STATEMENT OF PETER JOHN MIACH

I Peter John Miach of c/- the Bundaberg Base Hospital in the State of Queensland states:

Qualifications and Experience

1. I am currently the Director of Medicine at the Bundaberg Base Hospital, a position that I have held since August 2000.

2. I did all of my schooling and primary medical training in Melbourne in the late 1960s. I hold a bachelor or medicine and a bachelor of surgery from the University of Melbourne.

3. I underwent 2 years of internship and registrar training at St Vincents in Melbourne, which is a large tertiary teaching hospitals.

4. I then worked at the Austin Hospital, which is now know as the Austin Repatriation Medical Centre where I received my membership of the Royal Australasian College of Physicians, and in the early 1970's, while I was still at St Vincent's Hospital I think it was 1972, I became a Fellow of the Royal Australasian College of Physicians.

5. In the Austin College I was engaged in a great deal of research and between 1976 and 1979 I went to work in a large nephrological hospital in Paris.

6. When I was in Paris I undertook research and was awarded a Doctor of Philosophy from the University of Melbourne.

7. I returned to the Austin Hospital where I was offered a full time position as a nephrologist, as a kidney or renal specialist is known.

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

Deponent

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

8. I also worked as Director of Medicine and Chief Internist at a large military hospital in Saudi Arabia for about one year.

9. I worked mainly in clinical nephrology from then on until the year 2000 and continue to do so.

10. I took sabbatical leave in Oxford where I worked the John Radcliffe Hospital and Sir Peter Morris for about 8 months.

11. I was invited to become a Fellow of the Royal College of Physicians of Edinburgh. That invitation was as a result of my research work and my standing in the field of nephrology both within Australia and Internationally.

12. I was appointed as a senior lecturer to the University of Melbourne, a position that I believe I still hold. I am also a senior lecturer at the University of Queensland;

13. For many years I have been an examiner and censor for the Royal College of Physicians.

14. In the early 1990's I spent some time as locum tenens in Rockhampton Base Hospital when I was a locum Director of Medicine for approximately 3-4 months.

15. I had previously worked with the former Director of Medical Services at the Bundaberg Base Hospital, Dr Brian Thiele. Dr Thiele is a vascular surgeon. We had worked together at the Austin Hospital previously where I was a nephrologist and Dr Thiele was a vascular surgeon. We knew each other quite well.

16. During the 1990's there were a number of changes at the Austin Hospital. As a result of those changes my wife and I decided to try living in Queensland for a while. Our children had grown up and were working overseas. We came to Bundaberg.

17. Not long after I started in Bundaberg I was offered a number of positions elsewhere. However, I had given a commitment to the Bundaberg Hospital and I decided to stay.

Signed: . . . . . Witness: . . . . . .

18. I was appointed as Director of Medicine for the Bundaberg Base Hospital. I work as a general physician and nephrologist. There are not too many nephrologists in Queensland between the sunshine coast and Townsville. As well as doing general medicine, I also built up a nephrology unit. Subsequently I was given the title of Director of Renal Services for the Wide Bay area which encompassed the Bundaberg District Health Service and Fraser Coast region. I run the renal services for this area.

19. When I started there were 2 physicians where I now have a team of 4 physicians, myself, two general physicians and a cardiologist.

20. Part of my practice includes working at the University of Queensland rural clinical school. I was instrumental in building the library and I am involved in the teaching.

Renal Ward at the Bundaberg Base Hospital

21. There are 4 units at the hospital, two general medical units, 1 cardiology unit and a large renal unit

22. The two general medical units at the Bundaberg Base Hospital are run by 2 physicians. Dr Martin Strahan is a Visiting Medical Officer (VMO). I am also assisted by Dr Dawid Smallberger, who is a South African trained Doctor who does not hold an Australian fellowship. Dr Smallberger works under my supervision.

23. Dr Antre Conradie is a Cardiologist VMO. He runs the cardiology unit.

24. To assist, the Department of Medicine has a number of other more junior doctors to assist, three Principal House Officers (PHO) and two junior doctors, a Junior House Officer (JHO) and an intern. One of the PHOs works directly for me and Dr Conradie. The junior doctors cover both cardiology and renal medicine, although neither has any significant experience in renal medicine;

Dialysis and the Baxter Program

25. There a two types of dialysis: haemodialysis and peritoneal dialysis.

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26. As far as haemodialysis is concerned, to put it simply, blood is taken out of a patient and run through a filter and then put back into the patient. The amount of blood removed is very large. It is necessary to get a catheter inserted into a large blood vessel in the patient to extract sufficient blood when acute haemodialysis is required.

27. When I see a patient for a very long time I do a number of things. For example I may ask a surgeon to perform a minor operation on a patient's wrist where the surgeon connects up two blood vessels in the wrist, it is then necessary to wait for some weeks before that operation is effective. Then those blood vessels can be used for haemodialysis.

28. When patients arrive and are quite sick and need treatment quickly, I need to be able to access large volumes of blood fairly quickly. In that case I would put catheters into large vessels within the patient's body, for example the groin or neck. Those catheters allow access to large volumes of blood for haemodialysis, but they are temporary. They are used 3-4 days to one to two weeks.

29. I sometimes insert these catheters myself. I may insert groin catheters or central venous catheters although I rarely insert central venous catheters anymore.

30. Where I need to put in something permanent I organise to put in an arterio venous fistula in an arm. A semi permanent device involves a catheter being inserted in to the neck region and tunnelled under the skin. It then comes out somewhere near the anterior chest wall. That type of catheter may last for a few weeks or with luck, up to several months. Often it may become infected or blocked and then other alternatives need to be considered.

31. This technique is usually used while establishing another type of vascular access.

32. The other type of dialysis is called peritoneal dialysis and is where we introduce a catheter inside the abdomen (peritoneal catheter). These peritoneal catheters are sometimes inserted by physicians. However in my experience, in the vast majority of cases, they are inserted by surgeons. Usually they are inserted laprascopically, which is a type of keyhole surgery.

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33. These catheters are placed into the peritoneal cavity. They have to be placed in a specific spot. The incision has to be precise. For this reason they are usually inserted by surgeons.

Dr Patel's surgery

34. As a physician I get to know good surgeons. When I find a surgeon who is competent or reasonable I will get them to perform surgery on my patients for example, inserting peritoneal catheters.

35. When Dr Patel arrived at the Bundaberg Base Hospital I asked him a number of questions to find out what sort of surgery he did. He told me that he did basically everything. I thought this was a bit strange. However, I arranged for him to insert some catheters for me and I was not happy with the result.

36. Dr Patel did a number of different operations for me which gave me cause for concern.

37. One example was a patient Mr Kevin Dean [P51?]. He was not a renal patient but I became involved in his treatment, as he was being managed by Dawid Smallberger, one of the physicians.

38. This man was admitted under Dr Smallberger. The way admissions are conducted at the Bundaberg Hospital is that a patient with a medical condition is admitted under which ever physician is on duty at the time of admission. This person was admitted when Dr Smallberger was on duty. He was therefore Dr Smallberger's patient.

39. He came in with chest pain. The first thing that has to be excluded was a heart condition. That is potentially fatal. A cardiograph had been performed and the physician who was treating him believed that he was suffering angina, which is an unstable coronary syndrome. This man's haemoglobin was about 8 or 9 when normal persons should be about 15 or 16. Dr Smallberger had decided to do a CT (computer tomography) of his abdomen.

Signed: . . . . . Witness: . . . . . .

40. While he was waiting in radiology I was informed me that Dr Patel came wandering through and looked at the X-ray. Dr Patel apparently decided that this man was anaemic and had a ruptured spleen, which is a very serious condition.

41. Dr Patel insisted on taking this man to theatre. He absolutely insisted that he be taken directly to theatre. Dr Smallberger called me at this point. I came down. I had a look at the x-ray. Although I am not a radiologist I have seen a lot of x-rays in my time. I said to Dr Patel that the spleen looks normal to me. I said to Dr Patel that this mans is not being taken to theatre. He is going to be transferred to Brisbane. If he had a cardiac problem then we need to know what is going on with his heart before any operations.

42. To have a ruptured spleen, in my experience, is usually as a result of a lot of trauma, This man had not suffered any falls or apparent trauma for several weeks.

43. I told the medical team that this man should not be operated on. The reason I became involved was that Dr Patel was putting a lot of pressure on the medical staff to have this man taken to theatre.

44. He was transferred to Brisbane. A report from the radiologist in Brisbane agreed that there was nothing wrong with this man's spleen.

45. After this incident I started being more circumspect with Dr Patel.

46. Another instance was a patient, P45, who was a patient who I wanted to have a Tenchoff catheter inserted. However, this man had a hernia which had to be repaired before the catheter can be inserted.

47. It is not possible to perform peritoneal dialysis when a person has a hernia. It is necessary to repair it first. I asked for an opinion from Dr Patel. He advised that the patient did not have a hernia.

48. I thought this was unusual. I sent P45 to another surgeon, Dr Pitre Anderson. He agreed that there was a large hernia and repaired it for me. The operation to insert the then catheter proceeded.

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49. There was lady that came into hospital with chest pain. I checked up on this lady. I made a point of going through her chart. This lady had a previously carcinoma on her breast and had had it treated.

50. The surgeons who had been at the Bundaberg Hospital before Dr Patel reviewed her every 6 months.

51. Dr Patel saw her once and then discharged her.

52. The heart problem with which she presented on this day was totally unrelated to her previous breast cancer. When examined she had an obvious carcinoma which should have been picked up during the regular reviews she would have been having had Dr Patel not discharged her.

53. Another case involved P33, who is a man in his mid 70's. He was admitted into the coronary care division of the Intensive Care Unit. He was under the care of one of the other physicians. This man had suffered a heart attack. He was also suffering from severe kidney failure and was quite anaemic. He was suffering from a condition called atrial fibrillation which is routinely treated with anti coagulants (blood thinning drugs). This man was also a Jehovah's Witness.

54. He was in intensive care, as he was so sick. Quite correctly, the staff looking after him attempted to put a central line into his neck. Inserting a central line is where you attempt to insert a catheter into the jugular vein in the neck. The carotid artery is very close by to the jugular. However, as sometimes accidentally occurs, the staff missed the vein and got the artery. As the patient was on anti-coagulants, he was bleeding quite badly

55. Dr Patel was there. The staff asked me to come down even though he was not my patient.

56. I came down into this almost surreal situation where there were a number of nurses around, all very silent; the patient was in a cubicle with a doctor was putting pressure on the carotid artery with a blood soaked bandages; and Dr Patel, in his surgical gown,

Signed: . . . . . Witness: . . . . . .

insisting that he was going to take this patient into theatre to repair his carotid. The nurses had called me down to assist with trying to stop Dr Patel.

57. I looked at the situation. I took Dr Patel aside. I said to him that this man is not being operated on. He is staying here. We will stop the bleeding and then transfer him to Brisbane. The bleeding was stopped by reversing the anticoagulants and putting pressure on the wound for a period of time. There was never any need for surgery. Usually in these cases, the hole in the artery is small. It will heal itself.

58. If this man had gone to theatre after his heart attack, in my opinion, he would have died.

59. This man was transferred to Brisbane. He came back to Bundaberg and I later saw him in my clinic as a kidney patient.

60. These instances all caused me a deal of concern.

61. When Dr Patel first joined the hospital he did do some renal work for me which was reasonable.

62. One example was a thyroidectomy, which is the removal of part of the thyroid, for a young woman with carcinoma of the thyroid. This woman was referred to him directly by the local GP.

63. Dr Patel performed an operation where he inserted a gortex a loop into one female patients arm. The gortex loop is another type of vascular device that is used if we cannot create a fistula. It is a prosthetic pipe connected up in the arm.

64. A thyroidectomy is significant surgery, as is the placement of a gortex loop. That type of surgery (gortex loop) is mainly done by vascular surgeons.

65. Normally I would only allow a vascular surgeon to perform this operation. However Dr Patel persuaded me that he had done this procedure numerous times and, in this particular case, he performed it well. It worked and the patient is still using it.

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Patient 34

66. Patient 34 was one of my patients who had been on chronic dialysis for several years. He was very frail and, although he was quite young, he had developed a number of medical problems. He developed cancer of the oesophagus. The cancer had formed at the bottom of the oesophagus.

67. Surgery is usually prohibited on patients that are suffering from other significant co-morbid conditions. The surgeon must be very careful if he or she chooses to operate.

68. The approach of most physicians, including me, is that, if I have a medical patient has a surgical problem, I get a surgical opinion. The reason I do that is that it helps me understand more about what might be possible from the surgical point of view.

69. It helps the patient and his or her family understand what might be possible. However, the understanding always is, if you ask an opinion, you get an opinion.

70. In this case, Dr Patel fast tracked the patient into theatre. I do not know exactly what day he underwent surgery. Three days out of ten I am in Hervey Bay. I do not now recall whether I was in the hospital when this man went to theatre.
But I was surprised to learn he had gone to theatre.

71. He underwent an oesophagectomy. He never recovered.

72. I do not believe this man should have ever gone to theatre. I never received the opinion that I asked Dr Patel to provide.

73. Another patient, Ms P53, that I recall was a lady who had major problems with her vascular access. Dr Patel performed a procedure on her and she nearly lost her arm. Eventually she was transferred urgently to Brisbane where they managed to save her arm.

74. I subsequently spoke with the vascular surgeon, Dr Jason Jenkins at the Royal Brisbane Hospital, somewhere between June or July 2003, who warned me that he didn't think

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that Dr Patel should do any more vascular surgery at all. Which was a conclusion that I reached myself because of what I saw in relation to this patient.

P52

75. Another matter which also involved Dr Jenkins who is the Director of Vascular surgery at the Royal Brisbane Hospital involved a young Aboriginal lady. She was a severe diabetic and was suffering from severe kidney failure. She had been a patient of mine for a while. She would periodically miss appointments as she lived in Gayndah, a couple of hours away from Bundaberg.

76. Unbeknown to me, she was admitted under Dr Patel for a below knee amputation. I am not questioning whether she needed a below knee amputation. That surgery may have been appropriate. But her post operative care was most inadequate. Dr Patel left her in the ward under himself without advising me even though she was suffering from severe kidney failure and diabetes. I do not remember who told me specifically. A number of staff came to me and told me that she was in the ward. I was surprised. I should have been informed in order to ensure she was properly treated for her kidney condition. Because I am a Nephrologist and my speciality is renal disease it was extraordinary that Dr Patel did not seek my advice.

77. I went to see her in the ward. She was almost comatose. She was suffering from uraemic encephalopathy. This condition develops when your kidneys are failing badly and the poison builds up causing the patient to become unconscious.

78. It took several weeks of treatment for her to recover. She was then transferred to the Royal Brisbane Hospital for creation of a definitive vascular access.

79. Dr Jenkins wrote to me at that time. He advised that he had other serious concerns. Six weeks after her operation, her stitches were still inside her leg. She had not been surgically reviewed at all after her surgery. Several of her stiches were embedded inside her leg and very painful to remove. Annexed to this statement and marked with the letters PJM2 is a copy of that letter dated 2 November 2004.

Decision to prevent further operations on renal patients

Signed: . . . . . Witness: . . . . . .

80. Between the end of January and April 2004 I was on sabbatical. I did not return to Bundaberg until the middle of April. While I was away I engaged two locums, Dr Martin Knapp and Dr Malcolm Cochrane. Before I left for my sabbatical, I said to Dr Knapp that if any surgery needs to be done on renal patients, he should stay clear of Dr Patel.

81. As far as I am aware, no surgery was performed on renal patients by Dr Patel whilst I was on sabbatical.

82. After my return, I too never again referred patients to Dr Patel.

83. Before I set up the Baxter program, I attempted to send patients to Brisbane to have the peritoneal catheters inserted. From November 2003 I determined not to refer patients who required peritoneal catheters to Dr Patel because I got a feeling that there were too many complications after his peritoneal catheter placement surgery. In response to that request, I got a letter from the Director of Surgery at the RBH to the effect that the operation is not difficult. This put me between a rock and a hard place. I needed a way to have peritoneal catheters placed in Bundaberg without referring to Dr Patel. It should be able to be done in Bundaberg and at Hervey Bay.

Patient P31

84. P31 was a young patient who arrived at the hospital comatosed and suffering kidney failure. During his treatment, he developed an unusual rare complication which is very dangerous.

85. He ended up with fluid around the heart and became critically ill a few times. We drained the area a couple of times before deciding to do a pericardial window. This is a procedure where you put a hole in the pericardial space and insert a drain into that space.

86. Dr Patel did the operation. I decided to go to theatre. When I arrived in theatre I came in late so that I could see what was being done. When I arrived the patient was not anaesthetised. He was screaming in pain.

Signed: . . . . . Witness: . . . . . .

87. I have been involved in a number of these procedures. In my experience, it was always done with the patient fully anaesthetised in complete calm and peace.

Catheter Audit

88. I arranged for my staff to perform an audit on the peritoneal catheters. Because of my concern from November 2003. I personally took that directly to the Director of Medical Services, Dr Darren Keating. I do not now recall whether it was before I left in January 2004 or after my return in April 2004.

89. I also raised the issues I was having during the Clinical Forum meeting. I informed the meeting that I was not happy as far as patients' safety was concerned.

90. I do not recall the exact words that I used but I let people know that I was concerned about Dr Patel and he was not to operate on any of my renal patients.

91. I also informed the nursing staff that Dr Patel was not to operate on renal patients

92. I also told Drs David Smallberger and Strahan. Dr Strahan had a patient that needed an operation for a tumour in the abdomen. He asked me my advice. I told him that he needed to discuss the issue with Director of Medical Services Darren Keating and tell him that he had discussed it with me and had decided to transfer his patient to Brisbane.

93. The audit I caused to be carried out was carried out by two senior nurses, Lindsay Druce and Robyn Pollock. The outcome of the audit was a 100 percent failure rate with insertions of the peritoneal catheter into the abdomen by Dr Patel.

94. I gave the audit to Darren Keating. I heard no response from the Executive in relation to the 100% complication rate with this surgery performed by Dr Patel.

Signed: . . . . . Witness: . . . . . .

95. I did raise the problem with Dr Patel at an early stage in 2003. I believe I showed him a protocol that is used on how to insert and position these catheters. I tried to get Dr Patel to read it. I offered to take him through it. He did not seem interested.

96. On 21 October 2004 I had a conversation with Dr Keating about a number of issues. I raised the topic of the audit. He then said, "What audit"? I said, "The one I gave you". He said, "You didn't give me any audit". I replied, "Of course I did. I handed it to you personally". He then said, "I can't remember that" and I replied, "Well I can and I've got a pretty good memory". I then said word to the effect "There is no doubt about it. I handed it to you personally with my own hand. I brought it up and handed it to you". He said to me words to the effect "I don't remember that and I have some queries about your memory and whether you're telling the truth".

97. He then sent me an email dated the 21st of October 2004. It says, "Peter as per this meeting this afternoon please forward a copy of the data concerning J. Patel and your renal patients? Thanks Darren". Annexed to my statement and marked with the letters PJM3 is a copy of that email.

98. Again I received no response from Dr Keating on the audit results.

99. By this time, the issue of peritoneal catheters was no longer critical. I had been in negotiations with the Baxter Group since in or about May 2004 to arrange for what is now known as the Baxter Program in Bundaberg. Under that program the Baxter Group would pay for public patients to have peritoneal catheters inserted in private hospitals. Once the catheters are inserted, the public patients return to public hospitals for ongoing dialysis.

100. I had decided that as nothing was happening at the Bundaberg Base Hospital, I had to take step to protect my patients. I had previously used Dr Brian Thiele to insert those catheters and he was practicing in the private sector in Bundaberg.

101. I called Brian and asked him about whether he would be interested in participating in the Baxter program, and he agreed.

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102. The Baxter Access Program had been done in other states but I was the first to set up the program in Queensland. Baxter have an interest in the program as they supply the fluid and catheters, which they supply exclusively, however they would supply that regardless of who inserted the catheters. However, we have always used the Baxter products because they are very good, and we would have done so regardless of where the catheters were inserted.

103. Since the Baxter program has been going, There has been no complications from catheter insertion. Even that was not as a result of the surgery.

Dr Darren Keating Director of Medical Services

104. When Darren commenced as Director of Medical Services, I attempted to set up regular meetings to discuss issues with him in an informal way. I wanted to have the opportunity to discuss staffing levels and other issues that arose in the hospital. He told me that he was not interested. He went on to say that I should make a formal appointment if I wanted to discuss matters.

105. Dr Keating also changed the entire system of on-call rostering without any consultation with me or any other staff. I discussed this with him several times. I believed that patients were suffering as a result of these changes.

106. The result of these changes was that admissions were after done by the accident and emergency ("A&E") staff who were usually junior. Previously, there was surgical and medical staff on call to admit surgical and medical patients.

107. Emergency staff often knew very little about medicine and surgery. Having the A&E staff do some after hours admissions meant that the surgical and medical PHO's no longer needed to be given fatigue leave.

108. This meant that the surgical PHOs were available for elective day surgery. In my experience, a surgeon will not operate without an assistant. If a PHO is on fatigue leave, the surgeon cannot get through their operations. The Bundaberg hospital made a lot of money from elective surgery. There was always a big push to keep the elective

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surgery going. By having PHOs available for elective surgery rather than A&E, this could occur.

109. If the surgical PHO's have to take fatigue leave they cannot operate. The surgeons are unable to get through the elective surgery lists. The hospital does not receive additional funds.

110. I believe that this system of rostering was introduced so that the hospital could make as much money from elective surgery. But it was counter to the interests of medicine.

111. I raised these issues with Darren Keating. I informed him that, in my opinion, this system was damaging the practice of medicine, and ultimately damaging the community purely because the hospital wanted to make money out surgery.

112. As soon as some stability returns to the Bundaberg hospital, I intend to change the system back to the previous system.

113. I have always believed that when patients are admitted to a hospital, they need to be seen by the best possible doctors available. In my opinion, under the new system that is not happening.

114. Darren Keating ordered me to change the protocol for the treatment of peritonitis. I refused to do this. There was nothing wrong with the protocol being used. The protocol has been used for many years and was developed internationally.

115. As far as the Baxter Program is concerned, I arranged a meeting with various people to discuss the issue. I sent an email on 18 May 2004 to Darren Keating to determine dates for that meeting. I also discussed it with Terry Hanelt, Allan Cooper, and Brian Thiele.

116. We had a meeting on 15 June 2004 at the Friendly's Hospital.

117. I got the hospital administration involved out of diplomacy. The program was done with patients in the private system. Baxter paid for it. It did not really have anything

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to do with Queensland Health. It did not make any difference to me if the administration said yes or no. I would have done it anyway. It was in the best interests of my patients.

118. I got the impression that Dr Keating was not particularly happy about the program. I might be totally wrong about that. I never received any feedback from Dr Keating about the program.

119. Another issue I raised with Daren Keating related to vascular access in the hospital. Vascular access in Australia is a very complex issue. There are very few vascular surgeons around.

120. Dr Brian Thiele, as I have stated above, is a vascular surgeon. He visits Bundaberg. I thought that the Bundaberg Base Hospital should be able to use him for vascular surgery. I wrote a letter on 8 November 2004 to Dr Keating. In that letter, I used an example of a young aboriginal male patient who had suffered immensely. He kept coming into the hospital. We kept inserting temporary catheters. Eventually, he was referred to the Royal Brisbane Hospital but was unable to go. He was too ill. I used him as an example of where the entire problem could be prevented by having Dr Thiele perform vascular access locally.

121. I never received a response to that letter.

122. I raised the issue again at a central zone committee meeting for renal services. I recall the zone manager Dan Bergin saying that there is a problem with vascular surgery throughout Queensland, yet in Bundaberg there is a vascular surgeon which the hospital cannot use. He asked why we could not use him. I explained that he works in the private sector. I explained that the Bundaberg Base Hospital buys a range of services from the private sector such as radiology.

123. I suggested that a similar arrangement could be put in place for vascular surgery. I explained to Dan that I had had no response from the administration in Bundaberg. Dan asked for a copy of my letter to Dr Keating.

Signed: . . . . . Witness: . . . . . .

124. Two weeks later a teleconference was arranged with Dr Keating, Dan Bergin, Mike Alsop, Peter Leck and myself to discuss this proposal. I suggested for access surgery to be done in the private sector. It was agreed to at the meeting.

125. Darren Keating wrote to Dr Thiele. He forwarded a copy of that letter to me. In that letter Dr Keating offered Dr Thiele 1 session at the hospital every two or three months and nothing else. It was totally inadequate for our need. I believe that the problem was due to budgetary constraints. Dr Keating and Mr Leck were worried about the impact on budget or employing a VMO on a regular basis.

126. I pointed out that the Queensland Government in the last election made available a fund for renal services in Queensland and that some of that money was specifically for vascular surgery. I suggested that the hospital apply for access to those funds. I have no knowledge of whether any application was made by the Hospital for funding.

127. In this geographical area of Queensland, I am the only nephrologist. When patients get sick in other hospitals I usually transfer them to Bundaberg. This arrangement has been in place in an informal way for sometime. I have been doing this for years but last year they decided that they wanted to formalise that process. As part of that I was at a meeting with Linda Mulligan, Darren Keating and the Charge Nurse, Robyn Pollock. I told Darren Keating that the renal practice had become very large with two renal units and that I was seeing hundreds of patients every year and I said that I need some help. Darren said to me words to the effect "Peter – you have to understand that this is a business. It's not a hospital." He said this twice.

Threats

128. I recall two occasions when I believe I was threatened by Darren Keating. Both were somewhat veiled. When the whole Patel issue was first in the Media, Darren Keating came into the wards, although I had never seen him in the wards previously.

129. He sought me out one afternoon. I was in my office in the ward. He said words to me to the effect of "you know what goes around comes around". I laughed and replied to him words to the effect of "Darren you and I see things very very differently".

Signed: . . . . . Witness: . . . . . .

130. Many of the other physicians here have said that they wanted to support me. I advised them to stay out of it. Many of those doctors had restricted registration due to their visas and, therefore, were more vulnerable to Queensland Health.

Dr Qureshi

131. I am not sure if Dr Quershi was ever really a doctor. I had conducted a test of Dr Quershi to determine his clinical competence. He had failed that test completely.

132. I remember allegations being raised about Dr Quershi sexually harassing both staff and patients.

133. I had several complaints from staff and patients, one patient was Karen McInnes about Dr Quereshi's behaviour.

134. I believe that she complained to the nursing staff and I assumed that the complaint would have gone up through the nursing channels.

135. Following that complaint staff were informed that Dr Quershi was to have a chaperone.

136. Dr Keating transferred Dr Quershi between departments in the hospital. I advised Dr Keating that I did not want Dr Quershi in my department.

137. The issue was resolved when the police turned up one day and Dr Quershi disappeared.

Checking of Dr Patel's CV

138. On one occasion when Darren Keating was away, Dr Kees Nydam was acting as Director of Medical Services. I asked Dr Nydam if I might be able to look at Dr Patel's CV. I wanted to see it. There was something quite discordant about the whole situation.

Signed: . . . . . Witness: . . . . . .

139. I approached Dr Nydam as I did not believe that Dr Keating would allow me to look at Dr Patels's CV.

140. When I reviewed the CV it appeared to me to be in order.

Executive Meetings

141. I attended the Executive Committee meetings. These occurred monthly on a Friday afternoon. That meeting was chaired by Peter Leck, the District Manager. It was attended by all of the clinical directors including Dr Patel.

142. I did not raise my concerns at these meetings. I had already conveyed my concerns to Dr Keating who was my immediate superior.

Complaints Process

143. I am not entirely sure what the complaints process existed within the hospital.

144. I believed that medical complaints were to be referred up to the Director of Medical Services, in the case of my department, through me.

145. If complaints come to me I would take it to the Director of Medical Services

146. Adverse Events forms were routinely filled in the hospital. These were sent to the Executive. In my experience, there was very little feedback from the Executive about such complaints.

147. Staff generally did not get much feedback on complication rates or complaints from patients.

148. I initiated a system of electronic minutes of clinical forum meetings. I received no feedback on this initiative.

149. I have given copies of the letter from DJason Jenkins to Darren Keating and also to Gerry Fitzgerald, I had kept a copy of that letter.

Signed: . . . . . Witness: . . . . . .

150. I have occasionally been asked to do investigations into incidents within the hospital

151. On one occasion I was sent a request from the Director of Medical Services to review one particular patient who had a problem testing certain enzymes in the blood. I examined the file and reviewed the complaint to see what the problem was. I provided my comments as I was requested.

152. My usual process, when I get a request like that is to ask for further information. I will make comments for patients managed by other physicians

153. However I only did this for medical patients.

154. I never received any feedback from the Executive on any report.

155. I am on the following committees, the Executive Council Committee, the Clinical Science Forums, I'm a company director for the Bundaberg Health Promotion Unit, I am on the Ethics Committee, I am on the Audit Committee for the Friendlys Hospital. Every few months I go through some of the Friendly's Hospital's. Outside the hospital I'm on the Central Zone Renal Committee.

156. I chaired the Medical Staff Advisory Committee for a short time. In principle, I chair the Clinical Science Forum.

157. I received the agendas and minutes for those meetings. I do not recall disciplinary action or complaint issues ever being discussed. The issues generally discussed included medical issues, surgical issues and obstetrics and gynaecology issues. A significant thing discussed is the budget.

Peter Leck

158. I have had several occasions where I have spoken with Mr Leck. I always found him to be affable and well mannered. I have written to him on several occasions. I always found him to be polite.

Signed: . . . . . Witness: . . . . . .