7

UR	NAME	DOB	ADMIT	SURG	ADMIT DATE	STATUS	DC DATE	COMMENT
	P274	15/02/1932	GAF	PAT	25/10/2004	05 - DIED IN HOSPITAL	7/11/2004	
	P276	02/01/1922	PAT	PAT	17/07/2004	05 - DIED IN HOSPITAL	25/07/2004	
034546	PHILLIPS, JAMES	27/03/1957	MCAR	PAT	19/05/2003	05 - DIED IN HOSPITAL	21/05/2003	SL14
	P281	28/08/1938	KNAPP		4/02/2004	05 - DIED IN HOSPITAL	11/02/2004	
	P283	17/12/1931	SML	PAT	9/02/2004	05 - DIED IN HOSPITAL	4/03/2004	
	P297	19/05/1915	PAT	PAT	12/12/2003	05 - DIED IN HOSPITAL	24/12/2003	CR13 LH, C11, CR17
	P301	28/07/1935	MIA	MIA	29/03/2003	05-DIED IN HOSPITAL	04/04/2003	
	P311	23/04/1934	GAF	PAT	8/07/2004	05 - DIED IN HOSPITAL	13/07/2004	C12
	P313	26/07/1932	CON	PAT	27/08/2004	05 - DIED IN HOSPITAL	12/10/2004	Em51, SL7
	P44	13/08/1941	PAT		18/12/2004	05 - DIED IN HOSPITAL	20/12/2004	
	P316	18/08/1931	MCAR	PAT	25/11/2003	05 - DIED IN HOSPITAL	28/11/2003	
1	P98	19/11/1930	PAT	PAT	29/12/2003	05 - DIED IN HOSPITAL	30/12/2003	CR12 JW, LH Coroner
	P317	17/04/1939	PAT	PAT	4/02/2005	05 - DIED IN HOSPITAL	4/02/2005	
	P326	12/01/1927	PAT		7/10/2003	05 - DIED IN HOSPITAL	22/10/2003	
	P328	03/06/1920	GAF	PAT	9/10/2004	05 - DIED	28/10/2004	**32 Patients**

PPENDIX C PATIENTS DR PATEL
RANSFERRED

RN	Name TRANSFERRED	DOB	Dr Discharge	Surgeon	Admit Date	Discharge Disposition	Discharge Date	Transfer Hospital	COMMENT
	P165	02/02/1970	PAT		16/11/2004	16 - TRANSFER TO ANOTHER HOSP	18/11/2004	Royal Brisbane & Womens	
	P167	26/10/1918	PAT	PAT	27/01/2004	16 - TRANSFER TO ANOTHER HOSP	22/02/2004	Monto	
	P168	12/12/1964	PAT		26/09/2004	16 - TRANSFER TO ANOTHER HOSP	26/09/2004	PRINCESS ALEXANDRA	
	P173	31/08/1944	PAT	PAT	21/12/2004	16 - TRANSFER TO ANOTHER HOSP	24/12/2004	Biggenden	
	P12	17/06/1941	MCAR	PAT	6/07/2003	16 - TRANSFER TO ANOTHER HOSP	13/07/2003	Royal Brisbane & Womens	SL1
	P179	06/12/1972	PAT	PAT	24/04/2004	16 - TRANSFER TO ANOTHER HOSP	24/12/2004	Royal Bris	
	P50	09/04/1945	COCH	MCAR/GAF/PAT	17/02/2004	16 - TRANSFER TO ANOTHER HOSP	22/02/2004	Royal Bris	
	P185	11/04/1913	PAT		2/08/2004	16 - TRANSFER TO ANOTHER HOSP	3/08/2004	Royal Brisbane & Womens	
	P188	23/07/1965	PAT		25/09/2004	16 - TRANSFER TO ANOTHER HOSP	25/09/2004	Royal Brisbane & Womens	
	P191	05/06/1948	MIA	PAT	1/12/2003	16 - TRANSFER TO ANOTHER HOSP	17/12/2003	Royal Brisbane & Women's	
	P193	04/07/1920	PAT	THI	8/07/2003	16 - TRANSFER TO ANOTHER HOSP	10/07/2003	GLADSTONE HOSPITAL	
	P194	07/01/1949	PAT		7/10/2003	16 - TRANSFER TO ANOTHER HOSP	10/10/2003	GAYNDAH HOSPITAL	
	P196	09/04/1943	PAT	ROB	16/11/2004	16 - TRANSFER TO ANOTHER HOSP	17/11/2004	NAMBOUR HOSPITAL	
	P197	11/04/1986	PAT		9/07/2004	16 - TRANSFER TO ANOTHER HOSP	10/07/2004	Royal Brisbane & Women's	
	P156	29/04/1959	MIA	PAT	27/10/2003	16 - TRANSFER TO ANOTHER HOSP	2/12/2003	Royal Brisbane & Women's	
	P201	07/12/1952	PAT		19/09/2003	16 - TRANSFER TO ANOTHER HOSP	23/09/2003	Royal Brisbane & Women's	
	P206	30/05/1944	CHAU		16/11/2004	16 - TRANSFER TO ANOTHER HOSP	17/11/2004	MARYBOROUGH HOSPITAL	
	P209	05/03/1913	STR	PAT	28/11/2004	16 - TRANSFER TO ANOTHER HOSP	17/12/2004	GIN GIN HOSPITAL	
	P211	17/08/1940	PAT		20/04/2004	16 - TRANSFER TO ANOTHER HOSP	21/04/2004	Royal Brisbane & Women's	
	P212	01/01/1961	PAT	PAT	13/12/2004	16 - TRANSFER TO ANOTHER HOSP	17/12/2004	CHILDERS HOSPITAL	
	P213	22/09/1933	PAT	PAT	22/09/2004	16 - TRANSFER TO ANOTHER HOSP	24/09/2004	Royal Bris	
	P220	11/12/1947	PAT	PAT	30/07/2004	16 - TRANSFER TO ANOTHER HOSP	18/08/2004	BIGGENDEN HOSPITAL	
	P221	26/07/1908	PAT		16/01/2004	16 - TRANSFER TO ANOTHER HOSP	20/01/2004	FRIENDLY SOCIETY PVT	
	P222	15/10/1938	PAT	PAT	1/10/2004	16 - TRANSFER TO ANOTHER HOSP	13/10/2004	BIGGENDEN HOSPITAL	

RN	Name-TRANSFERRED	DOB	Dr Discharge	Surgeon	Admit Date	Discharge Disposition	Discharge Date	Transfer Hospital	Comment
	P226	12/11/1936	PAT		27/07/2004	16 - TRANSFER TO ANOTHER HOSP	29/07/2004	GIN GIN HOSPITAL	
	P20	05/11/1947	PAT	PAT	19/11/2004	16 - TRANSFER TO ANOTHER HOSP	4/12/2004	Royal Brisbane & Women's	Em51 C2 IR18 staple
	P228	20/09/1931	DELA	PAT	14/03/2005	16 - TRANSFER TO ANOTHER HOSP	16/03/2005	FRIENDLY SOCIETY PVT	
	P232	03/06/1930	PAT	PAT	28/08/2003	16 - TRANSFER TO ANOTHER HOSP	29/08/2003	Royal Brisbane & Women's	
	P233	22/08/1945	SML	PAT	9/02/2004	16 - TRANSFER TO ANOTHER HOSP	12/02/2004	GREENSLOPES PRIVATE	
	P239	12/05/1942	PAT	PAT	22/03/2005	16 - TRANSFER TO ANOTHER HOSP	25/03/2005	Hervey Bay	
	P240	20/08/1940	PAT	PAT	24/09/2004	16 - TRANSFER TO ANOTHER HOSP	25/09/2004	Mater - Bundaberg	
	P243	30/11/1930	PAT	PAT	30/10/2004	16 - TRANSFER TO ANOTHER HOSP	1/11/2004	WESLEY HOSP-A'FLOWER	
	P245	25/08/1983	PAT	PAT	6/02/2005	16 - TRANSFER TO ANOTHER HOSP	7/02/2005	Holy Spirit	Em24
	P253	10/10/1927	MCAR	PAT	8/07/2003	16 - TRANSFER TO ANOTHER HOSP	8/07/2003	ST ANDREWS WAR MEMO	
	P254	22/01/2001	PAT	PAT	10/11/2004	16 - TRANSFER TO ANOTHER HOSP	12/11/2004	Royal Children's	
	P256	18/08/1933	MCAR	PAT	25/04/2004	16 - TRANSFER TO ANOTHER HOSP	10/05/2004	REDCLIFFE HOSPITAL	
	P258	20/05/1935	JEN	PAT	10/11/2003	16 - TRANSFER TO ANOTHER HOSP	8/12/2003	MATER ADULT PRIVATE	
	P262	18/10/1943	PAT		15/02/2005	16 - TRANSFER TO ANOTHER HOSP	17/02/2005	Royal Brisbane & Women's	
	P263	05/12/1933	PAT		17/09/2004	16 - TRANSFER TO ANOTHER HOSP	23/09/2004	GAYNDAH HOSPITAL	
	P265	26/01/1923	PAT	PAT	12/08/2003	16 - TRANSFER TO ANOTHER HOSP	14/08/2003	ST ANDREWS WAR MEMO	R5-Gas In biliary tree
	P26	16/07/1989		PAT	23/12/2004	16 - TRANSFER TO ANOTHER HOSP	1/01/2005	Royal Brisbane & Women's	Em24, R6, SL2, Em41
	P269	20/12/1966	PAT	PAT	3/03/2005	16 - TRANSFER TO ANOTHER HOSP	7/03/2005	Royal Bris	
	P271	05/05/1938	PAT	PAT	17/08/2004	16 - TRANSFER TO ANOTHER HOSP	18/08/2004	Royal Bris	
	P275	10/10/1937	PAT	PAT	2/03/2004	16 - TRANSFER TO ANOTHER HOSP	3/03/2004	Royal Bris	
	P32	07/10/1937	MCAR	PAT	7/02/2004	16 - TRANSFER TO ANOTHER HOSP	11/02/2004	Royal Brisbane & Women's	SL1-TH
	P277	13/11/1951	PAT	PAT	4/03/2005	16 - TRANSFER TO ANOTHER HOSP	4/03/2005	PAH	
	P282	21/09/1944	PAT	PAT	29/09/2003	16 - TRANSFER TO ANOTHER HOSP	30/09/2003	CHILDERS HOSPITAL	
F	P286	27/10/1951	PAT	PAT	23/11/2004	16 - TRANSFER TO ANOTHER HOSP	25/11/2004	Royal Brisbane & Women's	
F	P257	11/05/1969	PAT		14/11/2003	16 - TRANSFER TO ANOTHER HOSP	15/11/2003	MATER ADULT PUBLIC	
	P36	17/04/1931	PAT	PAT	18/01/2005	16 - TRANSFER TO ANOTHER HOSP	14/02/2005	MATER ADULT PUBLIC	Em51

RN	Name-TRANSFERRED	DOB	Dr Discharge	Surgeon	Admit Date	Discharge Disposition	Discharge Date	Transfer Hospital	Comment
	P289	19/02/1924	PAT	PAT	3/02/2005	16 - TRANSFER TO ANOTHER HOSP	5/02/2005	Royal Brisbane & Women's	
	P90	24/10/2003	PAT	PAT	11/11/2003	16 - TRANSFER TO ANOTHER HOSP	13/11/2005	Royal Children's	
	P299	18/12/1950	PAT	PAT	23/09/2003	16 - TRANSFER TO ANOTHER HOSP	24/09/2003	Holy Spirit Northside	
	P303	17/03/1926	PAT	PAT	23/12/2004	16 - TRANSFER TO ANOTHER HOSP	24/12/2004	Royal Brisbane & Women's	
	P304	19/09/1926	PAT	CHAU	16/11/2004	16 - TRANSFER TO ANOTHER HOSP	26/11/2004	CALVARY PRIVATE HOSP	Em25
	P307	14/09/1952	ROB	PAT	9/09/2003	16 - TRANSFER TO ANOTHER HOSP	3/10/2003	Royal Brisbane & Women's	
	P309	28/10/1935	PAT		11/11/2003	16 - TRANSFER TO ANOTHER HOSP	12/11/2003	FRIENDLY SOCIETY PVT	
	P312	16/11/1935	CON	PAT	5/03/2004	16 - TRANSFER TO ANOTHER HOSP	9/03/2004	Royal Brisbane & Women's	
	P314	02/05/1948	PAT		19/02/2004	16 - TRANSFER TO ANOTHER HOSP	22/02/2004	REDCLIFFE HOSPITAL	
	P53	10/02/1945	MIA	PAT	10/12/2003	16 - TRANSFER TO ANOTHER HOSP	12/12/2003	Royal Brisbane & Women's	PL5, FN7, C5
	P319	14/09/1924	PAT	AND	1/02/2005	16 - TRANSFER TO ANOTHER HOSP	10/02/2005	FRIENDLY SOCIETY PVT	
	P320	03/11/1938	PAT		16/02/2005	16 - TRANSFER TO ANOTHER HOSP	23/02/2005	BIGGENDEN HOSPITAL	
	P323	03/03/1978	PAT	PAT	29/11/2004	16 - TRANSFER TO ANOTHER HOSP	3/12/2004	GIN GIN HOSPITAL	
	P324	30/11/1932	PAT	PAT	7/11/2003	16 - TRANSFER TO ANOTHER HOSP	11/11/2003	Royal Brisbane & Women's	
	P327	24/09/1920	PAT	PAT	20/09/2003	16 - TRANSFER TO ANOTHER HOSP	23/09/2003		
	P46	19/04/1961	CON	PAT	26/09/2004	16 - TRANSFER TO ANOTHER HOSP	27/09/2004	Royal Brisbane & Women's	

66 WITH 6 DECEASED

Patients of Dr Patel Discharged to another hospital

URN	Name	DOB	Dr D/C	Surg	Admit Date	Discharge Disposition	Discharge Date	Transfer Hospital	Comment
1	P18	22/12/1939	PAT	PAT	5/06/2003	02 - OTHER HOSPITAL	20/06/2003	MATER ADULT PUBLIC	
	P137	11/11/1935	MCAR	PAT	9/05/2003	02 - OTHER HOSPITAL	14/05/2003	ROYAL BRIS & R'MOUNT	IR15
	Note: Patient P18 on Transfer/Deceased Elsewhere list								

APPENDIX D. POTENTIAL ADVERSE OUTCOME PATIENT LIST

APPENDIX D		ADVERSE OUTCOMES			OTHER PATEL	
Patient Name	Ur No	DOB	DOA	D/C	Referral	Comment
P71		06/07/1941	03/03/2005	11/03/2005	Complaint, interview & email	JW CR3, Em24
P8		12/08/1942	19/09/2003	20/09/2003	R3- peritoneal dialysis cath	
P9	(	13/09/1924	16/01/2004	28/01/2004		dehis R1 Em5, R6
P170		05/02/1973	11/10/2004	12/10/2004	R6	
P171		18/06/1964	30/01/2004	30/01/2004	Liaison referral	
P10		19/6/25	19/06/1925	3/07/2003	CR20	dehis R1, Em5
P174		24/09/1949	22/04/2003	22/04/2003	Liaison referral	
P175		19/11/1927	16/05/2003	19/05/2003	Liaison referral	LH- bladder punc CR7
P178		08/06/1949	31/07/2004	02/08/2004	C31	
P181		29/06/1988	21/11/2004	25/11/2004	Liaison referral	
P183		4/04/1920	4/11/2004	22/11/2004	Liaison referral	
P186		9/10/1937	8/08/2003	11/08/2003	Liaison referral	
P190		30/07/1997	07/07/2003	07/07/2003	interview/email	
P14		5/09/1930	19/10/2003	8/04/2004	radiology report, Ms Hoffman referral	SL1 R6
P15		4/05/1941	25/10/2004	15/11/2004	post op haematoma incident report	R6, IR3
P151		2/07/1944	13/08/2003	22/08/2003	WS24, PL1, C6	
Daisy, Marilyn	005225	15/04/1961	16/09/2004	06/10/2004	SL13, 18	
P16		21/09/1932	11/04/2003	11/04/2003	radiology report, Patient Complaint	SL1
P198		18/04/1948	17/11/2003		Patient Complaint C1	
P203		10/08/1941	23/08/2004	24/08/2004	Ms Hoffman referral	
Fleming, Ian	016934	12/01/1955	19/05/2003	23/05/2003	C13, 21	
P214		30/10/1928	27/09/2004	12/10/2004	Ms Hoffman referral	
P216		3/06/1970	10/02/2005	10/02/2005	Ms Hoffman referral	
P219		16/11/1931	3/09/2003	21/09/2003	Ms Hoffman referral	
P223		5/10/2020	29/05/2003	3/06/2003	infected hip wound Robinson surgery	IC Report

Patient Name	Ur No	DOB	DOA	D/C	Referral	Comment
P265		13/03/1953	13/09/2004	13/09/2004	Liaison Referral	
P231		7/10/1943	23/09/2004	22/10/2004	Allied Health Referral	Em51
P230		02/02/1929	14/02/2005	23/02/2005	Allied Health Referral	Em51
P237		13/9/1976	7/8/2003	12/8/2003	follow up post surgery- colonoscopy 18/6/05 after liaison referral	WS10
P127		14/10/1937	3/08/2004	17/08/2004	wound dehiscence 3/7 post op ?who closed the wound	R6,IR4
P2		26/02/1931	5/08/2004	5/08/2004	Em24	
P249		09/10/1935	27/08/2004	03/09/2004	thoracotomy 31/8/04	wedge resection Em38
P250		4/10/1967	18/03/2004	18/03/2004		
P5		23/07/1931	3/02/2005	4/02/2005	referral from A/HRs Nurse/email	JW, LH CR1 Em24
P108		11/11/1962	20/09/2003	22/09/2003		
P252		18/06/1967	21/03/2005	22/03/2005	Allied Health Referral	Em
P255		21/12/1969	31/10/2004	03/11/2004	chart not copied	completed JW CR6
P257		10/11/1942	28/05/2003	30/05/2003		
P24		29/11/1943	30/09/2003		R3- Peritoneal Catheter, R7	WS1-OTD, infection
P261		3/03/1945	27/10/2003	10/11/2003		
P267		1/11/1941	10/11/2004	22/11/2004		
P27		21/03/1956	27/1/04	30/1/2004	Dr Carter Patient	SL1 re transfer CR27
P270		15/02/1937	7/03/2005	14/03/2005	R6	
P31		23/09/1962	12/08/2003	23/08/2003	R3- Peritoneal Catheter, R7	
P99		21/08/1959	15/03/2004	15/03/2004	WS17 C15	
P106		23/04/1968	14/03/2005	19/03/2005		
P280		18/08/1943	16/11/2004	1/12/2004		
P35		10/03/1999	19/03/2004	19/03/2004	Gall Aylmer referral Em28	CR7 LH
P285		8/05/2002	6/08/2004		Complaint from Mother	
P284		19/01/1951	4/07/2003	14/07/2003	C8	
P131		9/12/1937			CR30 breast Carcinoma	PL3,4 FN6 & C3
P288		07/02/1931	14/04/2003	03/05/2003	R6	

Patient Name	Ur No	DOB	DOA	D/C	Referral	Patient Name
P293		22/06/1982	10/03/2005	10/03/2005		C4
P37		7/02/1932	10/08/2004	6/09/2004	radiology report	SL1-Ms Hoffman
P298		25/09/1952	22/03/2004	22/03/2004	Liaison Referral	
P39		06/08/1930	29/08/2003	20/09/2003	Hoffman COI statement	
P300		10/02/1944	6/07/2004	9/07/2004		
P40		26/09/1957	4/07/2003	13/07/2003	SL11, R6	
P38		13/03/1943	11/02/2005	inpatient	C14, 20 R6	Allied Health Referral
P49			? Patel Patient		Hoffman COI statement IR22	Inapprop. admit to paeds
P305		29/03/1945	14/07/2003	16/07/2003	Liaison Referral	
P41		9/07/1942	18/10/2004	1/11/2004	SL1-TH R6	
P42		9/06/1999	? Patel Patient		Gail Aylmer referral- re appendicectomy Em28	
P306		25/03/1943	6/01/2004	16/03/2004	R6-WOUND DEHISCENCE	IR12
P310		28/01/1955	22/12/2003	27/12/2003	Incident report-pigtail catheter introducer left insitu	
P315		29/12/1952	22/10/2004	22/10/2004	C10	
P318		25/01/1948	3/10/2003	5/10/2003	Em51-Allied Health	
P321		19/09/1926	06/10/2003	07/10/2003	Hoffman COI statement	R3, R7
P330		11/04/1968	28/01/2004	30/01/2004		69 Patients

APPENDIX D ADVERSE OUTCOMES					NON PATEL PATIENTS	
Patient Name	Ur No	DOB	DOA	D/C	COMMENT	COMMENT
P8		1/08/1945			Not admitted, **not correct patient**	diabetic neuropathy CR25
P332		4/09/1930			chart not copied	CR9 MM
P336		1/9/1914			Complaint from Family	CR33 MM Query faecal impact-acute abdo not diagnosed
P338		25/11/1971	26/04/2002	28/04/2002	website	CR33MM
P339		16/01/1963	16/01/2003	episode change	referred ICU staff ?Joan not Leesa	PAH BIU CR32MM ?CORRECT PATIENT
P340		29/10/1952	9/08/2004	10/08/2004	complaint, website & letter	Ortho WS32 Scar, sorenessCR31MM
P51		19/05/1949	22/12/2003		Dr Miach Referral	Incorrect Clinical Diagnosis CR45MM
P341		29/07/1966	28/09/2002		Legal Report	CR14 JW
P342		16/12/1983			Allied Health referral	CR2 JW- no issues id.
P129		4/04/1954			Allied Health Referral	Em51 CR37MM
P344		24/04/2002	24/04/2002	28/04/2002	website child of siobhann brown	WS33 CR19MM
P345		31/01/1953	21/01/2004	21/01/2004	Liaison Referral	CR38MM
P346		19/01/1940	15/03/2002	20/03/2002	Liaison Referral DOD 15/5/2002	CT scan Missed lesion on first scan (report)
P347		2/02/1922			chart not copied	CR8 MM, C30 NZ Transfer
P130		27/04/1948	28/08/2004	11/09/2004	R6, IR19 necrotising fascitis	CR33MM
P105		27/01/1943	1/02/2002	5/03/2002	Em51, C23	incident report-necrotizing fascilitis CR42
P348					R6-Rectal Bleeding not reviewed for 6 days	CR40
P349		27/12/1960	29/10/2002	5/11/2002	Website, Letter WJ/Stumer	Post op haematoma CR24, PL7, WS35
P350		26/12/1948	2/11/2004	4/11/2004	Website WS26	behaviour, hernia, infect O&G OP R/V CR43
P351		23/06/1981			??? Correct patient, never an inpatient	CR36MM
P352		22/01/2005	21/01/2005	25/01/2005	Website letter	CR23, WS25
P353		15/08/1980	14/03/2005	17/03/2005	Jenny White OT notification FN11	Patel/Stumer op- appendix- no histology CR29MM
P354		21/05/1916	21/08/2003	4/09/2003		MI/Acute abdo Gaffield op issue with xray reports CR26
P355					Gynae Pt NUM ANC referral	CR39 MM
P356		20/03/1958	18/11/2004	18/11/2004	PLO Referral confusion over surgeon	Ovarian cyst spontaneously resolved CR21
P357		18/08/1964	16/04/2005	19/04/2005	StrachanTransfer to St Andrew's ICU	Strachan-Junior doctor to care for sick patient CR28
P162		28/04/1938	24/03/2003	9/04/2003	Original oesophagectomy Dr Feint	CR15 JW & CR22MM WS7 ?WRONG RESULTS
P358		14/03/1942	22/04/2004	23/04/2004	Dates on pathology & op notes vary, histo track path original request done	CR22 WS7
P359		28/01/1960	13/08/2004	19/08/2004	FN18 PLO log CR34 haemorrhage post hysterectomy-Wijeratne	29 Patients (2 Incorrect patients)

2. List of those patients with a brief clinical summary in whom Dr Patel was considered <u>to have contributed</u> to an adverse outcome.

P170

11/10/04 Repair of incarcerated right inguinal hernia. Vas deferens divided inadvertently, scrotal haematoma became infected. Reoperation 3/12/04, further re-operation 10/12/04. Cultured organism, staphylococcus aureus. The patient's son of 10 years age was admitted as an inpatient around this time for staphyloccal infection of both lungs and kidneys.

P175

Underwent completion thyroidectomy and associated neck dissection 16/5/03 for tall cell variant papillary thyroid cancer. Inadvertent jugular venotomy repaired. Post operatively considered to have a residual metastatic node. Excised and shown histologically to be the right submandibular gland. Salivary fistula resulted.

P11

Admitted under the care of Dr Gaffield 25/7/04 following blunt chest trauma. CT scan revealed contusions of both lungs and fractured ribs. Clinically well for two days but deteriorated noticeably at 1300hrs 27/5/04, BP falling to 50mm and haemoglobin 77 gdl. Noted to be in acute respiratory distress and right underwater seal drain non-functional. Transferred to the Intensive Care Unit. Second intercostal drain, endotracheal intubation and ventilation performed. Flight Coordinator contacted at 1620hrs. CT scan showed right haemothorax under tension with no evidence of pericardial collection. Underwater seal drain recorded as patent with minimal drainage at 2315hrs 26/7/04. Stable throughout the night with no complaint of pain. Statement of Dr Patel and Dr Carter document the rapid deterioration of the patient's condition. Following provisional diagnosis of pericardial tamponade Dr Patel attempts to drain the pericardium. Patient in extremis, considered too ill for transfer which was cancelled at that time. He succumbed and at autopsy was found to have three (3) litres of clotted blood in his right chest under tension with displacement of the mediastinum to the left. No pericardial effusion nor damage to the myocardium.

P180

Admitted 8/6/03 with five (5) day history of constipation and abdominal distension, past history of hypertension and cardiac arrhythmia. X-ray revealed multiple fluid levels. Dr Patel's notes 8/6/03 1930hrs, an example of comprehensive and lucid assessment. Surgery 9/6/03 Incarcerated epigastric hernia repaired. Inadvertent enterostomy oversewn. Discharged home 15/6/03, incision clean and dry. Readmitted 20/6/03 with shortness of breath and confusion. Klebsiella pneumonia. Pleural effusions- drained 800mls serosanguinous fluid. Failure to wean from ventilator. Transferred ventilated to the Mater Private Hospital, Intensive Care Unit, Brisbane 30/6/03.

P14

Underwent removal of ovarian carcinoma and sigmoid colectomy 29/3/04. Discharged home but brought by ambulance 8/4/03 with wound dehiscence. Radiology 29/7/04 suggests obstruction of left kidney.

P15

Admitted 25/10/04 following fourth attack of acute cholecystitis. Underwent laparoscopic cholecystectomy that day. Developed post operative haematoma and bile leak, washed out 26/10/04. Further abdominal wall haematoma resulted in open re-operation 29/10/04. Discharged home 15/11/04. On 23/11/04 noted to have incisional hernia. Booked for repair.

P126

Following repeated rectal bleeding seen by Dr Patel 29/4/03. CT scan showed no phlegmon or abscess. Left abdominal tenderness and localised segment of sigmoid colon abnormal on CT scan. Pros and cons of management considered. Dr Patel records that patient wanted to proceed with surgical resection. Procedure, alternatives and risks discussed, consent obtained and sigmoid colectomy booked. Admitted 19/5/03 and discharged 23/5/03. Attended 29/5/03 with sero-sanguinous discharge from the wound. Admitted. Initially managed conservatively by Dr Patel but continuing purulent discharge, wound opened completely. Discharged home 4/6/03. Continued PR bleeding post operatively. Colonoscopy 20/1/04 reports multiple and large diverticula 30cms from the anal verge. Histology of resected specimen describes 70 x30 x 30 mm segment of colon with diverticula extending to resection margins.

P18

Trans-hiatal oesphagectomy and partial gastrectomy 6/6/03. Noted to have metastases in the pericardium and nine (9) of fourteen (14) lymph nodes positive and liver metastases present. Suffered a vocal cord paralysis and respiratory failure post operatively. Developed AMI and peritonitis. Transferred to the Mater Intensive Care Unit. Past history of coronary artery bypass graft and occluded left internal carotid artery. Paralysed vocal cord contributed to post operative aspiration. Two (2) wound dehiscences- 12/6/03 and 16/6/03, both required suturing in operating theatre. Leakage from jejeunostomy site oversewn in operating theatre 18/6/03. Patient discharged home 18/8/03.

P20

Laparoscopic cholecystectomy by Dr Patel. Developed subhepatic haematoma which became infected. Drained by Dr Patel 26/11/04. Further laparotomy 28/11/04. Transferred to Royal Brisbane Hospital 9/12/04 because of failure to wean from ventilator, continued sepsis and development of ARDS. Transferred back to Bundaberg Hospital and seen by Dr Patel 25/12/04. Noted to have a soft, non-tender abdomen. Drain removed. Discharged home 31/12/04.

P263

Admitted with pancreatic mass producing biliary and gastric obstruction. CT scan revealed 4cm pancreatic carcinoma. CA-19-9 measured 90. At laparotomy, the 10-15cm mass considered unresectable. Cholecystojejeunostomy and gastrojejeunostomy performed 22/9/03. Patient died 1/10/03.

P238

Admitted to the Royal Brisbane Hospital 14/12/02. Underwent partial removal of pancreas and stomach. Further procedure performed Royal Brisbane Hospital February 2003 for drainage of pseudocyst. This subsequently recurred. Cultures grew pseudomonas. CT scan 3/6/03 reported 5-6cm cyst in lesser sac posterior to stomach adherent to gastric wall. 24/6/03 Dr Patel records proposed procedure and alternatives. Explains risks to the patient and records that all questions were answered and consent signed. Admitted 30/6/03. Dr Patel's operative notes of that date describes the satisfactory drainage of the pseudo-cyst into the stomach. Patient died 2/7/03.

P136

Attended the Day Surgery Unit for removal of skin lesions. Both he and the first patient on list had Christian name P136 Nurse addressed patient by just first name. No formal nursing handover. Armband not checked by nurse, Dr Patel or anaesthetist. OGD performed on Mr P136 prior to performing his planned procedure.

P21

Ivor Lewis Oesophagectomy for tumour at the gastro oesophageal junction on 20/12/04. Unacceptable quantities of bright blood accumulated in the drains post operatively. Returned to Operating Theatre for exploratory laparotomy and right thoracotomy. Splenectomy performed. Despite thirty-nine (39) units of blood/products, patient exsanguinated. History included repair of abdominal aortic aneurysm in 2002 accompanied by renal failure, on fourth post operative day transferred to Royal Brisbane Hospital. CT scan preceding oesophagectomy described ectasia of his thoracic aorta and loss of tissue definition between oesophagus and aorta.

P26

Transferred to Bundaberg by helicopter following motorcycle accident. Deep extensive left groin laceration and lacerated femoral vein. Examined in Bundaberg 1150hrs, peripherally shutdown, HR 150, BP 80 and pallor++. Bleeding from left groin oozing through packs held in place by manual pressure. First aid team reported massive blood loss at scene. Resuscitated via 16 and 14 gauge cannulae in right arm with 0 negative blood. He received eleven (11) units of red cells or fresh frozen plasma. Taken straight to the operating theatre.

Findings included 1cm laceration in left femoral vein at saphenofemoral junction, transected rectus femoris with lacerated fascia and adductor muscles. Femoral artery and nerve considered intact. Pubic ramus periosteum on view. IDC placed. Manual pressure pack removed. Femoral vein clamped to achieve haemostasis. Venous laceration sutured with 5/0 prolene. Artery and nerve explored. Thorough washout performed. Dead tissue and foreign body debridement performed. Adductor fascia approximated,18 french bellovac drain placed and wound closed. Sent to x-ray for CT scan and other x-rays. Foot remained pulseless and cold. Returned to operating theatre. Fasciotomies performed. Returned to ICU at 1750hrs 23/12/04 but pulse still absent. Urine output 130mls per hour, noted to be dark and considered to contain myoglobin. Tested positive for blood. Shock persisted despite adequate volume replacement. Left leg considered threatened. The cause was questioned. Noted that pulses were absent but good supply to tissues. Considered ischaemia may be secondary to venous obstruction. Comment expressed "if no improvement may need to consider transfer to the Royal Brisbane Hospital".

Ultrasound examination of left groin reported fair flow through the iliac proximal to the injury site, haematoma in the groin and no arterial flow in the 'posterior tibial artery, peroneal and dorsalis'. Seen by Dr Patel at 2030hrs. He recorded need for urgent exploration and evacuation of clot. He informed the family, took Mr P26 to theatre and grafted an occluded femoral artery. Seen again by Dr Patel 24/12/04 at 0630hrs, foot described as having scattered patchy mottling. Foot warm with good capillary filling and sensation 'ok'. His recorded assessment was of a repair of a lacerated femoral vein with left leg and thigh fasciotomies and repair of endoluminal injury of the common femoral artery. Reported as stable with a perfused foot, skin mottled secondary to microembolisation. The coagulopathy had been corrected. Dr Patel records that he still has haemoglobinuria, myoglobinuria- plan continue observations, clear fluids only, check labs. 24/12/04 1730hrs Dr Patel, fasciotomy site changed with significant bulging of muscles, fibres viable, some reduction in area of mottling. 25/12/04 0740hrs, remains ecchymotic distally, warm with capillary filling. 0940hrs haemoglobinuria clearing with mannitol infusion. 1810hrs dressings attended by Dr Patel. 26/12/04 0815hrs stable, urinary output 'tick', muscle viable, leg warm to ankle, foot cold with diffuse mottling, foot drop. Assessment- stable, graft open, may lose some foot tissue secondary to microemboli. Plan- mannitol today, continue current management. Dr Gaffield will follow until Dr Patel returns from leave 11/1/05. 27/12/04 Palpable dorsalis pedis & posterior tibial pulse recorded but not found with dopler. Commented that there was clinical evidence of improvement.

Transferred to ward and reviewed with Dr Gaffield. Ward round with Dr Gaffield on 1/1/05, reported posterior tibial pulse palpable but discussion with Dr Gaffield re transfer of the patient to the Royal Brisbane Hospital. Comment recorded by vascular staff at the Royal Brisbane Hospital that the arterial

reconstruction with PTFE performed by Dr Patel on the night of 23/12/04 was still functioning. Limb gangrenous and amputated at the Royal Brisbane Hospital.

P270

7/3/05 Symptomatic para oesophageal hernia repair and splenectomy
Wound dehiscence 8/3/05

P30

Tenkhoff catheter 12/11/03 but 'flipped under the liver'. Clinical background included end stage renal failure, chronic peritoneal dialysis, haemoptysis and a positive d-dimer. 17/12/03, Dr Patel attempted a permacath insertion. This proved difficult. Difficulty attributed to previous catheter placements and radiotherapy. Patient died 17/12/03. Post mortem- death attributed to haemopericardium associated with perforated thoracic veins, cardiac failure, end-stage renal failure, hypertension and chronic obstructive airways disease.

P34

Oesophageal biopsy 23.4.03- poorly differentiated invasive adenocarcinoma associated with Barrett's oesophagus. No evidence of metastases.
Underwent oesophagectomy 19/5/2003. End-stage renal failure, on dialysis and suffering hyperkalaemia. Patient died 21/5/03 2215hrs.

P288

Low anterior resection 14/4/03. Post-op anastomotic leak. Treated with transverse colostomy and mucus fistula. Colostomy closed 18/7/03. Admitted with wound infection 3/8/03. Discharged home 11/8/03.

P37

Admitted 10/8/04 with acute abdominal pain. Past history of AMI and coronary stent. At 0710hrs, 13/8/04, Dr Patel notes the patient continues to have abdominal pain. CT scan confirms incarcerated ventral abdominal wall hernia. 23/8/04, 10 days post operatively, some wound breakdown is noted. CT scan reveals a mass, query collection. Original operative note records serosal tear with the diathermy. 25/8/04, formal evacuation of haematoma performed. No fascial defect evident.

P40

History of sigmoid colectomy for diverticula disease 24/11/01. 4/7/03 underwent laparotomy where rectosigmoid mass considered unresectable and therefore transverse colostomy and mucus fistula performed. Following closure of colostomy 23/2/04, developed significant post operative right iliac fossa pain. 27/2/04 at 2300hrs noted by Dr Patel to be tachycardic and febrile. Abdomen distended and tender. Presence of abdominal sepsis of questionable aetiology raised by Dr Patel. 28/2/04, he performed exploratory laparotomy. Two (2) litres of non purulent fluid drained. On testing anastomosis 2mm enterotomy noted. 4/3/04 Dr P Andersen expressed

concern regarding ongoing intra abdominal sepsis and recommended further laparotomy. Later that day, Dr Patel explored abdomen, drained abdominal abscess and performed loop ileostomy. Although he comments that the colonic anastomosis was intact, he considered this source of the sepsis. Discharged 15/3/04.

P41

Colonoscopy 4/3/04- two (2) large flat adenomas distal to caecum. Considered too large for endoscopic removal. Dr Patel performed subtotal colectomy 22/4/04. Histology revealed multiple adenomata with high grade dysplasia. No evidence of malignancy. Second procedure by Dr Patel 27/4/04, bowel leak oversewn at the anastomosis and covering ileostomy performed. Ileum transected with a GIA80 stapler. Third procedure performed by Dr Anderson 8/5/04 following wound dehiscence. Non STEMI MI occurred 26/4/04. During August 2004, ileostomy closed. Note recorded 24/11/04 from clinic that patient returned for review post drainage of abdominal wall collection which occurred following the closure of the ileostomy.

P306

6/1/04 following perforated diverticulum and abscess formation, colectomy performed with the establishment of colostomy. Protracted recovery, metabolic dysfunction, ongoing fever spikes and recurrent abdominal collection. Subsequent wound infection leading to dehiscence, DVT occurred in left leg extending into iliac veins. Stoma retracted, eventually requiring second operation for colostomy refashioning due to development of subcutaneous fistula to midline abdominal wound.

3. Did Dr Patel contribute to adverse outcomes? Maybe

P10
Sigmoid colectomy and high anterior resection 26/6/03 for colonic obstruction. Wound dehiscence 3/7/03 one day post discharge.

P71
Following abdominoperineal resection 24/1/05, suprapubic catheter placed. Letter from Dr Anderson 18/4/05 states the patient sustained urethral injury while undergoing AP resection performed by Dr Patel. Dr Patel's operative note of the abdominoperineal resection states large anterior rectal carcinoma invading into the prostatic urethra and bladder, accidental tear of bladder neck while dissecting the tumour secondary to tumour invasion was repaired and drained. The sigmoid was divided with a GIA stapler.

P190
Operation notes by Dr Patel 7/7/03, left hydrocele requiring left herniotomy, hydrocele sac ligated. 3/9/03, recurrent hydrocele post repair. Aspirated 8mls of yellow fluid. 10/9/03, further 5mls of fluid aspirated. 17/9/03, swelling much smaller. 12/10/03, hydrocele returned- 13mls drained via 25 gauge needle. Parents anxious to have definitive treatment. Patient reviewed by Dr Patel 29/10/03 with a note, return in 6 weeks for possible sac excision.

Daisy 15/4/61 Ur 005225
Amputation of second left toe January 2004. Three other toes noted to be ulcerated in this diabetic patient suffering end-stage renal failure. 6/8/04, amputation of the left 4th toe performed by Dr Patel. 7/9/04, wound noted to be infected with a draining foot. Dr Patel performed below knee amputation. 14/10/04, stump noted to have three areas of localized skin necrosis. 5/10/04, Dr Gaffield placed permacath for further dialysis. 25/11/03, although correctly situated permacath was not working. Dr Miach spoke to the Royal Brisbane Hospital and arranged transfer for permanent access.

P56
12/11/04 Permacath insertion by Dr Patel not working. Appropriate Transfer

P200
Admitted 13/9/04 with ruptured abdominal aortic aneurysm. Crystalloid resuscitation produced free intraperitoneal rupture, troublesome juxtasuture line bleeding encountered. Patient died.

P214
Invasive adenocarcinoma of rectum excised 27/9/04. Letter of 4/3/05 states his principle complaint is urinary incontinence. Post void bladder scan suggests bladder empties normally and slight leakage may be due to nerve damage at the time of AP resection. Denies any new pains and is eating well. During operation GIA60 stapler used. Histology revealed rectal

adenocarcinoma which infiltrated perirectal fat. Adenocarcinoma within 4 perirectal lymph nodes. 23/10/04, drainage of pelvic abscess by perineal access performed by Dr Patel.

P161

Presented with jaundice, weight loss and anaemia. CT scan revealed a 5cm lesion in the head of the pancreas with streaming of the peri pancreatic fat planes, displacement and encasement of SMA & V. Malignancy closely applied to small bowel loops and considered there may be localised extension to small bowel mesentery. Suggestion in bony mode of the scan of a few small lesions. Whipples operation September 2004, surgery and early post operative care appears to have gone well. Histopathology reports focal soft tissue metastases to the soft tissues of the greater curvature area, the tumour extends to the surgical margin of the pancreas. Comments in progress notes of hypoxia, over sedation and pneumonia. Patient died 12 days post operatively of Klebsiella pneumoniae considered to have followed aspiration of vomitus.

P216

Referred to Dr Patel following failed right vasectomy by GP under local anaesthetic. Underwent right redo vasectomy 10/2/05. Infection evident 14/2/05 as was haematoma and swelling. 9/3/05, one month post vasectomy, haematoma still present and hadn't reduced in size. No pain in testicle, occasional pain running into the inguinal region. Suture line had not healed and palpation of periwound area produced some ooze from incision. Dr Patel reviewed patient and commented on a residual haematoma, no sign of infection. Dr Patel reassured patient haematoma would resolve spontaneously.

P222

Seen by Dr Patel 15/9/04, noted CT findings of large left renal mass assessed as metastatic renal cell carcinoma. Left nephrectomy booked. Patient developed pathological fracture of left humerus. Gram positive cocci cultured from subsequent nephrectomy wound. Considered the patient's malnutrition, anaemia and renal failure a contributing role in development of wound infection. Trauma and blood loss considered possible significant contributing factors.

P224

Admitted 26/5/03 with history of carcinoma of lung and thyroid cancer, poorly differentiated. CT scan revealed large thyroid mass displacing the trachea, with some retrosternal extension and partial obstruction of left jugular vein which contained thrombus. Tumour declared non resectable. Incisional biopsy was obtained, trachea and tumour were inseparable. Carotid artery could not be identified. Died 1/7/2003.

P127

5/8/04 segment of sigmoid and descending colon excised. Moderately differentiated adenocarcinoma with invasion of pericolic fat. Following passage of nasogastric tube, a gag reflex resulted and is claimed to have ruptured the suture. Consequent visceral dehiscence repaired. Discharged home 17/8/04 following uneventful recovery. Represented 21/8/04 with abdominal pain and assessed as suffering possible intra-abdominal sepsis. 28/8/04 markedly improved. Discharged home 2/9/04 but reported to have large hernia in the abdomen from past surgery performed years ago.

P245

Fractured femur jumping from roof to surrounds of swimming pool 9/1/05. Subsequently developed acute gangrenous appendicitis. Open appendectomy by Dr Patel 26/1/05. Further collection occurred around caecum. Drained through sciatic notch by Dr Nathanson following transfer to Wesley Hospital.

P5

Parathyroidectomy, post-operative DVT. Stockings but no chemical DVT prophylaxis.

P259

Admitted 29/9/03 with vomiting++ and tender abdominal mass. Provisional diagnosis of partial bowel obstruction. Complex history having undergone aorto-femoral bypass 1993, aorto-renal bypass 1998. Despite COAD still smoking and in June 2003 being cared for by Dr Miach and Dr Kerswell for chronic renal failure. Initially managed conservatively. 3/10/03, during the night oxygen 'saturations' reduced, urinary output likewise reduced. Temperature, rigors and rapid atrial fibrillation developed. Discussed with Dr Gaffield and Dr Patel agreed to review question of laparotomy. Performed 3/10/03. Assessed by Dr Patel post operatively 7am 4/10/03 and noted 5/10/03 at 0745hrs to remain drowsy but more awake than last night after Narcan. At 7.20pm sudden marked deterioration. 7am following day, Dr Patel notes progressively more acidotic and still had no urinary output. Patient died 7/10/03.

P28

Sigmoid colectomy and colostomy 23/5/03 for bleeding diverticula disease. Past history radical radiotherapy for Ca prostate. 30/5/03 'retching at times throughout night', wound dehiscence, fascial defect closed with O nylon and tension sutures. 1/6/03 4.15pm abdominal distension and ascites, tympanitic colostomy site completely occluded by stoma adhesive. Ultrasound- 3x3cm echogenicity right lobe liver. CT query normal. 14/6/03 faecal vomit and aspiration. ETT and transfer to ICU. Died 14/6/03.

p273

Long history of recurrent kidney infections and hypothyroidism. To undergo colonoscopy for investigation of iron deficiency anaemia. Long term Brufen for septic arthritis considered possible factor in anaemia although recent 6kg weight loss, development of colicky abdominal pain noted. Bowel prep arranged at home but attempted colonoscopy 16/4/03 abandoned because of inadequate preparation. Admitted 21/5/03 very disorientated, confused and unable to state what procedure she was having or date of birth. The performance of colonoscopy raises questions of appropriateness of case selection. No biopsy performed.

p99

Admitted 15/3/04 for hernia repair. At operation, no hernia found. Scar tissue from paramedian wound excised. 24/3/04, infection noted in wound associated with burning pain. Examination revealed tenderness in right iliac fossa and 7cm wound with purulent discharge.

p35

Right inguinal hernia repair 2/8/04 by Dr Patel. Mother noticed blood stained urine and thought the child was incontinent. Question of a bladder injury. Child passed urine satisfactorily and was discharged from hospital. Left inguinal hernia repair performed 12/8/04

p36

Diabetic patient admitted 18/1/05 with subacute bowel obstruction. 21/1/05, Dr Patel records observations and management plan. Operation 22/1/05, 4 litre aspirate removed from stomach via NG tube, subtotal colectomy for obstructive colonic carcinoma. Post operative biventricular heart failure and cardiac ischaemia. Dr Patel's notes of 23/1/05 0930hrs suggest 'third spacing'. Returned to theatre for abdominal decompression. Abdominal compartment syndrome diagnosed. Ischaemic colon just distal to anastomosis treated by ileostomy. 29/1/05, developed atrial flutter which reverted to sinus rhythm. Collapse after aspiration requiring re-intubation and ventilation. Transferred to Mater Hospital, Brisbane.

p297

p297 suffering chronic renal failure underwent low anterior resection 15/12/03. Died 24/12/03. In the clinical summary anuric renal failure mentioned. Dr Patel's post operative statements show maturity and compassion. Review of notes does not exclude the possibility of ureteric injury. The death certificate records respiratory failure, fluid overload for 7 days, chronic renal failure for years, hypertension, angina, gout and atrial fibrillation. This case raises questions of preoperative judgement.

p298

Outpatients 24/2/04 with bilateral inguinal hernia, reducible and symptomatic. Also noted an umbilical hernia. Bilateral inguinal hernia repairs 22/3/04.

Outpatients 21/4/04, noted he was well, the wounds were healed and he was discharged to the care of GP. Reviewed 28/4/05 by Dr Barry O'Loughlin, Director of Surgery, Royal Brisbane Hospital seconded to Bundaberg. He assessed P298 noting that his main complaint was of pain preoperatively which still persists post operatively including pain in the left testicle. He recorded that slowly things are settling down. On examination, the wounds were healed, no hernia obvious, tenderness in the left inguinal region, the testicles were normal both left and right. He diagnosed ongoing neuralgia and suggested an injection of local anaesthetic and hydrocortisone or removal of the mesh used for the hernia repair. An ultrasound examination of 3/8/04 reported that the thickening and echogenicity of the spermatic cord associated with an elongated anechoic structure is puzzling. No suggestion of flow. Possibly this represents a solitary thrombosed vessel or a thrombosed varicocele.

P38

Completion colectomy 11/2/05 with formation of ileorectal anastomosis. Laparotomy by Dr Gaffield 20/2/05 revealed 1200cc of bile stained fluid within peritoneal cavity. He fashioned loop ileostomy and left drain insitu. Mrs P33 : history was complex having undergone resection of appendiceal carcinoma in 2000 by right hemicolectomy. History of uterine carcinoma 2003.

P98

Admitted with painless jaundice, no history of fever or chills, the abdomen was non tender, no ascites, liver ++ and palpable gall bladder. Ultrasound revealed dilated intrahepatic ducts and gallbladder. Hypoechoic mass in porto hepatis noted. Distal common bile duct normal. CT scan confirmed above findings. Provisional diagnosis of cholangiocarcinoma just distal to the cystic duct. Explained to patient. Surgery undertaken 29/12/03, metastatic adenocarcinoma of the gall bladder and omentum found. Patient died 30/12/03. No obvious explanation of the mode of death. The case has been referred to the coroner.

4. **List of patients where it was considered Dr Patel operated outside his scope of expertise or that of the hospital**

P18

Oesophagectomy & partial gastrectomy -extent of surgical morbidity & complications

P21

Ivor Lewis Oesophagectomy and thoracic aortic disease- clinical judgement

P34

Oesophagectomy, the patient suffering end-stage renal failure on dialysis –clinical judgement

5. List of patients where it was considered Dr Patel <u>maybe</u> operated outside his scope of expertise or that of the hospital

P16

Ivor Lewis Oesophagectomy 2/12/03 & splenectomy. Review 17/ 2/04 doing fine weighed 65kg. 18/8/04 no nausea, vomiting, pain or diarrhoea. Still smoking 10 cigarettes per day. 1/9/04 CT scan no metastases – outcome puts patient in 'maybe'.

P161

Whipples operation for carcinoma head of the pancreas. CT findings indicating displacement and encasement of the superior mesenteric artery and vein – questions surgical judgement. Variance of Dr Patel's pre-op assessment and that of Radiologist.

P224

CT demonstration of a large thyroid mass displacing the trachea with some retrosternal extension and partial obstruction of left jugular vein which contained thrombus- clinical judgement.

P238

Drainage of a pseudocyst in a patient who had previously undergone two complex upper gastrointestinal procedures at the Royal Brisbane Hospital.- clinical judgement.

P297

Low anterior resection in a patient with chronic renal failure, hypertension, angina and atrial fibrillation. –clinical judgement.

6. Table: Patients where clinical management was considered reasonable

UR	DOB	Name	CLINICAL DIAGNOSIS
	19/9/36	P164	Died of peritonitis following steroid therapy
	2/2/70	P165	Burns- appropriate transfer
	12/10/64	P166	Self inflicted stab wound to the heart repaired. Discharged home
	035864	P8	Tenkhoff catheter insertion.
	13/9/24	P9	Sigmoid colectomy for carcinoma May 03 Biliary drainage Jan 04
	26/10/18	P167	Left above knee amputation for gangrene
	12/12/64	P168	Motor Vehicle Accident, multi trauma, appropriate transfer
	9/9/19	P169	Fractured skull following a fall, appropriate transfer
	18/6/64	P171	Laparoscopic cholecystectomy for symptomatic cholelithiasis
	9/4/84	P172	Incision and drainage of perianal abscess April 2003 A further abscess developed on the posterior aspect of the left thigh in May 2003
	31/8/44	P173	Metastatic bowel cancer palliative care RBWH
	24/9/49	P174	Excision of multiple skin lesions
	27/7/65	P176	Excision of multiple sebaceous cysts Nov 2003. Sustained a fatal unrelated cardiac arrest 15/8/04
	24/4/19	P177	Bleeding internal haemorrhoids normal colonoscopy
	8/6/49	P178	Anterior resection of poorly differentiated Duke's D tumour with multiple secondaries performed by Dr De Lacey at Mater Private Hospital. Post operative wound infection drained by Dr Patel.
	17/6/41	P12	Perforated duodenal ulcer oversewn with an omental patch July 2003. Slow post operative progress from respiratory view point, appropriate transfer
	6/12/72	P179	Multi trauma appropriate transfer
	9/4/45	P50	Underwent a wide resection by Dr Patel December 2003. The wound was closed surgically. Initially did well but later as an outpatient developed several areas emitting foul smelling discharge. Following a panniculectomy by Dr Gaffield in February 2004 developed a necrotic abdominal wall cavity with underlying calciphylaxis. Appropriate treatment of carbuncles.
	29/6/88	P181	Appropriate care
	27/7/28	P49	Hyperemesis secondary to a duodenal tumour. Multiple co-morbidities appropriate transfer
	8/10/32	P182	End stage renal failure, dysphagia, laparotomy 1/4/03 inoperable carcinoma, stent placed for inoperable oesophageal obstruction. Barium swallow revealed complete obstruction of a meshed oesophageal stent within the tumour. No surgical option available to relieve his oesophageal obstruction
	4/4/20	P181	Hemicolectomy for carcinoma of the caecum discharged home
	28/6/03	P184	Referred via the Royal Children's Hospital with terminal acute myeloid leukaemia for palliative therapy. Left subclavian Hickmans line septic, removed by Dr Patel 7/10/04. Patient died 6/11/04
	11/4/13	P185	Appropriate transfer.
	9/10/37	P186	Open cholecystectomy 8/8/03
	6/8/24	P187	Fatal ruptured abdominal aortic aneurysm
	23/7/65	P188	Motor vehicle accident head injury transferred from Biggenden to Royal Brisbane Hospital via Bundaberg
	15/8/42	P189	Carcinoma of the uterus 1998 Admitted for palliative care 19/4/03 Died 25/4/03

UR	DOB	Name	CLINICAL DIAGNOSIS
	5/6/48	P191	Appropriate transfer with Respiratory failure
	8/6/25	P192	Right direct inguinal hernia no operation
	4/7/20	P193	Transfer from Gladstone for placement of a caval filter for VTE by Dr Theile
	7/1/49	P194	Appropriate transfer
	2/2/44	P151	Total Hip replacement Dr Patel involvement satisfactory
	2/12/44	P195	Appropriate transfer
	9/4/43	P196	Appropriate transfer
	11/4/86	P147	Motor Vehicle accident appropriate transfer
	18/4/48	P198	Repair of recurrent inguinal hernia
	27/2/56	P199	Appropriate care
	7/12/52	P201	Appropriate transfer
	25/9/34	P202	Liver cirrhosis, carcinoma of the lung, incarcerated epigastric hernia repair. Died 23/4/04
	10/8/41	P203	Anal fistulotomy
	20/11/31	P204	Disseminated malignancy Total gastrectomy 4/11/03 Admitted 24/4/04 end stage disseminated malignancy Died 30/6/04
	14/4/47	P205	Appropriate care.
	30/5/44	P206	Appropriate transfer
	9/7/25	P207	Admitted 19/8/03 with superior mesenteric embolism. Laparotomy -extensive necrotic bowel supportive treatment only. Died 19/8/03
	9/3/65	P208	Admitted 20/9/03 with multiple co-morbidities including gram negative sepsis and neutropaenia. Underwent left femoral embolectomy 21/9/03. Died 21/9/03
	5/3/13	P209	Appropriate transfer
	5/7/59	P210	Admitted 8/9/04 cholangiocarcinoma with left lung metastasis. A percutaneous stent insitu. Appropriate transfer Died 11/1/05
	17/8/40	P211	Appropriate transfer
	1/1/61	P212	Excision of angiomyolipoma involving right ureter discharged home
	22/9/33	P213	Acute pancreatitis with an impacted stone in the ampullae Dilated ducts appropriate transfer
	20/4/27	P217	Admitted 3/4/03 with gall stone pancreatitis. Previous cholecystectomy at RBWH. Appropriate transfer
	18/10/47	P218	Admitted 17/11/03 with metastatic pancreatic carcinoma Discharged home 21/11/03 Died 6/12/03
	16/11/31	P219	Removal of portacath and insertion of permacath
	11/12/47	P220	Admission 30/7/04 exploratory laparotomy large necrotic mass in the region of the head of the pancreas. Gastrojejeunostomy and T tube drainage of the bile duct. Discharged to Biggenden Hospital 18/8/04
	26/7/08	P221	Appropriate transfer
	5/10/20	P223	Fractured left neck of femur appropriate supervision
	13/3/53	P225	Complex recurrent breast cancer following previous surgery and radiotherapy
	12/11/36	P226	Left below knee amputation. Appropriate transfer
	19/3/44	P227	Admitted 9/3/04 with disseminated malignancy including liver metastasis and malignant ascites. Died 28/3/04
	20/9/31	P228	Incision and drainage of perianal abscess Appropriate transfer
	17/10/30	P229	Admission 13/12/04 with abdominal and back pain weight loss and anaemia. Open gall bladder exploration 13/12/04 & liver biopsy. Findings carcinoma of the gall bladder with a mass involving the bowel and invading liver. Portal structures involved in the mass which was considered unresectable. Three core biopsies were taken of the liver. Referred to Gayndah Hospital for palliative care

UR	DOB	NAME	CLINICAL CONDITION
	27/4/48	P130	Admitted 28/8/04 with cholecystitis. Laparoscopic Cholecystectomy Dr De Lacey 29/8/04. Developed necrotizing fasciitis CT findings included gas in the abdominal wall and the subcutaneous fat. The underlying tissue was oedematous and infected tracking back to the lateral edge of the extensor back muscles. Dr Patel performed an extensive debridement and fasciotomy Discharged home 11/9/04
	13/8/27	P19	Complex dialysis access in a frail patient involving Dr Patel on 13/12/03 and Dr Theile on 24/12/04 Patient deceased 25/1/04
	2/2/29	P230	Nissen Fundoplication 14/2/05 Patient offered laparoscopic treatment in Brisbane but declined
	7/10/43	P231	Debridement of diabetic foot
	3/6/30	P232	Appropriate transfer for treatment of a 10cm abdominal aortic aneurysm in August 03. Excision of a left hydrocele in August 04. Incisional hernia repair October 04
	22/6/45	P233	Removal of infected intrathecal catheter for chronic pain relief. Appropriate transfer
	1/11/45	P234	Appropriate palliative care following laryngectomy and radiotherapy for carcinoma
	3/7/27	P235	Excision of skin lesions
	13/9/76	P237	Resection for Crohns disease
	11/11/35	P137	Admitted 9/5/03 underwent a splenectomy for a splenic tear which occurred secondary to a laparoscopic adrenalectomy by Professor Gough at Royal Brisbane Hospital on 14/4/03. Patient was transferred back to the RBH on 14/5/03 –a portion of a "non cutting" suture needle broke and become embedded in the pancreas and was left insitu
	12/5/42	P239	Peripheral vascular disease with multiple co morbidities Appropriate transfer
	20/8/40	P240	Palliative care of advanced lung cancer
	17/11/56	P241	Admitted 23/5/03 with metastatic breast carcinoma Deceased 24/10/03
	25/4/24	P242	Admission 17/2/04 Discharged 19/2/04 No surgery Deceased November 2004
	30/11/30	P243	Admitted 30/10/04 to the Bundaberg Hospital with peritonitis and overwhelming sepsis as a consequence of a rectal polypectomy by colleague at the Mater Private Hospital on 28/10/04. Dr Patel's comment of 30/10/04 12MN recorded the extremely poor prognosis of the required laparotomy. The patient was transferred post operatively to the Wesley Hospital and died on 22/12/04
	8/2/78	P244	Laparoscopy revealing pelvic inflammatory disease plus the removal of a normal appendix
	18/6/10	P22	Admitted to the BBH from a nursing centre with a sigmoid volvulus with impending perforation. Sub total colectomy with an ileostomy was performed 31/7/04. Patient developed renal failure and died 17/8/04
	26/2/31	P2	Excision of skin lesions
	7/2/62	P246	Admitted 22/11/04 for palliation following right hemicolectomy in February 03 by Dr Baker at which time hepatic metastases were evident. Died 21/2/05
	6/4/20	P247	Respiratory arrest 6/4/03 following resection of haemorrhagic small bowel with areas of focal haemorrhage, mucosal infarction and perforation with localised peritonitis Patient died 22/4/03

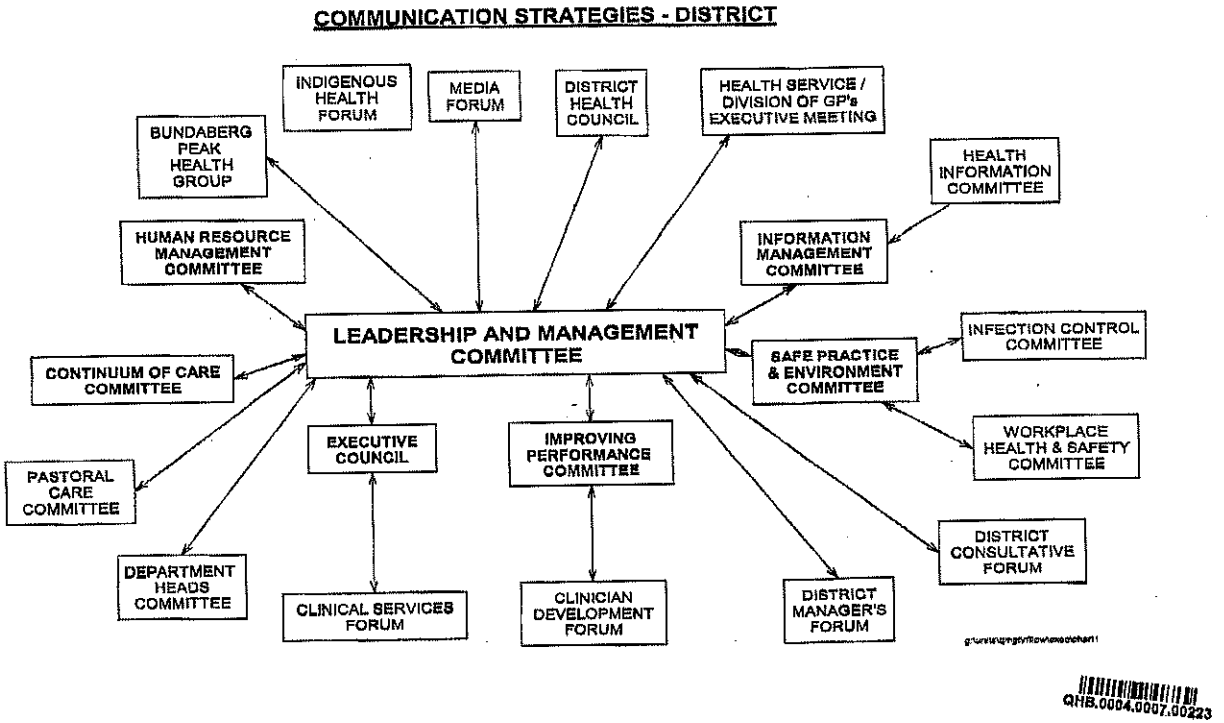
IR	DOB	NAME	CLINICAL CONDITION
	4/7/42	P248	Palliative care for terminal carcinoma
	9/10/35	P249	Wedge resection left lung
	4/10/67	P250	Excision of sebaceous cyst
	12/12/26	P251	Palliative care of colonic cancer
	11/11/62	P108	Perianal abscess
	18/6/67	P252	Waiting list for lap cholecystectomy
	10/10/27	P253	Transfer from SFPH with perforated colon following a colonoscopy by Dr Strahan Laparotomy and repair of perforated sigmoid colon Dr Patel 8/7/03 CT angiogram 6/8/03 extensive pulmonary embolus Patient died of Pulmonary embolus 6/8/03
	22/1/01	P254	Swallowed coin
	21/12/69	P255	MVA Appropriate treatment
	13/9/38		Transferred to Childers Hospital for palliative care following right hemicolectomy for metastatic carcinoma
	18/8/33	P256	Admission from SFPH with sub acute bowel obstruction. Carcinoma of the colon resected with establishment of colostomy on 29/4/04. End stage COAD resulted in a tracheostomy on 7/5/04. Transferred to the Redcliffe Hospital for long term ventilation. Died 30/ 5/04
	10/11/42	P257	Excision of breast lesion
	29/11/43	P24	Tenkhoff catheter insertion and repositioning
	20/5/35	P258	Appropriate transfer
	9/12/21	P260	Infection and recurrent carcinoma of the thyroid subsequent to previous non-Patel surgery. Dr Patel management appropriate.
	3/3/45	P261	Recurrent abdominal hernia problems following initial repair in May 01 with mesh. Abscess April 02. Treated December 02 by Dr De Lacey for periumbilical empyema. Wound probed. CT 29/10/03 reported a sub cutaneous abscess and enterocutaneous fistula. At operation by Dr Patel on 5/11/03 a fistula was apparent between the appendix and the anterior abdominal wall. The appendix stump was stapled.
	18/10/43	P262	Appropriate transfer
	5/12/33	P263	Appropriate transfer
	14/8/09	P264	Admitted from Gayndah 21/3/04 with bowel obstruction and an irreducible right inguinal hernia. Previously considered unfit for surgical repair of his inguinal hernia in both Maryborough and Bundaberg Hospitals by other surgeons. Removed from Dr Baker's category one waiting list 3/12/01. Dr Patel elected conservative treatment Patient died 23/3/04.
	26/1/03	P265	Admission 12/1/04 for end stage palliative care of thyroid carcinoma Patient died 17/1/04. This record gives insight into the compassion and concern of Dr Patel
	12/3/1905	P266	Ischaemic right leg, amputation. Appropriate transfer
	1/11/41	P267	Anterior resection of rectal carcinoma locally invading bladder wall
	21/3/56	P27	Multi trauma Appropriate transfer after relief of a tension pneumothorax
	14/6/25	P268	Admitted 11/9/03 under Dr Miach with shortness of breath, vomiting and diarrhoea History of many admissions for COAD, iron deficiency anaemia with a haemoglobin 64 and RCC 2.64. A colonoscopy in 2001 had revealed diverticular disease. It was considered that the patient was not for resuscitation and the patient expired 16/9/03
	20/12/66	P269	Appropriate transfer for management of obstructive jaundice

UR	DOB	NAME	CLINICAL CONDITION
	5/5/38	P271	Appropriate transfer
	23/9/62	P31	Complex dialysis patient Appropriate removal of pericardial tube
	15/7/53	P272	Excision biopsy left groin
	15/2/32	P274	Laparotomy 4/11/04 Inoperable tumour Pleural effusion drained Patient died 7/11/04
	10/10/37	P275	Recurrent laryngeal carcinoma Appropriate transfer
	2/1/22	P276	Transferred from Eidsvold Hospital 17/7/04 with PR bleeding Past history of 3 total hip replacements, CVA, diabetes & bronchiectasis. Dr Patel's preoperative assessment and management considered appropriate. Patient continued to bleed PR. Sigmoid colectomy performed on 23/7/04. Troponin leak Patient died 25/7/04
	7/10/37	P32	Admitted with bowel obstruction of 7 days standing Appropriate transfer
	13/11/51	P277	Appropriate transfer
	23/4/68	P106	Multilocular clear cell carcinoma of the kidney
	4/7/50	P278	Appropriate transfer
	1/2/42	P279	Referred from Childers Hospital with non functioning colostomy Narrowed stoma refashioned Patient suffering widespread metastatic disease
	8/8/43	P280	Subtotal gastrectomy for carcinoma
	28/8/38	P281	Transferred from RBH 4/2/04 Ischaemic heart disease, extensive vascular disease, COAD, CRF. Died 11/2/04
	21/9/44	P282	Recurrent breast cancer Appropriate surgery and transfer Recurrent ovarian carcinoma with metastases Levine shunt 23/2/04 Patient died 4/3/04
	17/12/31	P283	Recurrent ovarian cancer with metastases subsequent to previous non-Patel surgery 2002. Dr Patel management appropriate
	19/1/51	P284	Laparotomy and adhesiolysis for small bowel obstruction
	8/5/02	P285	Challenging cystic hygroma Managed with appropriate consultation with Staff at the RCH
	27/10/51	P286	Appropriate referral
	11/5/69	P287	Appropriate transfer
	9/12/37	P131	Management of breast disease in consultation with Dr Gaffield
	19/2/24	P289	Appropriate transfer
	24/10/03	P290	Appropriate transfer for surgery to correct pyloric stenosis. Vomiting post operatively required re-operation
	3/2/26	P291	Admission 10/9/03 with 8 weeks of abdominal discomfort and nausea 12/9/03 ilio-colic anastomosis for a non resectable caecal carcinoma Discharged home 17/9/03 Follow up at surgical outpatients 30/9/03 patient satisfactory
	13/12/41	P292	Amputation of toe
	22/6/82	P293	Excision of swanuoma right thigh
	29/11/21	P294	Laparotomy 25/11/03 at Mater Private Bundaberg –Dr Andersen. Inoperable situation with tumour antrum invading the pancreas. Cholegastrojejeunostomy performed. Sustained respiratory arrest in recovery. Transferred to Bundaberg Hospital to the care of Dr Patel. Died 26/1/04
	25/2/93	P295	Admitted 8/2/04 Discharged 13/2/04 to the RCH with subacute bowel obstruction. Died 7/1/05
	7/4/38	P296	Metastatic neck carcinoma. Fine needle aspiration, panendoscopy revealed normal tissue. Dr Patel biopsied a cervical node. The wound healed satisfactorily. The patient died 31/8/04.

UR	DOB	NAME	CLINICAL CONDITION
	6/8/30	P39	Motor Vehicle accident, 5 fractured ribs, loculated haemothorax left chest with poorly expanded lungs 10/9/03 left thoracotomy DR Patel
	8/12/50	P299	Appropriate transfer
	27/7/34	P334	Medical demise
	10/2/44	P300	Pancreatitis, cholecystectomy Appropriate transfer
	28/7/35	P301	Complex dialysis patient of Dr Miach suffering polycystic disease Admitted 29/3/03 with chills, fever, pain in the right upper quadrant and jaundice. It was considered that he may have ruptured a liver cyst. His condition deteriorated and on 3/4/03 Dr Miach on his ward round noted that he was unwell, jaundiced, confused with a blood pressure of 63/50 oximeter recorded 85 despite supplemental oxygen. The CT of his abdomen suggested a likely enlarged gall bladder. The patient was seen by Dr Patel on the request of Dr Miach. Dr Patel's comments are informative- Cholecystostomy 1500hrs Patient expired 4/4/03 2220hrs
	27/7/36	P302	Appropriate palliative treatment
	17/3/26	P303	Appropriate transfer
	8/10/87	P49	Insertion of PICC line
	19/9/26	P304	Appropriate transfer
	29/3/45	P305	Appropriate management of breast pathology
	9/6/99	P42	Not seen by Patel despite email to the contrary
	14/9/52	P307	Appropriate transfer
	30/6/41	P308	Abdominoperineal resection for adenocarcinoma with unresectable liver metastasises Died 20/12/04
	28/10/35	P309	Conservative management of PR bleeding transferred
	28/1/55	P310	
	23/4/34	P311	Admission 8/7/04 exploratory laparotomy revealed severely necrosed pancreas and colon. Considered non salvageable Patient died 13/7/04
	16/11/35	P312	Appropriate transfer
	26/7/32	P313	Admission 27/8/04 with ischaemic leg. Management discussed with RBH in relation to transfer. Toe amputated under local anaesthesia 7/9/04. Subsequent below knee amputation Died 12/10/04
	25/548	P314	Admitted 19/2/04 with pancreatitis. Appropriate transfer 22/2/04
	29/12/52	P315	Appropriate management of axillary mass
	13/8/41	P44	Appropriate management
	18/8/31	P316	Admitted 25/11/03 with cholecystitis. Histological examination of the gall bladder removed the following day revealed severe acute cholecystitis with focal gangrenous change in the wall. The patient's ejection fracture on echo cardiography was thirty per cent (30%). Appropriate discussion pre operatively of the prognosis and consent. Died 28/11/03
	17/4/39	P317	Ruptured abdominal aortic aneurysm with preoperative arrest
	25/1/48	P318	Appropriate management of chronic pancreatitis
	10/2/45	P53	Admitted 10/12/03 Difficulty obtaining dialysis access Transfer 12/12/03 Died 26/1/04
	14/9/24	P319	Admitted 1/2/05 following haemorrhage from presacral veins occurring during a rectopexy. Haemorrhage was controlled with packs. Following transfer to Bundaberg Hospital the packs were removed and the patient transferred back to FSPH on 10/2/05
	3/11/38	P320	Appropriate transfer
	19/9/26	P321	Insertion of Tenkhoff catheter

UR	DOB	Name	CLINICAL DIAGNOSIS
	27/12/25	P322	Right hemicolectomy
	3/3/78	P323	Lap Cholecystectomy Appropriate transfer
	30/11/32	P324	Appropriate transfer
	23/4/26	P325	Following a right nephrectomy by Dr Anderson on 16/9/04, the patient was admitted on 11/10/04 with lung metastases, cough and dsypnoea Patient died 21/10/04
	12/1/27	P326	Admitted 22/9/03 underwent a repair of a ruptured left common iliac aneurysm by Dr Theile. The wound dehiscence was resutured by Dr Patel on 23/9/03 Post operative fluid management was complex. There was suggestion of pulmonary embolism. The patient had a myocardial infarct. Patient died 22/10/03
	24/9/20	P327	Appropriate transfer
	3/6/20	P328	Admitted under the care of Dr Gaffield from Gin Gin Hospital on 9/10/04 with a diagnosis of oesophageal carcinoma OGD by Dr Patel complete oesophageal obstruction, malignant pleural effusion, palliative care
	15/3/27	P329	Admitted 8/12/03 defunctioning colostomy performed for an anal carcinoma Discharged home 12/12/03 Died 4/8/04
	19/4/61	P46	Appropriate transfer
	11/4/68	P330	Attempt at vasectomy under local anaesthesia abandoned and completed under a subsequent general anaesthesia
	9/10/31	P331	Insertion of portacath

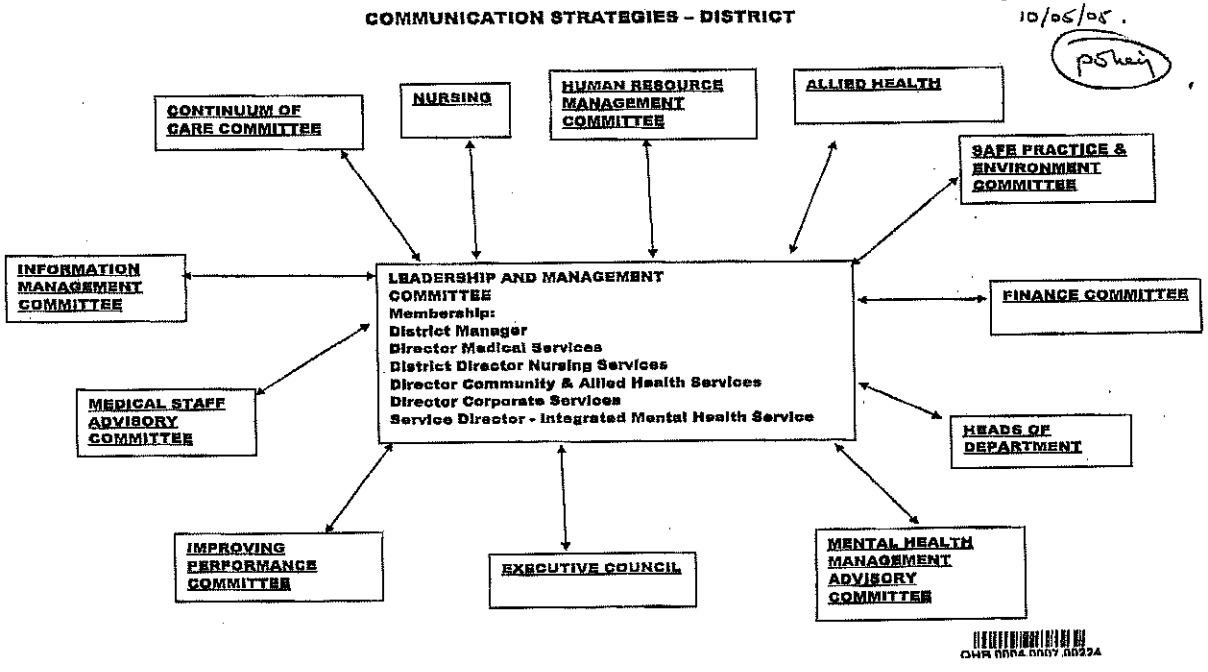
APPENDIX F. COMMUNICATION STRATEGIES MAP



APPENDIX F

developed last 2 weeks

provided by Justin McDonnell 10/05/05.



APPENDIX G SERVICE CAPABILITY FRAMEWORK CLINICAL SERVICE

Service Capability Framework Clinical Services and Levels of Complexity
Bundaberg Health Service District - BUNDABERG BASE HOSPITAL

	SCF Level for confirmation	SCF Range	Potential Gaps identified		Comments / Risk Management strategies
Core Clinical Services					
Emergency Services	Level 3	Primary, 1, 2 or 3 or Super-Specialist			
Endoscopy Services	Level 2	1, 2 or 3 or Super-Specialist			
General Surgery	Level 3	Primary, 1, 2 or 3 or Super-Specialist	Anaesthetic Services Pharmacy	Level 3 Level 3	
Internal Medicine	Level 3	Primary, 1, 2 or 3 or Super-Specialist	Pharmacy	Level 3	
Maternity Services	Level 3	1, 2 or 3 or Super-Specialist	Anaesthetic Services	Level 3	
Supporting Clinical Services					
Anaesthetic Services	Level 3	1, 2 or 3 or Super-Specialist			
Coronary Care Units	Level 3	1, 2 or 3			
Diagnostic Imaging	Level 3	Primary, 1 or 2			
High Dependency Units	N/A	Level 1			
Intensive Care Units (Adult)	Level 3	1, 2 or 3	Anaesthetic Services Endoscopy Services Pharmacy	Level 3 Level 3 Level 3	
Intensive Care Units (Paediatric)	N/A	Super-Specialist			
Interventional Radiology Level 1	N/A	Level 1			
Interventional Radiology Level 2	Level 2	Level 2			
Interventional Radiology Level 3	N/A	Level 3			
Neonatal Services	Level 3	1, 2 or 3			
Nuclear Medicine	Level 1	Primary, 1, 2 or 3			
Operating Suite Services	Level 3	Primary, 1, 2 or 3	Anaesthetic Services	Level 3	
Pathology	Level 3	Primary, 1, 2 or 3			
Pharmacy	Level 3	Primary, 1, 2 or 3			

6/08/2005

* An asterisk next to two Gaps means only one of the two need to be met to satisfy requirements.

Service Capability Framework Clinical Services and Levels of Complexity
Bundaberg Health Service District - BUNDABERG BASE HOSPITAL

Surgical Sub-specialty	SCF Level for confirmation	SCF Range	Potential Gaps Identified	Comments / Risk Management strategies
Cardiac-thoracic surgery	NA	2, 3 or Super-Specialist		
Colorectal surgery	Level 3	2, 3 or Super-Specialist		
Ear, nose and throat surgery	NA	2, 3 or Super-Specialist		
Endocrine surgery	NA	2, 3 or Super-Specialist		
Gastrointestinal surgery	Level 3	2, 3 or Super-Specialist		
Gynaecology	Level 3	2, 3 or Super-Specialist		
Hepatobiliary and pancreas	NA	2, 3 or Super-Specialist		
Maxillofacial surgery	NA	2, 3 or Super-Specialist		
Neurosurgery	NA	2, 3 or Super-Specialist		
Ophthalmology	NA	2, 3 or Super-Specialist		
Orthopaedic surgery	Level 3	2, 3 or Super-Specialist		
Otolaryngology - head and neck	NA	2, 3 or Super-Specialist		
Paediatric surgery	NA	2, 3 or Super-Specialist		
Plastic and reconstructive	NA	2, 3 or Super-Specialist		
Podiatric surgery	NA	2, 3 or Super-Specialist		
Urology	Level 3	2, 3 or Super-Specialist		
Vascular surgery	Level 3	2, 3 or Super-Specialist		

* An asterisk next to two Gaps means only one of the two need to be met to satisfy requirements.

5/05/2005

Service Capability Framework Clinical Services and Levels of Complexity
Bundaberg Health Service District - BUNDABERG BASE HOSPITAL

Medical Sub-specialty	SCF Level for confirmation	SCF Range	Potential Gaps Identified	Comments / Risk Management strategies
Burns	NA	2, 3 or Super-Specialist		
Cardiology	NA	2, 3 or Super-Specialist		
Clinical genetics/medical	NA	2, 3 or Super-Specialist		
Clinical haematology (excluding	NA	2, 3 or Super-Specialist		
Clinical immunology	NA	2, 3 or Super-Specialist		
Dermatology	Level 3	2, 3 or Super-Specialist		
Endocrinology	Level 3	2, 3 or Super-Specialist		
Gastroenterology	Level 3	2, 3 or Super-Specialist		
General paediatrics	Level 3	2, 3 or Super-Specialist		
Geriatrics	NA	2, 3 or Super-Specialist		
Hepatology	NA	2, 3 or Super-Specialist		
Infectious diseases	NA	2, 3 or Super-Specialist		
Neurology	NA	2, 3 or Super-Specialist		
Renal medicine	Level 3	2, 3 or Super-Specialist		
Rheumatology	Level 3	2, 3 or Super-Specialist		
Sleep medicine	NA	2, 3 or Super-Specialist		
Thoracic medicine	Level 3	2, 3 or Super-Specialist		

* An asterisk next to two Gaps means only one of the two need to be met to satisfy requirements.

6/05/2006

Service Capability Framework Clinical Services and Levels of Complexity
Bundaberg Health Service District - CHILDERS HOSPITAL

	SCF Level for confirmation	SCF Range	Potential Gaps Identified		Comments / Risk Management strategies
Core Clinical Services					
Emergency Services	Level 1	Primary, 1, 2 or 3 or Super-Specialist	Diagnostic Imaging	Level 1	
Endoscopy Services	NA	1, 2 or 3 or Super-Specialist			
General Surgery	Primary	Primary, 1, 2 or 3 or Super-Specialist	Operating Suite Services Diagnostic Imaging	Primary Level 1	
Internal Medicine	Level 1	Primary, 1, 2 or 3 or Super-Specialist	Diagnostic Imaging Pathology	Level 1 Level 1	
Maternity Services	NA	1, 2 or 3 or Super-Specialist			
Supporting Clinical Services					
Anaesthetic Services	Level 1	1, 2 or 3 or Super-Specialist	Operating Suite Services Diagnostic Imaging	Primary Level 1	
Coronary Care Units	NA	1, 2 or 3			
Diagnostic Imaging	Primary	Primary, 1 or 2			
High Dependency Units	NA	Level 1			
Intensive Care Units (Adult)	NA	1, 2 or 3			
Intensive Care Units (Paediatric)	NA	Super-Specialist			
Interventional Radiology Level 1	NA	Level 1			
Interventional Radiology Level 2	NA	Level 2			
Interventional Radiology Level 3	NA	Level 3			
Neonatal Services	NA	1, 2 or 3			
Nuclear Medicine	NA	Primary, 1, 2 or 3			
Operating Suite Services	NA	Primary, 1, 2 or 3			
Pathology	Primary	Primary, 1, 2 or 3			
Pharmacy	Level 1	Primary, 1, 2 or 3			

5/05/2009

* An asterisk next to two Gaps means only one of the two need to be met to satisfy requirements.

Service Capability Framework Clinical Services and Levels of Complexity
Bundaberg Health Service District - CHILDERS HOSPITAL

Surgical Sub-specialty	SCF Level for confirmation	SCF Range	Potential Gaps identified	Comments / Risk Management strategies
Cardiac-thoracic surgery	NA	2, 3 or Super-Specialist		
Colorectal surgery	NA	2, 3 or Super-Specialist		
Ear, nose and throat surgery	NA	2, 3 or Super-Specialist		
Endocrine surgery	NA	2, 3 or Super-Specialist		
Gastrointestinal surgery	NA	2, 3 or Super-Specialist		
Gynaecology	NA	2, 3 or Super-Specialist		
Hepatobiliary and pancreas	NA	2, 3 or Super-Specialist		
Maxillofacial surgery	NA	2, 3 or Super-Specialist		
Neurosurgery	NA	2, 3 or Super-Specialist		
Ophthalmology	NA	2, 3 or Super-Specialist		
Orthopaedic surgery	NA	2, 3 or Super-Specialist		
Otolaryngology - head and neck	NA	2, 3 or Super-Specialist		
Paediatric surgery	NA	2, 3 or Super-Specialist		
Plastic and reconstructive	NA	2, 3 or Super-Specialist		
Podiatric surgery	NA	2, 3 or Super-Specialist		
Urology	NA	2, 3 or Super-Specialist		
Vascular surgery	NA	2, 3 or Super-Specialist		

* An asterisk next to two Gaps means only one of the two need to be met to satisfy requirements.

8/05/2005

Service Capability Framework Clinical Services and Levels of Complexity
Bundaberg Health Service District - CHILDERS HOSPITAL

Medical Sub-specialty	SCF Level for confirmation	SCF Range	Potential Gaps identified	Comments / Risk Management strategies
Burns	NA	2, 3 or Super-Specialist		
Cardiology	NA	2, 3 or Super-Specialist		
Clinical genetics/medical	NA	2, 3 or Super-Specialist		
Clinical haematology (excluding	NA	2, 3 or Super-Specialist		
Clinical immunology	NA	2, 3 or Super-Specialist		
Dermatology	NA	2, 3 or Super-Specialist		
Endocrinology	NA	2, 3 or Super-Specialist		
Gastroenterology	NA	2, 3 or Super-Specialist		
General paediatrics	NA	2, 3 or Super-Specialist		
Geriatrics	NA	2, 3 or Super-Specialist		
Hepatology	NA	2, 3 or Super-Specialist		
Infectious diseases	NA	2, 3 or Super-Specialist		
Neurology	NA	2, 3 or Super-Specialist		
Renal medicine	NA	2, 3 or Super-Specialist		
Rheumatology	NA	2, 3 or Super-Specialist		
Sleep medicine	NA	2, 3 or Super-Specialist		
Thoracic medicine	NA	2, 3 or Super-Specialist		

8/08/2005

* An asterisk next to two Gaps means only one of the two need to be met to satisfy requirements.

Service Capability Framework Clinical Services and Levels of Complexity
Bundaberg Health Service District - GIN GIN HOSPITAL

	SCF Level for confirmation	SCF Range	Potential Gaps Identified		Comments / Risk Management strategies
Core Clinical Services					
Emergency Services	Level 1	Primary, 1, 2 or 3 or Super-Specialist			
Endoscopy Services	NA	1, 2 or 3 or Super-Specialist			
General Surgery	Primary	Primary, 1, 2 or 3 or Super-Specialist	Operating Suite Services	Primary	
Internal Medicine	Level 1	Primary, 1, 2 or 3 or Super-Specialist	Pathology	Level 1	
Maternity Services	NA	1, 2 or 3 or Super-Specialist			
Supporting Clinical Services					
Anaesthetic Services	NA	1, 2 or 3 or Super-Specialist			
Coronary Care Units	NA	1, 2 or 3			
Diagnostic Imaging	Level 1	Primary, 1 or 2			
High Dependency Units	NA	Level 1			
Intensive Care Units (Adult)	NA	1, 2 or 3			
Intensive Care Units (Paediatric)	NA	Super-Specialist			
Interventional Radiology Level 1	NA	Level 1			
Interventional Radiology Level 2	NA	Level 2			
Interventional Radiology Level 3	NA	Level 3			
Neonatal Services	NA	1, 2 or 3			
Nuclear Medicine	NA	Primary, 1, 2 or 3			
Operating Suite Services	NA	Primary, 1, 2 or 3			
Pathology	Primary	Primary, 1, 2 or 3			
Pharmacy	Level 1	Primary, 1, 2 or 3			

5/05/2005

* An asterisk next to two Gaps means only one of the two need to be met to satisfy requirements.

Service Capability Framework Clinical Services and Levels of Complexity
Bundaberg Health Service District - GIN GIN HOSPITAL

Surgical Sub-specialty	SCF Level for confirmation	SCF Range	Potential Gaps Identified	Comments / Risk Management strategies
Cardio-thoracic surgery	NA	2, 3 or Super-Specialist		
Colorectal surgery	NA	2, 3 or Super-Specialist		
Ear, nose and throat surgery	NA	2, 3 or Super-Specialist		
Epigastric surgery	NA	2, 3 or Super-Specialist		
Gastrointestinal surgery	NA	2, 3 or Super-Specialist		
Gynaecology	NA	2, 3 or Super-Specialist		
Hepatobiliary and pancreas	NA	2, 3 or Super-Specialist		
Maxillofacial surgery	NA	2, 3 or Super-Specialist		
Neurosurgery	NA	2, 3 or Super-Specialist		
Ophthalmology	NA	2, 3 or Super-Specialist		
Orthopaedic surgery	NA	2, 3 or Super-Specialist		
Otolaryngology - head and neck	NA	2, 3 or Super-Specialist		
Paediatric surgery	NA	2, 3 or Super-Specialist		
Plastic and reconstructive	NA	2, 3 or Super-Specialist		
Podiatric surgery	NA	2, 3 or Super-Specialist		
Urology	NA	2, 3 or Super-Specialist		
Vascular surgery	NA	2, 3 or Super-Specialist		

5/05/2008

* An asterisk next to two Gaps means only one of the two needs to be met to satisfy requirements.

Service Capability Framework Clinical Services and Levels of Complexity
Bundaberg Health Service District - GIN GIN HOSPITAL

Medical Sub-speciality	SCF Level for confirmation	SCF Range	Potential Gaps identified	Comments / Risk Management strategies
Burns	NA	2, 3 or Super-Specialist		
Oncology	NA	2, 3 or Super-Specialist		
Clinical genetics/medical	NA	2, 3 or Super-Specialist		
Clinical haematology (excluding	NA	2, 3 or Super-Specialist		
Clinical immunology	NA	2, 3 or Super-Specialist		
Dermatology	NA	2, 3 or Super-Specialist		
Endocrinology	NA	2, 3 or Super-Specialist		
Gastroenterology	NA	2, 3 or Super-Specialist		
General paediatrics	NA	2, 3 or Super-Specialist		
Geriatrics	NA	2, 3 or Super-Specialist		
Hepatology	NA	2, 3 or Super-Specialist		
Infectious diseases	NA	2, 3 or Super-Specialist		
Neurology	NA	2, 3 or Super-Specialist		
Renal medicine	NA	2, 3 or Super-Specialist		
Rheumatology	NA	2, 3 or Super-Specialist		
Sleep medicine	NA	2, 3 or Super-Specialist		
Thoracic medicine	NA	2, 3 or Super-Specialist		

5/08/2006

* An asterisk next to two Gaps means only one of the two need to be met to satisfy requirements.