Bundaberg Hospital *Commission of Inquiry*

STATEMENT OF P126

P126 makes oath and says as follows:

Background

1. I was born on 12 January 1955 in Melbourne, Victoria. I am married and a stay at home Dad with four children currently living at home. I reside in the Bundaberg district at an address I have provided to the Commission.

2. After my schooling, I became a registered home builder in Victoria. Later I joined the Victorian Police Force in 1978 and I served there until 1983. At that time, I received an honourable discharge because I suffered Post Traumatic Stress Disorder following some major set backs in my personal and professional life.

3. From 1990 through 1994 I studied at the Canterbury University, England via correspondence and was granted a Master of Business Administration (MBA) in International Trade and Business on 18 December 1994. Upon my return to Australia in 1996 I studied at the Airlie Beach Training College during 1999. We moved to Bargara later that year, and I worked as a fisherman, primarily spanner crabbing. In August 2000, following a serious motor vehicle accident and a serious boating accident (which occurred only a few days apart) I had a relapse of PTSD. I saw a Centacare Counsellor called Neil Crossland from 2001 to 2003 and I think that I only fully recovered in about late 2003.

Contact with Patel

4. In April 2001, I developed lower left abdominal pain. I was admitted to Bundaberg Base Hospital ("the Hospital"). I had a Barium Enema (Double Contrast) and a CT abdomen. I was diagnosed with diverticulitis and diverticular disease. They explained that it was a little rare for someone my age. They explained that it involves pockets of sediment and then infection in your lower colon and that you can die from it if it is not treated.

5. I continued to have a significant number of lesser attacks of pain in the lower left groin. In September 2002 I had a severe attack and I was admitted to the Hospital. The pain was excruciating. I was again admitted as an outpatient in February 2003 with a diverticular attack. The Hospital notes show that I was seen by a Dr Feint who conducted a Colonoscopy on 25 March 2003 and noted "moderate diverticular disease in sigmoid colon". The colonoscopy involved a general anaesthetic and the doctor putting a camera fitted with a light up the passage for exploration. By that time, the problems were becoming more frequent and increasingly painful.

6. In April 2003, I met Dr Patel. I was attending outpatients after a severe attack the previous month (March 2003) and I begged him to help me. By that time, I knew, from speaking to doctors, that surgery was only usually considered after there had been three serious attacks. Dr Patel was very charming. He

W.9.1 J.P. (C Dec'd)

was confident and he was a very powerful personality. He told me that he would do a sigmoid colectomy scheduled for 19 May 2003. He showed me the medical chart with the heading "Day Surgery Record Part B" dated 25 March 2003 and said that he would be resecting the section of colon from the first diverticulae to the last diverticulae, a length that he expected to be approximately 30cm of diseased area. He also showed me a diagram on the chart and explained when the colonoscopy was performed that the scope passed to the top of the ascending colon but at this stage the guiding wire in the scope fractured and the attempt was abandoned because steering of the scope was limited. He said not to be concerned, that the scope hadn't reached the caecum because the symptoms were of diverticular disease and he would be removing the whole diseased section. He explained that the operation involved taking out part of the descending colon from before and after the bend. I remember that he did not tell me anything about the dangers of infection although I certainly did know that such dangers existed.

7. On 19 May 2003, I attended the Hospital for the surgery as planned. I met with Dr Patel there. He told me that he would be performing the surgery and I believe that he did so. When I did a bowel movement after the surgery, I noticed that there was red blood. That had not happened before. The blood and internal bleeding continued and indeed continues to this day. It is a bright red colour and I understand now, from speaking to various doctors, that this is a sign that the blood is coming from an area close to the colon because, otherwise, it would be diluted and lose colour.

8. I saw Dr Patel again on 21 May 2003 when he was doing a ward round. He told me that the bleeding was normal. In any event, I was discharged on 22 May 2003.

9. The Hospital arranged for me to return on Wednesday 28 May 2003 so that Dr. Patel could remove the staples which had been affixed to my stomach wound during surgery. In the meantime I continued to notice blood with my bowel movements (so that I believe I was bleeding internally). There was also swelling and dark red discoloration around the operative wound on my stomach. I have two photographs taken by my wife on 28 May 2003 that show the infected wound on the morning the staples were removed by Dr Patel.

10. On Wednesday 28 May 2003, my wife went with me to see Dr Patel at the Hospital. I told him, as was the case, that I was in agony and that I couldn't eat or sleep or walk properly. The surgical wound was a deep dark red colour and the surrounding abdominal area was visibly affected. It was swollen and sore and I could barely walk because of the pain. My wife had to physically support me to enter into Dr. Patel's examination room. Dr Patel carefully inspected my wound and abdomen and said there was nothing wrong and there was no infection. He said it was all in my head and that I was bunging on an act. We were in outpatients at the time. There were two nurses with him. He said that, after the staples were taken out, I should go home, have a nice life and kiss the wife and kids.

Signed: . . . . . Deponent

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

11. Later on the following evening of Thursday 29 June, 2003, the wound blew out. That's the only way I can describe it. There was a hole about 1 or 1.5 cm at the top section of the surgery wound, and it was oozing puss and blood. My wife took me to the emergency department at Bundaberg Base Hospital at about 10.30 pm. The staff gave me morphine and made an additional incision measuring three cm to help drain the infection. I can remember that the nurses described the wound as sucking and blowing bubbles. They admitted me to the ward that night and my wife went home. I stayed in the ward for about a week.

12. On Friday or Saturday, one of the nurses treating me in the ward approached Dr Patel in my presence during his ward rounds. She said that she wanted to use a suction pump to drain more effectively the infection from the wound and that she also wanted to use wound dressings that she believed would be more effective in draining the infection. Dr Patel declined to authorise either. Indeed, he seemed to become angry that a nurse wanted to initiate any discussion about clinical solutions. I believe from discussions with nurses that a second nurse approached Dr Patel with the same requests over the Friday/Saturday period but, again, he denied the requests.

13. Dr Patel was not available on the Sunday. I understand from speaking to staff that he had that Sunday off. On the Monday 2 June 2003 at around 8 am he came in with a small entourage, as was usual, to conduct daily Ward Rounds. He was in a very bad mood and he seemed very agitated that the wound was not improving despite the massive and constant infusion of antibiotics over the previous 3 days. Dr. Patel said "We are going to have to fix this up."

14. After Dr Patel left the room, a junior doctor from the entourage came back to my room. It was a private single bed room. He said "Dr. Patel has sent me in to fix this up. Just lean back on your bed and close your eyes." I was not clear exactly what that meant. He told me to lean back, close my eyes and hold on to the sides of my Hospital bed. I started squirming from the pain, I had no idea what he was doing initially and immediately went into a state of shock as he proceeded to operate right there and then on my hospital bed. I felt a scalpel cut through my abdominal skin and then I felt him pulling the flesh of my abdomen apart. The doctor kept telling me to "keep still and stop moving around". I then felt him using an instrument. I looked up and saw that it was some type of surgical "Q Tip". He continued to separate the flesh of my abdomen down to the stomach muscles. The wound had been reopened an additional 15 cm, it was now approximately 18 cm in length, 5 cm in width and down to the underlying stomach muscles, which could be seen. I have a photograph that was taken by my wife the day after I was discharged from hospital.

15. The doctor didn't use or offer me any anaesthetic or any pain relief either before or after the procedure. It caused me excruciating pain. I screamed and indeed cried with agony. I had previously quit smoking cigarettes but later that day I was in such a distressed state that I rang a close friend to bring me a pack of cigarettes and unfortunately have still been unable to quit smoking again to this day.

Signed: . . . . . Taken by: . . . . . (c Dec)

Deponent Solicitor/Justice of the Peace

16. The doctor was in his early 20's. He had a medium to solid build and short brownish hair. He was Caucasian and he was about 5 foot 10 inches. I believe the man was a junior doctor but I cannot be sure of his exact identity without visual identification.

17. I have all copies of all the medical notes now, some extracts of which have been tendered before the Commission as Exhibit 66. They do not appear to disclose that someone other than Dr Patel did the wound reopening surgery. They do disclose that there was some dispute about my treatment amongst the staff.

18. Next time I saw Dr Patel I asked him why he didn't have someone give me an anaesthetic. He said that injections don't have any effect when you have a wound infection. I said he could have used morphine. I said I was on a drip and he could have just put morphine in there. He said it's expensive and he didn't want me to become addicted. I said that I had only received one shot of morphine when I was in the Emergency Department and that I hated the stuff but would have welcomed it before this procedure was performed. He seemed to scoff at my comments.

19. I was released on 4 June 2003 and booked into outpatients. The nurses told me that the wound was the kind that has to heal from the inside out. Because of that I needed regular cleaning and dressing. In the course of that process, I saw the two nurses mentioned in paragraph 12 who were with Dr Patel on 28 May 2003. I don't know their names. They are identified by signature or by number code on the charts. One was forty to forty-five; stout, short and with brown hair. The other was forty five to fifty, tall with dark brown hair. They both apologised and said that it was very obvious that I had a severe infection when I came in to have my staples removed but they said that they could not contradict the doctor. My last visit to the dressing clinic was on 7 July 2003. After this I dressed and cared for the wound myself.

20. In the Surgical Ward Review Notes there is an entry dated 16 July 2003 which states "wound healed completely discharged from clinic". This statement is not correct. The wound did not heal until late August 2003.

21. My problems never stopped. From August through October 2003 I attended at the Emergency Department at least 4 times and by ambulance on one of those occasions. I was suffering from constant abdominal pain now in the right central abdominal area, vomiting, nausea, dry retching, headaches and also the ongoing internal bleeding since the sigmoid colectomy. I visited my general practitioner often and I went to outpatients from time to time.

Signed: . . . . . Deponent

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

Formal complaint

22. On 28 October 2003 I made a complaint. I telephoned the executive offices at the Hospital. I said to a woman who identified herself as Joan that I'd like to make a formal complaint about my treatment by Dr. Patel. I asked how I do that in writing. She said that the complaint did not need to be in writing and that she could take it over the telephone and it would carry the same weight as if I myself had written. I said that there were four main points of my complaint, namely:
    (a) Dr Patel failed to diagnose the wound infection when the staples were removed;
    (b) Dr Patel refused to allow a suction pump and more appropriate dressings despite the requests of the nurses;
    (c) When the wound was reopened on 2 June, 2003, no anaesthetic or pain relief was used or even offered;
    (d) I was still bleeding internally and there was clearly something still wrong since the sigmoid colectomy surgery.

    Joan said that the Director of Medical Services would get back to me.

23. On Thursday 30 October 2003, I received a call from Dr Darren Keating, who introduced himself as the Director of Medical Services BBH and we had a lengthy conversation for 20 to 30 minutes. He said, "I hear you have lodged a complaint against Dr. Patel. I must tell you that he is a fine surgeon with impeccable credentials and we are lucky to have him here in Bundaberg. I understand you are bleeding internally since the operation but this can be caused by many factors."

24. I told him I had four complaints about Dr Patel and that the internal bleeding was just one of them. I asked if I could go through them with him and he said "sure".

25. I told him that my first complaint was that when I went to have my surgical staples removed my abdomen was red and swollen and I was in extreme pain and that the incision blew out the night after the staples were removed. I also mentioned that I had photographs of the wound. My complaint was that Dr Patel failed to diagnose that I was suffering from a serious post operative wound infection. Dr Keating said that wound infections are often hard to diagnose as your abdomen was often red and bruised after such an operation.

26. I told him that my second complaint relates to the next night when the infection blew a hole through the surgical incision and I was rushed to emergency and admitted to the wards. The nurses tried for two days to get permission from Dr Patel to use a suction pump to drain the infection and to use dressings that would be more suitable to draw out the infection. Dr Patel refused to allow the nurses to use the suction pump or dressings that they thought might help. Dr Keating said that it was up to the doctor and not the nurses to decide the best course of treatment.

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

Deponent

27. I explained that my third complaint was in relation to the wound being reopened, down to my stomach muscles, by a junior doctor without the use of anaesthetic. Dr Keating said that a local anaesthetic would not have worked anyway for a wound infection. I asked why I wasn't told what they were going to do and why I couldn't have been given some morphine through the cannula in my arm. Dr Keating replied that morphine was expensive and there was a danger the patient could become addicted to it.

28. I then told Dr Keating that I had been bleeding internally ever since the operation by Dr. Patel and that nothing was being done about it. Dr Keating said that he would make arrangements for me to have follow up procedures. He also said that he had made a full investigation into my complaint and there was no basis for any action and that the complaint would not go any further.

29. Dr Keating was intimidating, belittling and condescending. He told me that Bundaberg and I, personally, was lucky to have such a fine and competent surgeon as Dr. Patel working there and that I should be grateful that he had operated on me. He said that Dr. Patel was a surgeon of the very highest calibre. I was disgusted and disillusioned. He showed no interest in understanding what had happened. He made no intimation that he might speak to the nurses involved. He said he had no interest in looking at the photographs taken. He was just keen to make the complaint go away.

Ongoing medical problems

30. Following my formal complaint in October 2003 I made it clear that I did not want to see or be treated by Dr Patel again. I cancelled an appointment for 7 January 2004 for this reason. My hospital records are noted "appointment with Dr Patel cancelled by patient".

31. On 11 November 2003 I saw a junior registrar in outpatients, however the medical notes were written and signed by Dr Patel. On this same day I also attended the Friendlies Hospital for a Barium Swallow.

32. On 20 January 2004 I had a colonoscopy and endoscopy at the Hospital. At the time I did not know who had performed the procedure because I was anaesthetised. The surgeon's report of 20 January 2004 indicates that the procedure was done by Dr Patel assisted by Dr Boyd. I believe the Hospital tried to cover up that Dr Patel was involved because the report of 20 January 2004 to my GP was signed by Dr Boyd. I did not know that Dr Patel would be performing the procedure and I would not have agreed to it if I had known.

33. When I signed the consent forms for the procedure there was no indication of who would be performing the procedure. The date and names on the forms were inserted later. Dr Patel signed the forms, this was done later and not in my presence.

34. The report of the colonoscopy of 20 January 2004 states "multiple and fairly large diverticulae seen mostly at about 30cm from the anal verge". Two subsequent colonoscopies and a CT scan confirm the presence of diverticular disease.

Signed: . . . . . Taken by: . . . . . W.9. King . . . .

Deponent Solicitor/Justice of the Peace

35. The pathology report of the portion of colon removed during the sigmoid colectomy performed in May 2003 showed that Dr Patel had only removed 70mm from the colon. I understand now that this is a miniscule portion and that multiple and fairly large diverticulae remain which will inevitably require another major operation.

36. I decided to focus on positive things in my life rather than letting the Hospital problems get on top of me. I subsequently successfully completed a Mediation Skills Training course conducted by the Queensland Department of Justice and received a Statement of Attainment dated 23 April 2004, plus I also completed the required courses for Certificate IV Real Estate Agency Practice and received a Statement of Attainment dated 30 March 2004. However, due to my ongoing and at times quite debilitating symptoms I have been unable to consider even a part time or casual position until my health improves. Therefore my wife and I decided that she should start studying for a nursing degree full time at Central Queensland University Bundaberg campus and I became a stay at home Dad.

37. For a long time I didn't even bother going to a different hospital and simply self treated at home when I had diverticular disease symptoms or other abdominal pain. I believe that at some stage I will have major haemorrhaging and I am just living with this risk.

38. Since Queensland Health started reviewing patients in May 2005 some of my health problems are now being addressed.

39. I had gall bladder removal surgery on 6 June 2005 at the Mater Hospital, Bundaberg. This finally addressed the many symptoms I was treated for at the Emergency Department at Bundaberg Hospital from August through to October 2003. I have suffered in silence ever since that time until the operation on 6 June 2005.

40. I also have a referral for an appointment with Dr Les Nathanson at the Holy Spirit North Side Hospital for further procedures, namely another sigmoid colectomy and a laparoscopic nissens procedure, to address the ongoing internal bleeding and previously diagnosed Gastro Oesophageal Reflux Disease.

Request for copy of complaint documents

41. I rang the Hospital in April 2005 to say that I wanted a copy of my Formal Complaint lodged against Dr. Patel in October 2003. I spoke again to Joan. She said after some checking that my original complaint file indeed existed and consisted of several pages and that I would need to make formal application under FOI for its release and that the release would need to be approved by Dr Keating. I said that seemed like a bizarre system. A lady called Gail Chandler spoke to me a short time later. She said that my file had been sent to Brisbane so it would take a while to retrieve it. I said it was a little odd that the complaints had been sent down there without copies being made. I wrote to Ms Chandler on 14 April 2005, requesting records relating to my complaint. A copy of that letter is now shown to me marked "IGF1". Ms Chandler responded on 29 April 2005 and a copy of her letter is now shown

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

Deponent Solicitor/Justice of the Peace

to me marked "IGF2". In late May 2005 I received copies of Hospital file notes dealing with my complaint and they are now produced and shown to me marked "IGF3".

Role with Patient's Group

42. From my first dealings with him, I understood that Dr Patel was the Director of Surgery at the Hospital. I was not aware, prior to about March 2005, that other people had complaints about him. I assumed that I had just been unlucky.

43. After the Member for Burnett, Rob Messenger, was reported in the press as making allegations against Dr Patel, I contacted his office on 7 April 2005 with my own story. I said to them that I would like to contact other patients with a view to set up an informal support group.

44. Mr. Messenger's Secretary, Melinda, put me in contact with another ex-patient, and on 8 April 2005 I spoke to Beryl Crosby and I again said to Beryl that I would like to help establish a patient support group so that we could help each other by sharing our experiences. We arranged to meet and we then placed advertisements in the paper to see if there were others with grievances against Dr Patel.

45. After the advertisements in the paper, we were swamped with calls and letters. As a result we organised a Patient's Support Group. Since the first meeting held on 14 April 2005, we have held meetings of the group each Thursday night at Brother's Sports Club and at various other venues in Bundaberg. We have invited people such as the District Managers of Bundaberg Base Hospital, the Chief Health Officer Dr. Gerry Fitzgerald, the Queensland Coroner, the Health Rights Commissioner, the Queensland Police Service (who declined to attend), the Crime & Misconduct Commission and the Bundaberg Hospital Commission of Inquiry to address the subsequent meetings, and we have had as many as 300 people attend particular meetings.

46. I attended a meeting with the previous acting manager of the Hospital, Dr. Michael Cleary and Beryl Crosby. I believe the meeting took place on Friday 27 May 2005. I have some handwritten notes which I believe were taken by Beryl at that meeting which indicate that Dr Cleary told us that at that time 2332 patients had been identified as having been seen by Dr Patel in the hospital or as outpatients. That included about 887 surgery patients, 407 endoscopies plus an unknown number of colonoscopies or other scope procedures and an unknown number of Outpatients which I now believe includes 800 to 900 outpatients. I understand that the number does not include people that Patel attended to whilst they were officially recorded as someone else's patient. The Patient Support Group holds the names, addresses and other details for about 500 former Patel patients. At the time of this meeting with Dr. Cleary, 1264 persons had contacted the Hospital Patient Liaison Office for further treatment, procedures and services.

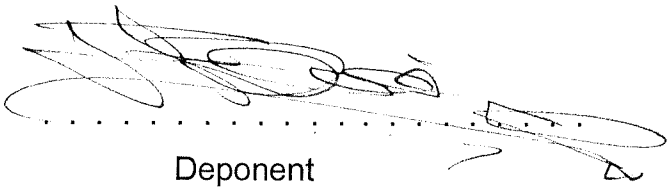
47. All the facts and circumstances set out above are true and correct to the best of my knowledge.

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

Deponent Solicitor/Justice of the Peace

Affidavit sworn on 30 June 2005

at Bundaberg in the presence of:



. . . . . .

Deponent

. . . . . W.G. Ling . . . . . .

Solicitor/Justice of the Peace (C. Dec)

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

Deponent Solicitor/Justice of the Peace

"I & F / "

April 14, 2005

Gail Chandler
Manager Health Information Services
FOI Decision Maker – Bundaberg Health Service District

RE: Formal Complaint of Incompetence against Dr. Jayant Patel made by myself to the Director of Medical Services on 28 October, 2003, following Colon surgery performed by said Doctor upon myself on 19 May, 2003.

Dear Gail,

As you requested in our phone conversation yesterday that in addition to the release of all Hospital Records made last Friday April 8, 2005, I am also hereby making formal application that the Executive Branch, Office of Director of Medical Services, Bundaberg Base Hospital release to me personally forthwith copies of ALL notes, correspondence, files, statements and documents that relate in any way with:

1. The formal complaint of incompetence I made against Dr. Jayant Patel with the Director of Medical Services on October 28, 2003.

2. The investigation of my Complaint

3. The results of the outcome of this investigation as expressed to me by Mr. Keating the Director of Medical Services when he contacted me by telephone on October 30, 2003 and which he conveyed to me in a lengthy conversation at that time.

In closing I would like to comment that I find it bizarre and disconcerting to be told that Mr. Keating must himself authorize the release of these documents and particularly of concern to me in the light of recent events.

I look forward to hearing from you at your earliest convenience.

Yours Sincerely,

Ian G. Fleming

Received 14/4/05

"I LF 24

Queensland Government

Queensland Health
Enquiries Health Information Services
Bundaberg Base Hospital
PO Box 34
BUNDABERG QLD 4670
Telephone (07) 4150 2151
Facsimile (07) 4150 2159

Our Reference: FOI No. 04/05:41

29th April 2005

Mr Ian Fleming

Dear Mr Fleming

INFORMATION REQUEST

I refer to your application for access to documents concerning your complaint held by the Bundaberg Health Service District. Your application was received in this office on the 14th April 2005 and will be processed under the *Freedom of Information Act 1992* (the FOI Act). I confirm that you are seeking access to documents held by the Bundaberg Base Hospital and that the details of your request are as follows:

1. *The formal complaint of incompetence I made against Dr Jayant Patel with the Director of Medical Services on October 28, 2003.*
2. *The investigation of my complaint.*
3. *The results of the outcome of this investigation as expressed to me by Mr Keating the Director of Medical Services when he contacted me by telephone on October 30, 2003 and which he conveyed to me in a lengthy conversation at that time.*

FOI PROCESS AND APPEAL RIGHTS

As the officer authorised to make decisions under the Freedom of Information legislation for the Bundaberg Health Service District, I will be pleased to process your request. Records held by the Bundaberg Health Service District are documents of the Health Service District. You will be notified in writing when the processing of this request has been finalised. I have enclosed general information for applicants under the FOI legislation.

Please feel free to contact me on (07) 4150 2151 if you have any questions or issues you wish to discuss regarding this application.

Yours sincerely

Gail Chandler
Manager Health Information Services
FOI Decision Maker – Bundaberg Health Service District

Queensland Government
Queensland Health

Legal and Administrative Law Unit
Administrative Law Team

FOI INFORMATION SHEET #1

Freedom of Information Act 1992 (Qld)
General Information for Applicants

What is Freedom of Information (FOI)?

The *Freedom of Information Act 1992* (the FOI Act) came into effect for Queensland Health on 19 November 1992. This Act gives you the right to seek access to documents held by Queensland government agencies such as Queensland Health. You do not have to give a reason why you want to see any documents, but Queensland Health will give you an explanation if you are not given what you ask for.

How to make an application

Your application must be in writing and should be forwarded to the FOI decision-maker within either Corporate Office or the Health Service District(s) to which your application refers. (The contact details for all Queensland Health FOI Decision-Makers are attached). However, use of the application form is optional.

What can you ask for?

You can ask for any documents held by Queensland Health. Under the FOI Act a "document" can be a paper file, microfiche, print-outs, computer records and files, visual material (eg x-rays, films, photographs) and audio-visual material.

Do you have to pay for this?

Access to documents containing information about your own personal affairs is free. An application fee of $34.40 is payable when you are seeking access to documents which do not concern your personal affairs, and a cheque/money order (made payable to Queensland Health) for this amount must accompany your application.

Where photocopies of non-personal affairs documents are requested there will be a charge of 20 cents per page for all A4 copies provided. Should you request documents in any other format, you will be charged the actual cost for production.

Time-based processing charges at a rate of $5.10 per 15 minutes (or part thereof) may also be applicable for access to documents of a non-personal nature. (FOI fees and charges are G.S.T. free.)

What is personal affairs information?

- Under the FOI Act, "personal affairs" does not cover every piece of information about a person, or his/her "affairs". It covers only information about those affairs that are "personal", that is, information about the private aspects of a person's life, not about things the person does in a job or business, or as part of a public activity.

Information about a person's work or business does not usually qualify as information concerning his/her personal affairs.

Examples of information about a person that usually concerns his/her personal affairs

- health
- family relationships
- personal relationships with other people
- personal details, like date of birth or height
- signature
- home address or telephone number
- information about a person's domestic residence
- personal income (however, it has been held that the public interest requires disclosure of the gross income payable to a public servant)
- personal/domestic financial obligations (as distinct from financial obligations of a business)

This is not an exhaustive list of the type of information which may fall under the meaning of personal affairs.

Issued: March 2002 (Last revised: September 2004)

FOI INFORMATION SHEET #1

Proof of identity

Before you are given access to documents containing information about your personal affairs, you will need to provide proof of your identity. This can be achieved by producing documents such as: (a) your original birth certificate; (b) a certified copy of an extract of your birth certificate; (c) a current Australian passport; or (d) a current Queensland or interstate driver's licence or learners permit.

Alternatively, you may provide this office with a copy of any of the abovementioned documents which has been certified as a true copy by a Commissioner for Declarations or Justice of the Peace.

What happens if you are asking for another person's documents?

Usually you cannot access documents which contain information concerning another person's personal affairs, unless that person has authorised you, in writing, to see them or you are able to provide sufficiently strong public interest arguments which would outweigh that person's right to privacy.

Consultation

While processing an FOI application, it may be necessary for the Department to consult with a third party/parties if the release of the documents in question may be of substantial concern to that party/parties. Their views about whether or not they object to disclosure of the documents in issue will be requested. However, while their views will be taken into consideration, the final decision lies with the relevant decision-maker.

For further information

If you have any questions or require additional information on the FOI Act or how to access information held by this Department, please call (07) 323 41735, send a facsimile to (07) 323 41977 or e-mail FOI@health.qld.gov.au.

Printed copies of the *Freedom of Information Act* may be purchased from: Goprint, Publications and Retail, Locked Bag 500, COORPAROO DC QLD 4151

The Act is also available, in electronic form, on the website of the Office of the Queensland Parliamentary Counsel: http://www.legislation.qld.gov.au/

Your appeal rights

1. The Department is generally obliged to provide a decision in relation to your application within 45 days, or 60 days if a third party needs to be consulted. If you are not satisfied with the decision about your application, you can ask for an "internal review" within 28 days of receiving the decision. A senior officer will review the decision.

2. If you are dissatisfied with the internal review decision, you have a right of appeal for external review by the Information Commissioner. You are required to submit your application for external review within 60 days of receiving the internal review decision.

3. If you have not received a response to either your original or internal review application within the time limit specified above, you may apply to the Information Commissioner for external review.

Complaints about the FOI process

If you are of the opinion that the correct procedures were not followed during the processing of your application (as opposed to being dissatisfied with the decision that has been made on your application) and wish to lodge a complaint in this regard, you should first contact the Manager, Legal and Administrative Law Unit, Queensland Health, GPO Box 48, Brisbane QLD 4001 - Telephone (07) 323 40302.

If you are still dissatisfied with the response received in regard to these procedural issues, you may contact the Queensland Ombudsman, GPO Box 3314, Brisbane 4001 Telephone (07) 3005 7000 or Toll Free (outside Brisbane) 1800 068 908.

As indicated above, if you are dissatisfied with the decision made in relation to your application, you should lodge an application for internal/external review.

This summary, prepared by the Administrative Law Team, Legal and Administrative Law Unit (LALU), Queensland Health, discusses matters of general principle only.

Any queries should be directed to the Administrative Law Team, LALU:

Telephone	(07) 323 41735
Facsimile	(07) 323 41977
E-Mail:	foi@health.qld.gov.au

Issued: March 2002 (Last revised: September 2004)

"IGF3"

Queensland Government
Queensland Health

Bundaberg Health Service District

COMPLAINT REGISTRATION FORM

This form is to be completed the staff member who is registering the complaint.

Complaint Identifier: 1003.15.
Office Use Only

Type of Complaint: ☐ Written ☐ Verbal ☒ Telephone

Name of person handling complaint: Darren Keating DMS
Name and Designation of Staff handling the complaint

Facility:	Bundaberg	Childers	Gin Gin	Mt. Perry

Source of Complaint			
	☒ Parent/Client	☐ Relative/Carer	☐ Friend/Advocate
	☐ Staff Member	☐ Volunteer	☐ Anonymous
	☐ Other – Please specify – MP		

Complainant Details			
	Name: Ian Grant Fleming		UR: 106934
	Election Status:	Admission Status:	
	Gender: M	DOB: 12/01/1955	Post Code:
	Complainant Name If different to above:		

Complaint referred by: If from an external source			
	☐ Ministerial	☐ Local MLA	☐ Other QH Department
	☐ HRC	☐ MP	☐ Staff Referral
	☐ Response to Survey	☐ Other	☐ Not Known

Complaint Handling Details Please provide the date each action was completed		
	Complaint submitted: 28/10/03	Complaint registered: 03/11/03
	Acknowledgment: 29/10/03	First progress report:
	Date of Resolution/Closure: 30/10/03	

Complaint Issue See Complaint Categories and Description	**Category**	**Description**
	1. Access to Services 2. Communication 3. Consent 4. Corporate Services 5. Cost 6. Grievances 7. Privacy/discrimination 8. Professional Conduct 9. Treatment	
Service Type	Location of Incident: Surgical	
Staff Category	Staff involved in the complaint:	

Severity of Complaint		
	☐	Level One: Trivial, misconceived, subject matter not warranting acceptance for investigation
	☐	Level Two: Complainant could have resolved complaint easily with support from staff involved
	☐	Level Three: Legitimate consumer complaints, especially about communication or practice management, but no lasting detriment
	☐	Level Four: Significant issues of standards, quality of care, or denial of rights, complaints with clear quality assurance implications
	☐	Level Five: Long-term or severe damage, including death, serious adverse outcome, professional misconduct

(3)

Complainant Objective What does the complainant want to happen?	☒ Register concern	☐ Receive explanation	☐ Obtain apology
	☐ Obtain refund	☐ Access service	☐ Change procedure
	☐ Change policy	☐ Compensation	☐ Disciplinary action
	Please provide details:		

Resolution Mechanism/ Outcome By what means was the complaint resolved?	☒ Concern registered	☒ Explanation given	☐ Apology provided
	☐ Costs refunded	☐ Services provided	☐ Procedure/practice change
	☐ Policy change	☐ Compensation received	☐ Disciplinary action taken
	☐ No action taken		
	Please provide details:		

Recommendation/ Action taken What action has been taken as a result of this complaint?	☐ Staff member/contractor counselled	☐ Training/education of staff provided
	☐ Duties changed	☐ Dismissal/ termination of contract
	☐ Quality improvement activity initiated	☒ No action taken
	Please provide details: Darren rang Mr Fleming and explained that he needed a referral by specialist, he needs to come to QRD 11 Nov. Patient noted that he needed medical attention, but was semi urgent & must wait.	

Adverse Outcome	

Narrative	Mr Fleming rang extremely concerned about his health and the lack of action that has been taken to investigate his condition, a private GP has recommended that he have an urgent colonoscopy to ascertain where the bleeding is coming from.

Office Use Only Performance Indicators	Acknowledgment letter – 3 days	Progress report – 21 days	Resolution – 35 days
Reported in trends analysis	Date		

28/10/03 BDDSO

Queensland Government
Queensland Health

Bundaberg Health Service District

NOTIFICATION OF COMPLAINT

This form is to be completed by either a staff member or the person lodging the complaint.

Date: 28.10.2003 **Time:** 1.20pm

Name of Facility: ☑ Bundaberg ☐ Childers ☐ Gin Gin ☐ Mt. Perry

Complainant: ✓Patient ☐ Visitor ☑ Other (Please state)

Name: Ian Grant Fleming **UR Number:** 106934

Address:

Phone:

Details of Complaint (attach additional information if necessary):

Had a colectomy in May 2003, followed by a wound infection, which healed in July 2003. Since this time he has been bleeding after a bowel movement. He has presented to DEM on 3 occasions, and on 1 occasion, waited for 5 hours so that he could be seen by the surgeon. On this occasion, the doctor who saw him in DEM told him that if he waited, he could see the surgeon, however Dr Patel was not available, and he subsequently saw the surgeon's assistant. The surgeon's assistant advised that he would be seeing Dr Patel that afternoon, and they would then contact him. This occurred 2/3 weeks ago and he has not been contacted. He was also brought into DEM by the QAS on Saturday with an extreme case of vomiting. Yesterday he had the worst bleeding that he has ever had, and this morning he contacted Elective Surgery to see when he was booked for a colonscopy, however they have advised him that he is to see Dr Patel in his clinic in 2/3 weeks.

Mr Fleming is extremely concerned about his health, and the lack of action that has been taken to investigate his condition; a private GP has recommended that he have an urgent colonscopy to ascertain where the bleeding is coming from.

28/10/03.
- Dr Patel 1330 28/10/03.
- He has authorised early OPD appt for Mr Fleming
- We will ring pt in OPD. with view to colonoscopy & resection

yesterday spec clinic gave * 8 Dr Patel 11 Nov 2.15

Phone call 1605 30/10/03
* Explained colonoscopy not done in OPD; req referral & IV bowel preparation.
* Explained he needs to come to OPD. - 11 Nov.
* Explained colonoscopy to see if PR bleeding but not only one.
* Explained Hb - remained constant.
* Agreed
* Pt noted that he needed medical attention, but was semi urgent + must wait.
- Referral sent.

3/11/03 1435 Attempt #1.

Signature: J Dooley (of person documenting the complaint) Date: 28/10/03 Designation: ESO (If staff member)

~~[illegible]~~

no of things happen w Dr Patel

⇒ Diverticular Disease Apr 2001

Dr Patel, sch for col. later problem was getting camera in. didn't get to see where all the [illegible] large/sm [illegible] in May 03.

had op. Dr P perf op. as a result of op. open wound, discussed Dr P, staples, ext agony, [illegible] [illegible] up, nurse up there told he had open [illegible]. incision blew open, then FRI nite, no anesthetic.. opened incis up, open complete incision w/ anasth

been in contact.

⇒ Dr Pagel - (Barolin Famil Medicine 41531151)

wrong hosp in surgery

Then / clean/[illegible] ([illegible] day)

⇒ (MAY.)

Assist surgeon

∨ Passing Blood

High inst

> then again SAT night

Stomach - Ambulance 3am

Pass mug full

Schedule -

(open wound) staples

DR 3 weeks ago S/ Dr.

DR Histo

H/P (6)

10 00002

Notes taken Oct 2003.

I have tried to decipher them as best I could. These were simply my scribble notes that I obtain before the DMS rang to speak to client.

As this was some time ago, I can't recall the exact conversation, so these are to the best of my ability.

Number of things happened with Dr Patel

Diverticular Disease – April 2001

Dr Patel scheduled for colonoscopy. Was told later problems getting camera in. Didn't get to see where all the large/small int.

In May 03 had operation. Dr Patel performed operation. As a result of operation, open wound, discharge, Dr Patel removed staple. Excruciating agony. Couldn't stand up. Nurse up there told him opinion incision blew open thurs. Fri nite.

No anaesthetic, open incision up. Open complete incision with anaes.

Been in contact with Dr Pagel (Barolin Family Medical – 4153 1155)

Rung hospital in Surgery

Clearly/Pain every day (may)
Passing blood
Then again sat night
Stomach - ambulance? 3am pass mug full

Scheduled
(open wound) stables
Doctor 3 weeks ago
5/DEM

PUBRE/1404/024

Queensland Government
Queensland Health

File / Meeting Note

Date/Location	13 April 2005
Attendees:	
Reason for Delay in Responding (If applicable)	

scussion:	Phone call from Ian Fleming (advising that he had made a complaint on 28/10/03 to Joan in relation to Dr Patel. He asked if we could check whether it was a verbal or written complaint as he was due to meet with Channel 9 at 12.00noon today and with Channel 7 at 1.00pm today and wants to make sure he gives them the correct information. His details are as follows: UR: 016934 He had complications relating to sigmoid colectomy. (Mr Fleming will be meeting at Beryl Crosby's mother's home prior to interview with TV channels). After checking with DCAHS, I advised Mr Fleming that he had lodged a verbal complaint and that our Director of Medical Services then provided a phone response to him on 30/10/05. Mr Fleming then asked if these records are in his chart at Medical Records. I explained that details of complaints aren't included in clients' charts. He then stated that he would like a copy of details of his complaint to refresh his memory. He also advised that he had already obtained a copy of his Medical Records' chart from Gail Chandler. I explained to him that he would need to discuss with Gail Chandler about accessing the information relating to his complaint under FOI Act. I discussed with Gail, who asked that DMS phone her in relation to this as it would take some time for Mr Fleming to access the information under FOI. DMS spoke with Gail and advised her that that was the process he needs to go through. Gail was then going to advise Mr Fleming of this.
Action Taken:	
Outcome:	

Prepared by:	Cheryl Miller	**Cleared by:**		**Noted:**	
Unit:	Exec Services	Title:		Name:	
Contact No:	2025	Unit:		Date:	
Date:	13 Feb 2005	Contact No:			
		Date:			

Tuesday 5 July, 05-07-5

Geoff Mullins
Counsel Assisting the Patient Support Group

Dear Gerry,

At the direction of Damien Atkinson, he has suggested that you should make the submissions and set the record straight. They are:

1. That in my evidence in chief, page 1870 line 30 in response to the question from Damien Atkinson he asks "that's the correct state of your belly" to which I have replied "Yes it is".
2. That the correct answer to that should have been is that that is the state of my belly prior to the lap surgical removal as stated in my sworn statement which in paragraph 39. Line 1 as a true and correct statement prior to the lap surgical removal of my gall bladder on 6 June, 2005, and that I tender photographical evidence of the true state of my abdominal scars following the lap surgical procedure for the removal of my infected gall bladder performed on 6 July, 20054.
3. I tender photographs of my abdominal scarring following the lap surgical removal of my gall bladder and convey that I have not suffered any post abdominal wound infections or complications as a result of this procedure.

Sincerely, Ian G. Fleming
P126

PS. It is of the greatest concern to me that should the Royal Commission be forced or should choose to stand aside that these corrections in my evidence in chief be entered in the transcript prior to such an event being acknowledged or indeed in fact, occurring.