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MEMORANDUM

FILE COPY

Confidential

To: Dr Gerry Fitzgerald
Chief Health Officer

Copies to:

From: Peter Leck, District Manager
Bundaberg Health Service

Contact No: 07 41502020
Fax No: 07 41502029

Subject: **Staff concerns regarding outcomes for some complex surgery at Bundaberg Hospital**

File Ref:

Thank you for your offer of 17 January 2005, for your office to be involved in the review of outcomes of some complex surgical procedures at the Bundaberg Hospital.

In late October 2004, the Nurse Unit Manager of the Intensive Care Unit, Ms Toni Hoffman, raised concerns about the outcomes of surgery for some patients being treated by the Director of Surgery, Dr Jay Patel. Ms Hoffman also highlighted conflict between herself and Dr Patel and suggested this conflict was repeated between Dr Patel and other medical and nursing staff.

On 22 October 2004, Ms Hoffman placed her concerns in writing (Attachment 1), and provided details of several patients where she had concerns about their treatment and outcomes.

After discussing the matter with both the District Director of Nursing Mrs Linda Mulligan, and Director of Medical Services Dr Darren Keating, a decision was made to confidentially meet with some medical staff in an attempt to ascertain whether there was a shared view about some surgical outcomes, or if the allegations more reflected personal hostilities. A summary of discussions with medical staff (Attachment 2) are attached.

Subsequently I made some enquiries about obtaining an appropriate clinician to review the relevant cases, and to provide advice as to whether some procedures being performed adequately took account of the capacity of the local intensive care service.

Dr Alan Maloney, an anaesthetist with intensive care experience at the Redcliffe/Caboolture District Health Service was recommended. The District Manger agreed to release Dr Mahoney to conduct a review if required. To date, Dr Mahoney has not been directly approached.

Some assistance for Dr Mahoney in conducting the review was sought from Audit and Operational Review Branch. The Branch indicated that as the matter was not one of official misconduct, that your office would be best suited to assist (Attachment 3).

Since the original correspondence from Ms Hoffman, several nurses have also provided correspondence raising their concerns. (Attachment 4). Some have sought protection under the Whistleblowers Protection Act.

The concerns raised were briefly discussed with Dr Patel on 13 January 2005, following his return to work from leave. Subsequently Dr Patel has advised that he does not intend to extend his contract when it expires on 31 March 2005. Dr Patel has been employed on a contractual/locum basis since April 2003. He had worked in the United States for many years prior to coming to Australia.

I would be grateful for an appropriate review of the cases where concerns have been raised.

Please do not hesitate to contact me if you have any queries.

Peter Leck
District Manager
19/01/2005

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FAX MESSAGE

Bundaberg Health Service District
PO Box 34
BUNDBERG Q 4670

CONFIDENTIAL

ATTACHMENT 1

TO:		FROM:	
Fax:	32341528	**Fax:**	41502029
Name:	Rebecca McMahon	**Phone:**	41502025
Organisation:	Acting Manager, Investigations, Audit & Operational Review Unit	**Name:**	Peter Leck
Date:	16/12/04	**Position:**	District Manager

CONFIDENTIAL COMMUNICATION

SUBJECT: Documents

Pages 7 **(Inclusive)**

FAXED 16/12/04 11-25 am cbm ✓

Dear Rebecca

Please find enclosed documents as per our telephone conversation of today.

Yours faithfully

Peter Leck
District Manager

22nd October 2004
Peter Leck,
District Manager,
Bundaberg Base Hospital,
P.O Box 34,
Bundaberg. 4670.

Dear Peter,

I am writing to you to officially inform you, of the concerns I have for the patients in ICU in relation to the behaviour and clinical competence of one of the surgeons, Dr Patel.

Dr Patel first voiced his displeasure with the ICU around the 19th May 2003. A patient UR number 034546 came to the ICU post oesophagectomy. This patient had multiple comorbities and for the last 45 minutes of surgery, had no obtainable Blood pressure. The anaesthetist who accompanied him into the ICU, stated " It was a very expensive way to die." He required 25ug of Adrenaline and 100% O2. Dr Patel stated the patient was stable. The Nursing staff who were communicating with the patients family told the patients mother that he was extremely ill. Indeed he progressed to brain death. Dr Patel continued to say the patient was stable. The course of treatment for this patient was very difficult, he required dialysis and there was constant conflict between the anaesthetists, Dr Patel and the Physicians about his care. The Director of Anaesthetics and ICU was away and Dr Younis was left in charge, he was reluctant to question whether or not we should be doing such large operations here at BBH. Dr Jon Joiner and I went to see Dr Keating to voice our concerns. We both believed we could not offer adequate post op care for oesophagectomies. The literature stated a hospital should be doing at least 30 per year to maximise outcomes. At this time I first stated my concern that Dr Patel could describe a patient on maximum Inotropes and ventilation as stable. I voiced these concerns to Dr Keating. After this incident Dr Patel and I had a conversation where I told him that the ICU wished to have a good professional working relationship with him. I tried to tell him that we were a level one ICU and that our staffing levels and scope of practice meant that we could only keep ventilated patients for 24-48 hrs , before transferring them to Brisbane. Dr Patel stated that he would not practice medicine like this and he would go to "Peter Leck and Darren Keating and care for his own patients." This incident was repeated relatively soon after the first. Dr Patel would threaten the staff with his resignation when it was suggested it was time to transfer out a ventilated patient. He continually stated he was working in the " third world" here. He would use "Peter Lecks" and "Darren Keatings" names as a type of intimidation and threat to the staff. He stated on several occasions he would go straight to Peter Leck as he had made him " half a million dollars this year". Every time we had a ventilated patient in the ICU that required inotropes he would argue with the anaesthetists about which inotrope to use. His choice of inotropes did not reflect best practice guidelines in Australia. He refused to speak to the writer, (myself). All requests for a bed would go through either another nurse or doctor. He would yell and speak in a very loud voice, denigrating the ICU and myself and at times the anaesthetists, The nursing staff felt they were often the " meat in the sandwich" He would harass them and ask them " Whose side they were on". At times he would actively try to denigrate my ability as a NUM to the nursing staff and other doctors. (See attached documentation).

Soon after Dr Patel started operating here the nursing staff observed a high complication rate amongst the patients. Several patients had wound dehiscence and several experienced perforations. This is a list of patients I believe require formal investigation. This is taken from our ICU stats and are not a full and comprehensive review as there are no stats from OT or Surgical Ward.

UR 130224 6/6/03 post op oesophagectomy
12/6/03 wound dehiscence.
15/6/03 2nd wound dehiscence
suffered a third wound dehiscence was transferred to Brisbane on the 20/6, had a J tube leak and peritonitis. A bed had been obtained earlier for this man, but Dr Patel went up to Dr Keating who advised our anaesthetist to keep him for a few more days, in which time the bed was taken, and he stayed several more days whilst another bed was sourced. The Doctors at RBH questioned why we were doing such surgery here when we were unable to care for these patients.

P16 post op oesophagectomy ventilated for 302 hrs.

P12 Ventilated for many days: transferred to Brisbane after many arguments in the ICU with DR Patel who refused initially to transfer this patient.

P27 issue with transferring patient to Brisbane.

P32 Bowel Obstruction Resection and Anastomosis on 7/2/04 T/F to Brisbane on the 11/2/04 on the 12/2/04 laparotomy showed perforation and peritoneal soiling.

P14 Wound Dehiscence and complete evisceration.8/4/04. Booked for sigmoid colectomy and found to have ovarian ca.

UR 020609 27/4 Wound dehiscence.

UR 29/6 Insertion of Vascath perforated ® IJ.

UR 086644. Delay in Transfer to Brisbane , See attached report, Pt died.

P37 10/7 laparotomy for Ventral Hernia, developed haematoma in ward and attempted evacuation done without any analgesia. Drs notes consistently say patient well when Pt was experiencing large amounts of pain and wound ooze.

P161 pt had Whipples , death cert stated he died of Klebsiella pneumonia and inactivity

P22 death cert stated pt died of malnutrition. Had been operated on 31/7/04. Several conversations were had with other doctors , Acting Directors of Nursing and NUMs. Dr Miach refused to allow Dr Patel to care for his patients as he stated he had 100% complication rate with Peritoneal Dialysis insertion. This was stated in a Medical Services forum as well as in a private conversation with myself. This data was shown to the Acting Director of Nursing Mr. Patrick Martin.

On the 27th July 2004, Pt UR number 086644 returned to ICU in Extremis with a chest injury, The events of these13 hrs is well documented. Dr Patel interfered in the arranged transfer of this patient to Brisbane and the patient died after it was thought the retrieval team were on there way to retrieve this patient. The subsequent events of this intervention and the traumatic pericardial tap (described by the nurse caring for the patient as repeated stabbing motions)resulted in the ICU staff requesting advice from the nurses union . The staff involved in this situation described it as the worst they had ever seen. They were acutely distressed. An attempt was made to seek EAS support, but they were unable to assist due to their workload. One staff member accessed Psychological support privately. I was requested to fill in a sentinal event form , by the then QI Manager Dr Jane Truscott. The events of this incident were discussed at length with the union, who offered support to the staff. They also offered me several ways I could report the long standing concerns I had with the current situation in ICU. The day after the patients death , when I thought he had safely been transferred to Brisbane , Dr Strahan came to talk to me in the office and found me very distressed. He offered to talk to some of the other doctors and get back to me as the representative of the AMA in Bundaberg. He did this stating " there is widespread concern, but at the moment no-

one is willing to stick their neck out" He urged me to keep stats on my concerns. I spoke with Dr Dieter Berens and informed him the nursing staff were going to report their concerns with Dr Patel to an official source. He stated he would support us , by telling the truth, but he was concerned he would lose his job and Dr Patel would be the one left behind. It is widely believed amongst the medical and nursing staff that Dr Patel was very powerful, that he was wholeheartedly supported by Peter Leck and Darren Keating and was untouchable. Anyone who tried to alert the authorities about their concerns would lose their jobs. This perception was indeed perpetrated by Dr Patel on a daily basis. Many of the residents and PHO's have expressed their concerns, Dr Alex Davis, and Dr David Risson, But were unsure of what to do because of the widespread belief Dr Patel was protected by executive.

The Nurses union have offered advice in that there are several ways these concerns can be reported if not dealt with internally, after my conversation with Peter Leck and Linda Mulligan on Wed, I believe they were not in receipt of the full concerns, but now that they are they will deal with them.

Dr Miach has reiterated he has dealt with the issue by not letting Dr Patel near his patients. These concerns were openly discussed at the medical services forum.

A peripheral concern is the reports the junior doctors have voiced about forms not being filled out correctly, of being told not to use certain words in discharge summaries, and various other chart irregularities. Toni Hoffman

Toni Hoffman.

Documentation from Karen Stumer,Karen Fox, Kay Boisen x2, Karen Jenner , Vivienne Tapiolas included.

ATTACHMENT 2

Notes of Meeting – 5 Nov 04

Present :

Dr Martin Strahan – VMO Gen Medicine - BBH
Mr Peter Leck – DM BHSD
Dr Darren Keating – DMS BHSD

Context :

Ms Toni Hoffman NUM ICU/CCU has made a number of allegations against Dr Jayant Patel, Director of Surgery BBH, including some allegations about his clinical competence. Dr Strahan was asked to provide any comment in relation to these allegations because Ms Hoffman had named him as one doctor who shared similar concerns.

Response :

Dr Strahan outlined a case where a woman from Biggenden was referred to him for investigation of abdominal pian. He performed a gastroscopy on the woman finding obstruction in the 2nd part of the duodenum and was unable to advance the scope any further, despite multiple attempts. After the procedure the woman experienced ongoing abdominal pain (? perforation), so was referred to BBH and seen by Dr Patel. A CT scan was performed and reported to Dr Strahan as showing dye in the abdominal cavity. He reviewed the films and believed the dye showed a nephrogram. Nevertheless Dr Patel operated and found carcinoma of the pancreas (which was confirmed as adenocarcinoma by biopsies taken at time of endoscopy). Dr Strahan believed this case showed Dr Patel was rigid in his thinking and judgement being unwilling to be flexible as new evidence came to hand. This lady was sent home and returned for a Whipples operation. Unfortunately she died several days after the operation. He also questioned whether the Whipples operation should be done in Bundaberg, whilst acknowledging most specialists (inc himself) in regional areas may have kept patients too long before referring to metropolitan hospitals.

Dr Strahan believed that Dr Patel had an aggressive and assertive personality, but had he had kept his distance from Dr Patel. Dr Strahan noted that the local specialists felt Dr Patel had arrived from the US, been appointed as Director of Surgery and given appropriate authority supported by management, which he had used to reduce surgical waiting lists. However he appeared to operate without some form of peer review. He was seen as a self declared expert from the 1st world here to help the 3rd world of Bundaberg. The local specialists saw him as 'a Johnny come lately' who had been given the 'inside running by management' with concerns held by the specialists over his university appointment and appointment to the local Oncology committee.

Dr Darren Keating
DMS

Notes of Meeting – 2 Nov 04

Present :

Dr David Risson –PHO (PGY3) - BBH
Mr Peter Leck – DM BHSD
Dr Darren Keating – DMS BHSD

Context :

Ms Toni Hoffman NUM ICU/CCU has made a number of allegations against Dr Jayant Patel, Director of Surgery BBH, including some allegations about his clinical competence. Dr Risson was asked to provide any comment in relation to these allegations because Ms Hoffman had named him as one doctor who shared similar concerns.

Response :

Dr Risson's concerns related to transparency of the current surgical audit process conducted in the Surgical Department, where he believed there was lack of structure. He was concerned that upon cessation of use of the Otago database, there weren't reasons provided about the change nor an adequate replacement put in place. He had concern (which was shared by nursing staff) about the apparent number of post-operative complications including infection.

Ms Hoffman had spoken to Dr Risson about the care of Mr Bramich but he wasn't involved in the care of this patient and couldn't comment. He did remember hearing about one case where insertion of a CVP line by Dr Patel had possibly pierced the SVC, leading to pericardial tamponade and patient death. Dr Risson was involved in getting consent for the procedure from the patients, but hadn't observed the procedure.

Dr Risson described his relationship with Dr Patel as amicable noting that he could be flighty and occasionally unpredictable. The resident staff believed that he was very severe in reprimands, particularly for minor issues.

Dr Risson had never been told to not write anything on a discharge summary and had attended a Surgical Department meeting where wound dehiscience and superficial infection had been discussed.

Dr Darren Keating
DMS

Notes of Meeting – 29 Oct 04

Present :

Dr Dieter Berens – Specialist Anaesthetist BBH
Mr Peter Leck – DM BHSD
Dr Darren Keating – DMS BHSD

Context :

Ms Toni Hoffman NUM ICU/CCU has made a number of allegations against Dr Jayant Patel, Director of Surgery BBH, including some allegations about his clinical competence. Dr Berens was asked to provide any comment in relation to these allegations because Ms Hoffman had named him as one doctor who shared similar concerns.

Response :

Dr Berens noted that he could only talk about areas that crossed over with Dr Patel, being primarily care of ICU patients. He believed that Dr Patel's critical care knowledge was not up-to-date in relation to choice of some drugs and fluids plus application of some physiology principles to care of critically ill patients. He remembered 2 cases related to his concerns. He acknowledged that he was aware of a difficult working relationship between Dr Patel and some ICU nurses.

As an anaesthetist, Dr Berens noted that Dr Patel's manual skills were very good and that patients being admitted to BBH (and ICU) were older and sicker than several years ago, when he was previously employed at BBH. He questioned Dr Patel's judgement to undertake some procedures (e.g. vascular, Whipples), with regard to his currency in doing such procedures. In one case of placement of a gastrostomy tube, he had concerns about the control of the trochar.

He believed that Dr Patel's attitude to other professionals made him hard to work with on occasions. He felt that Dr Patel made categorical statements, didn't appear flexible and wouldn't discuss alternative clinical options. Dr Berens believed that Dr Patel appeared reluctant to admit to other doctors his own mistake or error in care of patients. He didn't appear to be completely accountable and honest about his surgical actions.

Dr Berens noted that Dr Patel could be short with his resident staff (while acknowledging that most senior doctors had been short with residents at different times) and had a reasonable working relationship with nursing staff in theatre. He believed he could continue to work with Dr Patel in the future.

DK

Dr Darren Keating
DMS

FILE NOTE

Meeting of Toni Hoffman, Linda Mulligan and Peter Leck
20 October 2004 – 3.30pm

Peter Leck began meeting by thanking Toni for her time and advising that any issues raised would be followed through. Toni indicated that she had a number of concerns about patient safety relating to Dr Patel. She outlined them:

Patient Safety

1)

- Concerns re what constitutes a stable patient. Oesphagectomy. Dr Patel had written in notes patient was stable but was in fact brain dead.

2)

- Concerns that we were doing things outside scope of practice. When looking at transferring patient – Dr Patel threatened to resign.
- Funding used as a threat – made $500k for Director of Medical Services and District Manager if we couldn't guarantee to provide care he would resign. Beds in Brisbane would be booked but patients not transferred.
- He alienated anaesthetists so that every day there was a fight in unit about management of patients.
- Constantly denigrate ICU – describes it as third world.

3)

- Dr Patel very old fashioned in types of drugs used. Nursing staff caught in middle between anaesthetists and himself.
- Followed a nursing staff member around and kept at her, harassing her.
- When questioned about appropriateness of complexity of surgery (eg thoracotomy) said it was something else eg wedge resection of lung and that you have to do a thoractomy anyway for this.
- Mr Bramich - Dr Patel said wasn't sick enough to go to Brisbane – then - became too sick to go to Brisbane and patient died
- Pericardial tap – no evidence on echo that required. Coroner's review showed traumatic damage to heart on autopsy.
- This was final straw – 9 year old daughter watched her father die. Dr Patel screamed at patient's wife not to cry.
- Dr Strahan visited me after Mr Bramich's death and I explained my concerns. He said he was in AMA and would talk to other doctors. He came back and said doctors had concerns but did not have enough to stick their necks out with.
- Dr Miach said won't let Dr Patel near him nor his patients
- Jon Joiner and I have seen Darren
- Gail Aylmer and Robyn Pollock been to see Darren about lack of handwashing.
- Nursing staff involved in Mr Bramich's care contacted QNU. Nurses wanted it to be a coroner's case. QNU have said that they can take it to DG or nurses could seek whistleblower status and contact HRC or CMC.

- Approached Jenny Church but said won't fill in adverse events forms.
- Saw Di Jenkin – she not filling in forms, and said "what is the point".
- Dieter said wouldn't pursue as he might be one to lose job.
- David Risson has concerns.
- Heard second hand that Dr Patel told junior doctors not to use certain words in discharge summaries so that issues not picked up.
- Wound dehiscence – not all being reported.

I didn't want anyone to come and die in unit because he stops transferring patients.

And I think he is working outside scope of practice – Dr Miach openly questioned his qualifications and he has pushed us too far. We are working outside scope of practice.

Dr Miach said he managed situation by not allowing Dr Patel to go near his patients.

Mr Bramich – they may come back and said he would die anyway – but that isn't the point. It was about him interfering in process that would have got patient to Brisbane in the time for him to have the best chance.

Am quite happy to be proven wrong.

Want independent assurance outside of Bundaberg that right things being done.

Queensland Government
Queensland Health

Bundaberg Health Service District

Adverse Event Report Form

Ensure that any person involved is safe and that all necessary steps have been taken to support and trea this person and to prevent injury to others. Ensure medical records are factual and up to date.

DQDSU Use Only

Registration No.	P0334	Date Registered	3/8/04	Date Received
Risk Assessment	Consequence: Major	Likelihood: Possible	Risk Rating	RECEIVED 02 AUG 2004 DQDSU
Risk Level	Very High			
Assessed by	J Truscott			
Action required	Fwd to DM, DMS, DON 2/8/04			

Please print clearly using a black pen (Attach extra sheets if required)

Site: ☑ Bundaberg ☐ Childers ☐ Gin Gin ☐ Mt. Perry

Patient/Visitor Adverse Event

Bundaberg Hospital
BRAMICH
DESMOND

SEX: M
UR NO: 086644

M

PLANT OPERATOR

Department	ICU.		
Sex of subject	(Male)	Female	Not stated
Subject is	(Patient)	Visitor	Other
MHS Clients	Involuntary	Voluntary	Unknown
Reporters Details	Name: Karen Fox		
	Contact No.: Ext 2310		
Reporters Classification	Please specify: RN.		
1st Witness	Name & Contact No.: D. Aitken, Ext 2310		
2nd Witness	Name & Contact No.		
Site of Adverse event	ICU.		
Date of Adverse event	27/7/04	Time	
Current patient diagnosis/problems	Ventilated #ribs		
Adverse Event Type	ICC drain, no water in underwater seal section.		
Next of kin notified?	Yes (No) N/A	Name:	
Medical officer notified?	(Yes) No N/A	Name: DR PATEL.	

Staff Adverse Event
Enter details in this column

Full Name				
Employee Number				
Department				
Employment Type	Fulltime	Part time	Casual	Temporary
Shift Type	Fixed	Standard	Rotating	Other
Date of Event	Time			
Shift time	From	To		
Position title				
Supervisor's Details	Name			
	Contact No.			
Task	What were you doing at the time of the adverse event?			

years

✓
Already forwarded to DM, DMS, DON
Can you make sure they get a form for AE follow up. Thx.

Medical Officer's examination (This section to be completed for patien

If relevant, please describe the assessment of the subject's condition and list treatments/inv

Medical Officer's Signature:			Date & Time:	
Open Disclosure process initiated?	Yes	No	N/A	Name:

Please complete all sections on page 2 for all adverse events (Patient or Staff)

Description of Adverse Event - Please describe exactly what happened, including who was involved

On doing checks - noted no water in underwater seal drain section of ICC drain.

If this adverse event is a fall, pressure area or occupational exposure, please complete the relevant minimum data set form

Contributing factors - Identify causes/conditions/practice/human error/patient behaviour/staffing/experience etc that contributed to the incident

Busy, unstable pt.
From previous shift

Treatment/investigations ordered - Indicate what treatments or investigations were required as a result of this incident

Put water into appropriate section.

Impact or Outcome - What has been the outcome of this adverse event?

Unknown

Minimisation of Outcomes - What factors minimised the outcome, or if this was a near miss, what stopped the event from occurring?

Rectifying the situation

Prevention - How could this adverse event have been prevented?

More time, checking.

Signature		Date	28/7/04.

Thankyou for completing this form. Please give this form to your Shift Supervisor

Shift Supervisor /Management Report

Comment on action taken or action needed to be taken to prevent recurrence

↑ awareness of need for H2O in underwater sealed drainage, training of who set up unit. Emergency situation.

Has the adverse event been documented in the medical record?	Yes	No	If not, why not?
Name: Terri Brown	Signature: Terri Brown		

Please forward this form to the District Quality and Decision Support Unit

Director's Comment (Where required)

WHSO Comment (Staff Adverse Event Only)

DQDSU Comment

ATTACHMENT 3.

From: Rebecca McMahon
To: Peter Leck
Date: 17/12/2004 11:34:21
Subject: Intensive Care Unit

Hello Peter,

I refer to our telephone discussion yesterday and your subsequent facsimile in relation to issues with the Intensive Care Unit at the Bundaberg Hospital.

After reviewing the documents you provided, I spoke to Michael Schafer in relation to this issue.

Both myself and Michael are of the view that this matter involves issues of clinical practice and competence, rather than allegations of official misconduct. Accordingly, as discussed yesterday, it would be more appropriate for a suitably qualified team of medical practitioners to review the practices of Dr Patel and the ICU generally.

Michael has confirmed my view that Gerry Fitzgerald, Chief Health Officer, will be able to provide advice as to the manner in which this review should be conducted.

Should this review identify further evidence which raises a suspicion of official misconduct on the part of any of the officers involved please advise me and I will reassess this matter.

If you have any further questions in relation to this matter please do not hesitate to contact me on 323 40589.

Many thanks

Rebecca McMahon
A/Manager, Investigations
Audit and Operational Review Unit
Queensland Health
Ph: (07) 3234 1966
Fax: (07) 3234 1528
Email: rebecca_mcmahon@health.qld.gov.au

CC: Gerry FitzGerald

4 January 2005

ATTACHMENT 4.

Michelle Hunter
Acting Clinical Nurse
Surgical Ward
Bundaberg Health Service

CONFIDENTIAL

Lynda Mulligan
Director of Nursing
Bundaberg Health Service

Dear Lynda

I would like to express my grave concern about a recent patient P26 . P26 had a motorbike accident on 23/12/04 and sustained a laceration to his left groin area. He was subsequently taken to theatre on arrival to DEM and had a femoral vein repair and debridement/washout and wound closure. At the time of this surgery his femoral artery was intact. P26 was admitted to ICU intubated post op and a few hours later had to return to theatre with a pulseless left leg and he had fasciotomies performed to his thigh and lower leg. Again he returned to ICU for a few hours and then again went back to theatre with acute ischaemia to his left leg despite the fasciotomies. He had an exploration and arteriotomy with a Gortex bypass graft. My dealings with P26 started on the 30 December when I looked after him on an evening shift. He had recently been transferred to the ward from ICU. My assessment of P26 showed he was tachycardic, febrile and his left leg was grossly swollen and oozing very large amounts of serous ooze. His Left foot was purple and mottled to the ankle, he had a Posterior Tibial pulse on Doppler but no Dorsalis pedis pulse. He was unable to move his leg, was cold from the ankle down and had very patchy sensation. This information was made available to the Doctors on duty that afternoon.

I did not look after P26 again but was team leader for other shifts in which he was an inpatient in the surgical ward. P26 was transferred to the Royal Brisbane Hospital for vascular surgical care on 1 January 2005. I have since learned that P26 is in a grave condition in ICU there and he has undergone an amputation of his left leg as well as other procedures.

My concerns are with the surgeon that performed his initial 3 operations whilst in the care of the Bundaberg Health Service. I am concerned that if the patient had been transferred to Brisbane initially he my not of lost his leg or be in such a grave condition.

I would like his treatment at this hospital investigated as I fear his health and well being has been compromised by inadequate, sub standard treatment by the medical team.

Your urgent assistance in this matter is greatly appreciated.

Yours Sincerely

Michelle Hunter

I Jenelle Joy Lane, Enrolled Nurse Advanced Practice request anominimity under the WHISTLEBLOWERS PROTECTION ACT 1994 - Reprint no. 3G. I will be known as WB 06.

My name is Jenelle Joy Law. I am an Enrolled Nurse and am licenced to practice in the state of Queensland.
I am employed by Queensland Health and work at the Bundaberg Base Hospital in the Operating Theatres as an Enrolled Nurse Advanced Practice.
I was rostered to work on Monday 20th December 2004 and also rostered to be on call that same day.
This statement is regarding the death of Mr. Gerard Kemps who was operated on Monday the 20th December and passed away the following day, Tuesday 21st December. The procedure that he initially had performed, was a gastro-oesophagectomy. This was done by Dr. Jay Patel.
My issues regarding this matter are with Dr. Patel himself. I felt his professionalism was of a very poor standard. It began on the morning of the 20th December. I commenced my shift and was told that the gastro-oesophagectomy case may be cancelled due to there being no spare ventilators in the Intensive Care Unit. Dr Patel came into our tea room not very happy and complaining, saying that one of the patients was a head injury patient and the ventilator should be turned off, and the other was a private patient and should be sent to Brisbane, that way he would have a ventilator for his patient and the surgery could proceed. In a short period of time, a ventilator became available and his procedure went ahead.
Mr. Kemps was wheeled into the operating theatre. He was a happy, easy going man,and very pleasant to talk to. The gastro-oesophagectomy was performed. When the surgery was finished and we were preparing to transfer Mr. Kemps, it was noted that his Bellovac drain was filling quite rapidly. The anaesthetist, Dr Deiter Berens, asked for Dr Patel to please come and review the patient as he was concerned about the blood loss. While I was in the theatre Dr Kariyawasam came and saw the patient. He didn't have any answers for the situation. I was then asked to go for my lunch break.
By 5.30pm that same day, the theatre staff were informed that Mr. Kemps was required to return to theatre immediately or he would die. He was bought through from the Intensive Care Unit and a laparotomy, spleenectomy and thoracotomy was performed. The suction unit filled very quickly once the laparotomy was started. There was 2.3 litres of blood in the suction unit that I could visibly see. Two litres of normal saline wash was also used. Throughout the surgery I gave the scrub nurse, Registered Nurse Katrina Zwolak, 75 large sponges and 15 raytec. There was blood and blood clots all over the floor. Dr Patel stated a number of times, that the unexplained bleeding, had nothing to do with his surgery that he performed that morning.
During the procedure, Dr Patel stated that this patient is going to die and was yelling at us to get his family. The family was found and brought into the hallway of the theatres. Dr Patel left the operating theatre while still in his scrub gear and went and spoke to them. During the procedure Dr. Patel became anxious and agitated, and stated a few times, that this problem, being the excessive bleeding, was not his fault and had nothing to do with his surgery. The patient's incisions were closed. Dressings were applied, but had to be reinforced with combines as they continually oozed with blood. The patient was then transferred back to the Intensive Care Unit.
I personally found that being involved in this case was quite distressing. I fully understand that with every operation there is a risk, but what confuses me, is that there was no uncontrolled bleeding prior to Mr. Kemp's first surgery, then there was massive

bleeding afterwards. If this had nothing to do with Dr. Patel's surgery, why did this man start bleeding uncontrollably? Shouldn't some sort of official inquiry be done regarding this matter, and should Dr Patel be allowed to continue doing this type of surgery, as my understanding is, that all of his patient's that have had this surgery have not survived. Mr Kemps was due to go to Brisbane to have this surgery performed. Why was this changed? I understand that being an Enrolled Nurse I do not have a lot of the medical knowledge, but I do have compassion for people. Why was the big rush to have this surgery performed? Was it such of an emergency that it had to be performed before Christmas? Could it not have waited until after Christmas, so the Kemps family could have enjoyed Christmas together.

Jenelle Law

J Law

COVER NOTE

DAMIEN PAUL GADDES
REGISTERED NURSE (SINCE 1992)
BUNDABERG BASE HOSPITAL

QUALIFICATIONS

CERTIFICATE IN NURSING 1992
SARAH KEENAN SCHOOL OF NURSING
SINCE 1992 I HAVE HELD CLINICAL POSITIONS IN THE PERI OPERATIVE ENVIRONMENT.

I AM WRITING THIS STATEMENT TO VOICE MY CONCERNS IN MY OPINION OF DANGEROUS PRACTICE WITH DOCTOR J. PATEL (DIRECTOR OF SURGERY OF THE BUNDABERG BASE HOSPITAL.)

I ALSO REQUEST THAT I HAVE PROTECTION UNDER THE WHISTLE BLOWER'S ACT 1994. MY REQUEST IS FOR THE PURPOSE OF AVOIDING BULLYING (FROM DR PATEL) AND STAFF SPECULATION.

I began my shift at0730 hrs on the 20/12/04> The half hour early start was to accommodate organization of all necessary anaesthetic equipment and stock for Mr G.Kemp UR No.007900 scheduled for a "Gastro-esophagectomy" via a abdominal and thoracotomy approach. (IVOR-LEWIS esophagectomy).

I collected the Dangerous Drug keys from ICU and conversed with the staff re their readiness for Mr Kemp post op. Martin Brennan (RN) informed me that they do not have the staff for another ventilated patient; as they already had two patients on ventilators. I then decided to ring DR Berens Re the situation and the possibility of postponing or cancelling the case Dr Berens concurred with and stated we would postpone the case; I told Dr Berens that I would notify Dr Patel.

I asked switch to connect me to Dr Patel's mobile phone. I informed Dr Patel of the bed situation in ICU. His tone of voice became angry. He then stated that the *BRAIN-DEAD* patient should have had the

ventilator turned off and that the other patient had Private cover and could have been transferred to Brisbane. Dr Patel began to say how the ICU staff and DR Joiner were interfering with his planned case that day; also that he would clear the ICU for his patient. I interrupted Dr Patel and explained that I was passing on pertinate information and that I would not be preparing expensive equipment and waste it until I knew definitely whether the case would be going ahead. Dr Patel said, " I know Thank you" and then hung up.

I continued to prepare the theatre suite and anaesthetic equipment to where no items were wasted yet, were at the ready. We began the anaesthetic at approximately 0900 hrs post hearing the *Brain-dead* ventilator was switched off and a bed was now available.

Mr Kemp Received a C.V.C, Arterial line, Thoracic epidural, Left and right peripheral lines. The surgical case began at 0952 to 1312 hrs. The procedure began with the laparotomy; nothing I recall during this part of the operation was a

problem. We changed Mr Kemp's position to lateral and proceeded with the thoracotomy.
Approximately half an hour on I noticed the Bellovac drain was half full with no vacuum and the blood was still draining into the bellovac. By that time we had given the patient at least three units of packed cells. Dr Berens requested an Arterial blood gas the Hb was 70 g/L. Preoperatively it was 75 g/L. I observed his heart rate was climbing steadily during the case and his systolic was consistently less than 100 mmHg.
I stated,"Dr Patel the bellovac drain is over half full with no vacuum and was still draining freely". Dr Patel stated, "That's what drains are for Damien!" Dr Berens continued intravenous fluids as per the fluid balance and anaesthetic record sheets. Dr Berens ordered another arterial blood gas post additional units of packed cells; the patient's HB remained at 70 g/L.

Dr Berens relayed this information to Dr Patel and his impression that the patient is haemorrhaging. Dr Patel gave no response to Dr

Berens. The operation was complete bar closure and the bellovac was emptied twice before the operations end and was continuing to drain blood. Dr patel had left the theatre and left the junior staff to close the incision. Dr kariyawasam was asked after applying the dressing to obtain Dr Patel to review the flow from the bellovac drain (laparotomy) and the blood pressure was low and his pulse was elevated. Dr Kkariyawasam returned and informed us Dr Patel's orders were to admit the patient to ICU. All present staff looked at each other and statements carried the theme that the patient was bleeding. DrBerens stated," This patient will be back to theatre tonight" I was then instructed to go to my break, by then the patient was transferred to ICU.

I began my shift the next day (21/12/04) and heard at approximately 1000 hrs that Mr Kemp had died due to loss of blood. It was then I felt I needed to let my superiors know my concerns.

Damien P Gaddes

D Gaddes.

14/1/05.

I Katrina Gail Zwolak Registered Nurse level 1/ 5 am requesting anomininity under the Whistleblowers Protection Act 1994 – Reprint no 3G. I will be known as WB 07.

14.1.05

Statement of Katrina Gail Zwolak employee of Bundaberg Base Hospital Bourbong Street Bundaberg Queensland 4670 – dated 13. 01. 2005.

I am a Registered nurse licensed to practice in the state of Queensland and have been endorsed and practicing since 2001. I am employed as a registered nurse at the Bundaberg Base Hospital and for two years on February 17th 2005 I will have been working full time in the peri- operative department, performing rostered and on call shifts in this area.

I was rostered on from 8 am to 4 30 pm and the on call shift for the 20th of December 2004. I was aware on the 19th of December that the following day a gastro-oesophagectomy case was to be performed. Upon arriving to work on the 20th of December I was informed that this case was to be cancelled due to a lack of ventilators being available in the Intensive Care Unit (ICU). Dr Patel entered the theatre tea- room stating how there was a brain stem injury in ICU in which the ventilator should be turned off and that the private triple AAA (abdominal aortic aneurysm) patient should be sent to Brisbane. Within a short time a ventilator became available in ICU and the gastro- oesophagectomy case for UR 007900 proceeded.

I was not involved in the elective procedure however I was on call this day. At approximately 5 30 pm I was told to set up for the return to theatre of UR 007900 for a laparotomy. When the abdomen was re- opened blood poured out and the suction units were rapidly filled, my scout, Enrolled Nurse Jenelle Law observed 2.3 litres of blood in the suction units before washing with normal saline began, we then proceeded to use a total of 75 sponges and 15 raytec gauze. Kidney basin after kidney basin was filled with blood clots as Dr Patel removed them from the abdominal cavity, blood and blood clots ended up all over the theatre floor- it took an hour to clean the theatre post surgery.

During the procedure when the bleeding could not be stopped Dr Patel was stating loudly that "this was not from my surgery" even though no one had said that it was from his surgery. At one point in the procedure he also began yelling "get the family, get the family" when ICU was contacted and the family weren't present he continued to yell "get the family", he also kept saying "this mans gonna die, he's gonna die on the table", once the family were able to be present he walked out of the theatre in his scrub gear and spoke to them. Dr Patel also performed a spleenectomy and thoracotomy on UR 007900, whom I learned later died in ICU on the 21st of December 2004.

.....

Katrina Zwolak.

Queensland Government

Queensland **Health**

25.10.04

Dear Peter,

Here is the documentation to accompany my complaint, and the complaints of the nursing staff

Thanks

Toni Hoffman
NUM ICU

ICU ISSUES WITH VENTILATED PATIENTS;

BBH ICU is a
Designated level one unit, capable of ventilation for short periods of time 24-48hrs. Consistently exceed this. Can do this for short periods of time, but not longer than a few days. Level of Unit made clear to surgeons and this has appeared to distress one of the surgeons when their patients are going to require long term ventilation and be moved to Brisbane. Usually the process works well except when Dr Patel's patients are involved. When Dr Patel first came to BBH it was explained to him that we do not have the resources to ventilate long term patients. He then stated he would "not practice medicine like this and would resign". He stated that he "would not transfer his patients to other hospitals". He has consistently denigrated the ICU and made such comments such as:

"This would not have been missed on the wards" (Gentamicin being written up by physicians.)

He stated to one of the R.N's that he had "contacts" in Brisbane and would use them to block a patient being transferred. Dr Patel consistently vents his frustration at the current system by being insulting to the nurses and the ICU. He consistently talks loudly to his PHO and JHO about "How difficult it is to work in this ICU" How backward it is and how it is like working in the third world for him. He does not usually do ward rounds with the ICU physician and this causes problems with the ICU nursing staff when they are receiving conflicting orders about treatment. Dr Patel will not converse with the NUM. Dr Patel has attempted to cause conflict with the staff in ICU, By stating the NUM is unsupportive of her staff.

The Director of the Unit, Dr Carter, is usually supportive and proactive about transferring patients, except when Dr Patel's patients are concerned. Dr Patel creates such an atmosphere of fear and intimidation in the unit that his behaviour is rarely challenged. Dr Patel has repeatedly threatened to

A) Resign
B) Not put any elective surgery in ICU.
C) Complain to the Medical Director
D) Refuse to complain to the Medical Director any more and go "straight to Peter Leck" as "I have earned him ½ million dollars this year."

Dr Carter has approached the NUM several times about increasing the Nursing FTEs so that we can "care for Dr Patel's patients properly". It was explained to him that it is a complicated process that requires much more than an increase in FTE's. We do not need more nurses when we are acting in our designated capacity. It is when we consistently act outside of this role for extended periods of time that these issues arise.

. There is such a feeling of disunity in the ICU at present, it is upsetting to the nurses, every time we have a patient of Dr Patels's the staff anticipate an argument. When Dr Patel's ventilated Patients require ongoing care or have been ventilated for longer than 24-48 hrs ,it needs to be reiterated that they will need to be retrieved to Brisbane after 24-48 hrs , or sooner if there are two ventilators in ICU. The admission and discharge policy of ICU must be adhered to.

On several occasions when Dr Patel's Patients have been in the ICU, he has refused to transfer his patient to Brisbane, even when the patients have deteriorated and have been in ICU for much longer than 24-48 hrs. He has done this when a bed has already been obtained. This has, on several occasions placed the patient in jeopardy as they have further deteriorated

I have voiced my concern regarding the level of care required for some of Dr Patel's patients several times. I have accompanied Dr Jon Joiner to meet with Dr Darren Keating when the issue of doing oesophagectomies has arisen in the unit.

This week we had a critically ill patient transferred back to ICU in extremis. He was a 46 year old male with a crush injury to his chest, multiple # ribs and a flail segment. He was shocked, in pain, tachycardic and hypotensive. The Anaesthetist in charge attempted to place an arterial line and a central line as well as transfuse the patient. At one point the patient went

into ventricular standstill. Dr Patel was seen to make a comment to another surgeon and laugh. Dr Patel repeatedly stated in a loud voice the comments that this patient did not need to be transferred to Brisbane. He stated the patient did not need a thoracic surgeon. He asked the PHO "how much trauma had he done". He went on to say "no more trauma should be done at this hospital, if we cannot handle it" All of these comments were said in front of staff and other patients. A bed was arranged at PAH, and booked at around 1430 hrs. The clinical coordinator only needed to be notified to organise the retrieval. It was decided, before the clinical coordinator would be called a CT needed to be done. There was a delay in obtaining an anaesthetist due to one being required for a perforated bowel. Dr Patel insisted the surgery for the perforated bowel be performed prior to the CT, despite the patient requiring ongoing resuscitation. I called Dr Carter and he agreed to transport the pt to CT. On return from CT it was agreed the patient would be transferred to Brisbane. I had previously voiced my concerns to Dr Gaffield that although I had heard Dr Patel say the patient did not need transfer as he did not need a thoracic surgeon, there were other issues such as a lack of pathology and blood bank support and the fact we did not have an intensivist or other equipment. The patient was sent to CT and then it was decided to definitively transfer him to Brisbane. There was some delay in contacting the clinical coordinator as they were doing a ward round. After about fifteen minutes the clinical coordinator phoned back and spoke with Dr James Boyd. This was about 1930 hrs, 4-5 hrs post the initial confirmation of the bed being available at the P.A. During this time Dr Younis had been trying to resuscitate the patient, insert central and arterial lines, administer blood and intubate and ventilate the patient. Three ICU nurses were involved with this patient throughout his stay. The Retrieval team arrived about 2215 and whilst attempting to prepare the patient for transfer he deteriorated and died.

My concerns are:

The staff in the ICU is expected to function outside of the role of the level one unit, repeatedly when the limitations of the unit are well known.

The behaviour of Dr Patel in intimidating, bullying, harassing and insulting the staff in ICU continues.

The interference of Dr Patel with this particular patient which delayed his transfer. (Dr Patel was asked to review the patient). This delay may have contributed to the outcome of this patient.

My concern that the personal beliefs of Dr Patel concerning the types of patients he can care for here, actually endangers the lives of the patients as these patients that would be transferred to Brisbane are not being transferred early enough.

A Secondary concern of mine is the level of surgery which is performed that should only be performed in a tertiary hospital.

Terri Ibbotson

25.10.04

21 October 2004

Ms Toni Hoffman
Nurse Unit Manager
Intensive Care Unit
Bundaberg Base Hospital
BUNDABERG QLD 4670

Good Morning Toni

As a patient advocate I feel that I must advise you of particular instances which have come to my attention which may either:

- breach the duty of care which is owed to the patients of this hospital; and/or
- may constitute behaviour which is not of an acceptable professional standard.

On a number of occasions I have had concerns regarding Dr Patel's indiscrete behaviour concerning fellow colleagues and clinical management. I have outlined below examples of such behaviour:

1. 13 September 2004: As I left the lift towards the canteen I could hear Dr Patel discussing a present patient of ICU around the table with junior surgical doctors. He proceeded to say that "Dieter was being very silly about this patient and **he** knew what **he** was doing not Dieter". I could still hear the conversation after leaving the canteen and waiting back at the lift. As I found this extremely unprofessional I reported my concerns to Toni Hoffman and Dr Dieter Berens.

2. 25 August 2004: I was looking after patient P37 (post op evacuation of haematoma), and she expressed to me her concerns of Dr Patel's treatment. She stated that the day before in Surgical Ward on Dr's rounds they had removed sutures from her wound and tried to manually evacuate the haematoma with no local anaesthetic or pain relief.

3. On previous occasions I have been put into the situation of Dr Patel advising relatives that the patient's medical condition was improving. A number of these patients had been critically ill at the time and soon after died. This has caused a conflict between the relatives and myself in the following manner:

- During my clinical care of the patient I build up a repour with the relatives;
- The relatives want me to advise them of the condition of the patient;
- I advise them in a honest and caring manner about their condition, even in the event that their condition is critical and/or deteriorating;
- Dr Patel will then advise the relatives that the patient's condition is improving (in a number of occasions in my opinion this clearly appears to not be the case);

- This causes confusion and unrest for the relatives as they are told conflicting information; and

- This also causes great conflict for myself as I do not know whether to be honest with the relatives or to go along with providing an illusion that the patient's condition is improving (even if in my opinion this is not the case).

Please contact me if you require further explanation in relation to the above issues.

Regards

Karen Stumer

Karen Stumer

Statement by Karen Fox

STATEMENT OF EVENTS ON 27TH JULY 2004

NAME: Karen Lynne Fox

Registered Nurse in the State of Queensland
Initially registered in NSW in 1985, registered in Queensland in 1996.
I have a Graduate Certificate in Coronary Care, Midwifery, and an Intensive Care Certificate. I have worked in Critical Care since 1991.

Re: MR DESMOND BRAMICH DOB: 15/04/1948

On the 27th July 2004 I was called in to work an extra 12hr night shift. I commenced duty at 1900hrs. On arrival in the unit the unit was a hype of activity with a number of medical staff present, nursing staff and the NUM.

Other staff on this shift were: RN Vivian Tapiolas, RN Daniel Aitken, RN Sandra Sharp and a student nurse, Richard Dodsen.

I began caring for Mr Bramich at the commencement of the shift.
Mr Bramich's family were around the bedside and in the waiting room, including his nine year old daughter.

The busyness and need to attend procedures as required did not allow for a comprehensive nursing check of the patient or equipment.
At approximately 1930hrs we received a phone call from the RFDS flight nurse. I spoke to her regarding Mr Bramich being transferred to Brisbane. She asked if we had a confirmed bed, as I was unsure I enquired to the medical staff regarding this and was informed that we did not. I relayed this information to the flight nurse who stated that they would not come if the bed was not confirmed. I said we would follow it up and get back to them. This was discussed with Dr Boyd who said he would follow it up.

The cares for Mr Bramich were undertaken by myself and RN Tapiolas. At varying times one of us was away from the bedside obtaining blood from blood bank, making or receiving phone calls and gathering equipment. Bramich was extremely unstable, hypotensive and ventilated. Dr Younis was present and was ordering treatment. The unit was busy with beds full and another ventilated patient.

Times are approximate due to the busy nature of the events.

Dobutamine was commenced as I arrived on duty and then noradrenaline was commenced at approximately 2050hrs. He remained hypotensive. We commenced fluid boluses, blood transfusion and ongoing support.

Dr Patel reviewed the patient, ordered an echocardiograph at approximately 2015hrs. Whilst waiting for the echocardiograph Dr Patel, in a very loud voice, stated that they are too busy ventilating 90 year olds and looking after cardiac patients to care for this patient. On the result of the echo Dr Patel instructed us to set up for a pericardial tap, which we did. After numerous attempts under ultra sound guidance he inserted a pericardial drain and sutured it in place. Only 3-4 mls of blood was obtained during the procedure.

During this procedure Dr Patel was loudly making comments that the patient will die and does not need to go to Brisbane. I asked Dr Patel to mind what he was saying as the family were in the hallway. Dr Patel commented that they need to know, I in turn

commented that they need to be told face to face not over hearing what was being said behind the curtains.

During the insertion of the pericardial drain we did not have in stock all of the items that Dr Patel was requesting, when told he repeatedly said to get the Nurse Manger to get them as that was her job. I phoned and spoke to the theatre staff who also were unsure of what Dr Patel required.

Dr Patel then inserted a second chest drain, without the use of the introducer. Continuing in a loud voice he lectured the JHO as to why he did not use the introducer in a chest trauma and what he may do to the JHO if he caught him using one in a similar situation. During the insertion of the drain Dr Patel poked and prodded using his fingers through the incision. There was oozing from around the drain insertion site.

Following this Dr Patel spoke with the family, RN Tapiolas was present during the discussion. When the family came to the bedside the wife and daughter in law were extremely distressed, crying loudly and speaking to the patient. Dr Patel abruptly told them that they were not to cry at the bedside. During this time the daughter was also present.

A little later a call came from the RFDS stating that they were on their way. Dr Carter phoned in after this to enquire what was happening. I informed him that the retrieval team was on the way, he then stated that therefore he would not need to be further involved.

They arrived at approximately 2215hrs. Dr Younis was present and handed over to the doctor. Cares were as per the retrieval doctor's instructions.

During the preparation for the flight Mr Bramich deteriorated blood was pulsating from the intercostal drain site. This was sutured by Dr Boyd. The patient continued to deteriorate and subsequently had a cardiac arrest. Resuscitation was carried out as per orders from the flight Doctor. Dr Younis was present and assisted with the attempt.

The flight Doctor spoke to the family pre, during and post the arrest. I was present when she spoke to the family during the arrest and at her request I stayed with the family. I stayed with them until after she spoke with them when resuscitation attempts were ceased. This was at approximately 0012hrs.
Dr Boyd was also present during the arrest, and a JHO.

The family were allowed time with their loved one and offered support during this time. They remained with him until the police arrived at approximately 0300hrs.

I found this night to be very distressing and upsetting. I found Dr Patel's behaviour to be bullying.

Watching him do procedures was barbaric and unsightly.

I have many years experience and I have never seen a surgeon behave in this manner before.

Further to this incident was when Dr Patel took P43 to OT for amputation of his toes. Due to a dispute with the anaesthetist Dr Patel was responsible for the man's pain relief. On return to the unit the nurse from the OT stated that P43 was in pain throughout the procedure and had squeezed her hand until it was white.

I find Dr Patel's general manner to be intimidating, loud and often inappropriate.

(KAREN L. FOX)

From: Linda Mulligan
To: Toni Hoffman
Date: 26/08/2004 5:12pm
Subject: Re: ICU INCIDENT

** Confidential **

Dear Toni-Thank you for this additional information, it will be sent on a part of the review of the incident.

I have just arrived back to the office and urgently requested information re tomorrow's case you have outlined. I tried to call to speak to you personally, but have left, hence this email. Dr Keating has sought information re the same, and has confirmed the case is not a thoracotomy (which has been confirmed by Martin Carter who has seen consent form), but rather a wedge resection and the plan is for the patient to return to the Surg Ward, therefore advised suitable for this case to proceed.

It appears there is conflicting information, which at the best of times is difficult to sort out, but even more so this late the night before the surgery. This highlights to me the issues/strategies with communication that you and I have discussed previously are not resolving and further action needs to occur. In light of this matter not just involving nursing I will look at proceeding to involve others in discussing the issues at hand. Thanks Linda

Mrs Linda Mulligan
District Director of Nursing Services
Bundaberg Health Service
PO Box 34
Bundaberg Queensland 4670

Phone 07 4150 2025
Fax 07 4150 2029

>>> Toni Hoffman 08/26/04 09:49am >>>

Dear Linda,
I am attaching the report I have written concerning the care of MR Bramich and my concerns. MY first report was written in haste as I was asked to lodge it ASAP with DDSQU, as a sentinal event. Two of the other staff have written reports. One has accessessed EAS , But has had difficulty in doing so, so has been using a private psycologist. I have made several calls to EAS and none have been returned to me, I understand they are down some staff as well.I have discussed my concerns with DR Carter. A thorocotomy is booked for this Friday. DR Carter did ask me whether we are comfortable caring for a thorocotomy, DR Patel assurred him the pt would not be ventilated. I am concerned that large scale surgery is being sceduled on a Friday when over the weekend not all available staff are here.
Thanks
Toni

Toni Hoffman NUM
ICU/CCU
PO Box 34
Bundaberg Q 4670
Ph: 07 4150 2311
Fax: 0741 50 2319

My name is Toni Hoffman; I am the Nurse Unit Manager of the Intensive care/ Coronary Care Unit at Bundaberg Base Hospital. I have been employed here in this capacity since June 2000. I am a Registered Nurse, Midwife, and hold post graduate qualifications In ICU, a Graduate Certificate in Management and a Master of Bioethics.

Mr Desmond Bramich, a 55 yr old male, was admitted to the ICU on the 25-07-2004 after being involved in an accident where he had been pinned under a caravan when it slipped. He sustained a crush injury to his chest, multiple fractured ribs, a flail segment, Haemo - pneumothorax. He was stable during his initial stay in the ICU and was transferred to the surgical ward at 1400. Around 1200 on the 26-07-2004, ICU staff were notified a patient was deteriorating on the ward and required transfer to ICU. ICU was full and it was necessary to transfer out another patient before we could accept Mr Bramich back. He returned to ICU at 1300 on the 26-07-04. On his return he was diaphoretic, hypotensive and tachycardic.He was complaining of extreme chest/ back pain. Dr Younis, the anaesthetist was attempting to resuscitate Mr Bramich, by himself initially, as the other doctors were either busy with other patients. Three nurses were assisting Dr Younis. Blood was being delivered, and mention made of obtaining some platelets. Dr. Carter, Head of Anaesthetics came into the ICU at this time and stated "if the patient is going to need blood products, he will need to be flown out." We do not have access to platelets etc at BBH; at night, they need to be obtained from Brisbane... One of the doctors rang Prince Charles Hospital, but there were no beds there. The doctor from Prince Charles later called back and stated that a bed had been obtained for Mr Bramich at Princess Alexandra Hospital. This phone call was taken by me at approx 1430. The coordinator just stated the surgeons needed to speak to each other and then the retrieval team organised. I passed on this message to Drs Boyd, Gaffield, Warming ton and Carter. The surgeons in Bundaberg wished to do a CT prior to speaking to the surgeons in Brisbane... Meanwhile Dr Younis was still attempting to place a central line and an Arterial line in the patient. The patient went into Ventricular standstill whilst the central line was being inserted, an arrest was called and some atropine given.

Dr Gaffield had brought Dr Patel into the unit to review MR Bramichs' x-rays. Dr Patel heard the patient was to be transferred to Brisbane. He stated in a very loud voice, that the patient did not require transfer to Brisbane. He also stated the patient did not need a cardiothoracic surgeon, he asked the PHO, Dr Boyd, how much trauma he had done He also stated he would "stop doing trauma here if we could not handle it". I went and spoke to DR Gaffield and voiced my concerns about the delay in getting Mt Bramich to Brisbane. I was concerned Mr Bramich would die if we did not expedite the transfer. Dr Gaffield explained he wished to do a CT scan so he could give a definitive handover.

In the interim, Dr Patel came into the ICU, informed the staff he had perforated a patient's bowel, and required an anaesthetist, to repair the same. Another emergency was occurring and we did not have another anaesthetist to accompany Mr Bramich to CT. I rang and asked if Dr Carter could do it as the transfer was being further delayed. Dr Carter agreed, the CT was done and Dr Gaffield stated the patient would definitely be going to Brisbane. The phone calls to Brisbane were made with my assistance as Dr Boyd was unsure of the transfer procedure. We had some difficulty accessing the clinical coordinator at one point as they were having handover and we had to make several calls through switch.

Once the clinical coordinator had spoken with Dr Boyd and the retrieval team were on their way, I spoke with the after-hours nurse managers, the night staffs were here and I felt able to leave. (I was due off at 1630) The family had been told he was to be transferred; Dr Boyd had spoken to them and the procedure and accommodation in Brisbane, as well as

the patient's condition. The retrieval team arrived at 2015, he became increasingly unstable and he arrested and died at 0012.

Subsequent events in relation to the transfer of the patient were bought to my attention by the staff in the morning. At some point Dr Patel changed his mind about the patient not requiring transfer, to being far too ill to be transferred. The staff involved in the incident believe that Dr Patel impeded this patients' transfer to Brisbane. They are also concerned about his treatment of the family. I have offered and attempted to access EAS for the staff. I believe this is a coroner's case, and as such, expect to be involved in the investigation.

I was rostered in the Intensive Care Unit as a Registered Nurse for a night shift on Tuesday 27 July 2004.

That night I was allocated to be the runner for the ventilated patients. In total there were two that night. However, due to Mr Bramich's condition I was working very closely with RN K Fox and was assisting with the care for him.

Whilst RN Fox received a handover from the Day shift Nurse I was assisting Dr Younis's requests with respect to treatment for Mr Bramich. This treatment consisted of commencing an Noradrenaline infusion, taking observations, calling Pathology and generally carrying out requests from Dr Younis.

Dr Patel was in and out of the intensive care unit that night as he was requesting further treatment for Mr Bramich. At one point, Dr Patel was greatly concerned in relation Mr Bramichs's unexplained tachycardia and hypotension and he stated that he thought Mr Bramich had a pericardial tamponade. Dr Patel said that on the Cat Scan there was a small effusion and he was going to perform a pericardiocentesis. Dr Patel requested various pieces of equipment and I, together with others assisted his requests. He instructed that the radiologist be called and to bring the image intensifer so he could perform an echo on his heart. In following out these requests, I was sometimes required to leave the bedside.

There was an incredible amount of activity for this patient, and as well as that procedure, there was a necessity to go to Blood bank, (some distance away from intensive care) conducting and receiving telephone calls in relation to this patient, making up infusions and calling appropriate personnel. I only partially witnessed some of this procedure, as Dr Patel with assistance from Dr Boyd had repeated attempts to perform this procedure. At times I was in Blood bank and others in Theatre trying to locate Dr Patel's requests for equipment.

During the procedure I heard Dr Patel say that Mr Bramich was not going to Brisbane as he was too sick, and probably was going to die. RN Fox informed him to quieten down as the relatives could hear him and he needed to speak with them. He obliged with her request.

After Dr Patel finished the procedure, RN Fox requested I go with Dr Younis and Dr Patel to talk with the relatives who were in the waiting room. Dr Patel informed the relatives that Mr Bramichs's condition "was so critical he was going to die". He informed the relatives that "he had placed a needle around his heart and got

back only three or four mls, so it was not compromising him at all". He said his injuries were severe as his heart and lungs had been crushed from the caravan and often these injuries took 24 to 48 hours to surface. The relatives asked for Mr Bramichs to be sent to Brisbane, but Dr Patel informed them that he had been a "trauma surgeon in the United States for 10 years" and he knew that a cardio-thoracic surgeon could not operate on him in this instance.

They were informed Mr Bramich would not survive the plane trip to Brisbane. The relatives were visibly upset and asked " how could this happen?". Then they asked if there was any chance of survival. Dr Patel replied "1% and it would be a miracle".

After the relatives came in to see Mr Bramich they were visibly upset, crying loudly. Dr Patel walked over to the bedside and asked them to be quiet as how would Mr Bramich feel if he could hear them. Mr Bramichs's son calmed the family down.

There was much confusion with reference to Mr Bramichs's retrieval. I was informed that he was not going to Brisbane, even after receiving a telephone call from a Registrar in Brisbane and he doubted if he was going to be retrieved. Then I was informed by Dr Patel that he was not going. Then I was informed some minutes later by RN Fox that the retrieval team was on its way from Brisbane. After the arrival of the team and during transference of equipment, Mr Bramich became bradycardiac and arrested. His resuscitation is as documented, but he unfortunately passed away.

28/3/04

REPORT ON INCIDENT ON 4-5TH MARCH BY KAY BOISEN (BBHICU)

PATIENT: P40
SURGEON: Dr. Patel
ANAESTHETIST: Dr. Berens
NURSE: Kay Boisen RN

Dear Toni,

On March 4th, Dr. Berens discussed with Dr. Patel, his concerns about P40, in my presence. This discussion focused on the patient's slow improvement, his ongoing problems and current deteriorating ventilatory status. As we had two ventilated patients in the unit, Dr. Berens suggested that P40 be transferred to a Brisbane ICU. Dr. Patel stated forcefully that he was going to approach the executive about staffing increases in the Bundaberg Base Hospital ICU, to accommodate post-op ventilated patients. Dr. Patel considered that if the BBHICU could not accommodate post-op ventilated patients, the hospital "would lose a lot of money". Dr. Patel then commented further, that he may have to consider not operating on any patient requiring post-operative care in this unit. Following this debate, Dr. Anderson reviewed P40 and advised that he warranted further surgery. P40 was returned to theatre, the same evening.

On the 5th March 2004, at around 4 pm, Dr. Patel reviewed P40. Dr. Berens was also in the unit at the same time. During this ICU visit, Dr. Patel told me that he had attended a meeting with members of the Executive, including Mr. Leck, and Ms. Hoffman. Dr. Patel stated that despite him telling both Mr. Leck and Ms. Hoffman that the unit was understaffed, they informed him that the unit was fully staffed. Dr. Patel commented that "it's not very good when you boss doesn't support you". I responded that the unit was fully staffed for a Level 1 ICU, which is only meant to cater for one ventilated patient for a duration of 24 to 48 hours. I felt as though Dr. Patel was indicating that Ms. Hoffman wasn't supportive of the BBHICU or the unit staff. Dr. Patel then immediately repeated his same statement about the unit being understaffed to Dr. Berens. Since this statement was in my presence, I reiterated the limitations of the unit's level 1 status, again, before Dr. Patel left the ICU.

Yours sincerely,

K. Boisen RN

KAY BOISEN.

KAY BOISEN RN

ICU Bundaberg Base Hospital.

3rd August 2004.

Dear Ms Hoffman,

I would like to bring to your attention an incident that occurred in the ICU on Sunday 1st August 2004. I was rostered and working a 0700-1930 shift with CN Byrne and RN Cree. I was assigned to nurse a ventilated patient in bedspace 5. At approximately 0900 Dr Patel entered the unit via the door connecting ICU and Theatre. Nurse Manager Ms J McClure and I were standing at the end of bed 5 having discussed the full bed status of the unit. I was handing over the patient condition to Ms McClure.

Without preamble Dr Patel launched into a tirade "Why were there two ventilated patients in the ICU?" "What about the policy of only having ventilated patients for 48 hours and then moving them to Brisbane?" "It seems only surgical patients are transferred to Brisbane from this unit." "What is needed is a separate surgical unit." Dr Patel was directing this conversation to both Ms McClure and myself, I didn't respond initially but did speak up to point out to Dr Patel that the ventilated patient in Bed 5 was only ventilated four hours previous and that the ventilated patient in Bed 8 was of much longer duration but that consultation with Brisbane doctors, more than once, had resulted in the decision by the Brisbane doctors that the patient was not to be transferred. I further stated that we were, in fact, running the unit within the management guidelines. I felt that Dr Patel was stating derogatory remarks against the unit as a whole and to the ICU management team in particular.

Yours sincerely,

Kay E. Boisen.

RE: DR. PATEL

I was working in ICU looking after a patient in bay seven, when Dr Patel came over and started discussing Mr. Bramich's autopsy results (that had taken place that day) with me over the top of this conscious patient. He was convinced that I had cared for the patient and was telling me about the results. I informed him that I did not know the patient. He then finished the report and moved away. The problem that I have with this is that Dr Patel was discussing confidential patient details over the top of another patient who was aware and no doubt concerned about her own problems without thinking about another patient's autopsy.

I have had found that Dr Patel is prone to be indiscreet in discussing his personal opinions of other doctors and nursing staff (very loud). I have heard Dr Patel agree with the ICU consultant with regard to NG feeding a patient who had had abdominal surgery. The next morning when he was informed that the patient had not tolerated his NG feed, he informed me that it was a "silly" idea of the consultants yesterday to even consider feeds (once again very loudly).

Karen Jenner ICU

Queensland Government
Queensland Health

Bundaberg Health Service District

Sentinel Event Report Form

Sentinel events are rare and serious events that require prompt and in-depth investigation
Sentinel events must be reported verbally to the District Manager, Director of Medical Services, Director o
Nursing and other relevant Director within 12 hours.
This written report forwarded to DQDSU within 48 hours

Please print clearly using a **black** pen

Site	☒ Bundaberg	☐ Childers	☐ Gin Gin	☐ Mt. Perry

Details of the subject of the sentinel event (fill in applicable details)

Last Name:	Or affix Patient Label BRAMICH	Sex of Patient:	☒ Male ☐ Female ☐ Not stated
First Name:	DESMOND	IMHS Clients:	☐ Voluntary ☐ Involuntary ☐ Unknown
UR Number:	086644	Unit	Inpatient Unit ICU
DOB/Age:	15.4.1948		Unit where event occurred ICU
Reporters Details	Name: Toni Workman	Signature	Toni Workman
	Contact No. 4150310	Date	2.8.04
Reporters Classification:	☒ Nurse ☐ Medical Officer ☐ Allied Health Professional ☐ Other - specify		

Sentinel Event

Please indicate which Sentinel Event has occurred:

- ☐ Procedures involving the wrong patient or the wrong body part
- ☐ Retained instruments or other material after surgery requiring re-operation or further surgical procedure
- ☐ Haemolytic blood transfusion reaction resulting from ABO incompatibility
- ☐ Medication error leading to death of a patient reasonably believed to be due to incorrect administration of drugs
- ☐ Infant discharge to wrong family
- ☐ Maternal death or serious morbidity associated with labour or delivery
- ☐ Intravascular gas embolism resulting in death or neurological damage
- ☐ Suicide of a patient in an in-patient unit
- ☒ Any serious and rare event

Date of Event	27.7.04			Time of Event	1300 onwards hours
Reported to:	☐ DM	☐ DMS	☐ DON	Time reported	hours
so reported to:	☐ DCAHS	☐ DCS	☐ Service Director IMHS	Time reported	hours

Narrative Provide details of how this event occurred, including people involved, outcomes etc Attach additional sheets if insufficient space

Pt readmitted in extremis, Anaesthetist & pt, trying to stabilise pt, insert lines, give blood, surgeons with pt, pt had period of ventricular standstill. during central line insertion. DIW surgeons need to TfR pt to Brisbane where Pt facilities. Dr Gabriel pt's attending surgeon. DR Peter informed staff pt did not require Thoracic Surgeon or transfer. See attached notes and sequence of events. Initial attempt to obtain bed @ TPCH then PAH resulted in a bed being available & booked at 1430 hrs. Delay due to subsequent events on demise of pt.

Peritoneal Dialysis Catheter Placements - 2003

Patient	Surgeon	Date Catheter Placed	Date of Catheter Problem	Catheter Problem	Outcome	Catheter Position	Infection
P8	Patel	15/08/2003	19/09/2003	Migration	Surgical intervention 19/9/03 - catheter repositioned	upwards	chronic exit-site infection & peritonitis
P19	? Patel	3/12/2003		Migration	Deceased prior to catheter repair	side-upwards	
P24	Patel	30/09/2003	4/11/2003	Infection Catheter Position	MRSA treated with IV Vancomycin	side-upwards	exit-site infection MRSA
P31	Patel	19/09/2003		Infection Catheter Position	Peritonitis treated as in-patient with IP AB's	upwards	chronic exit-site infection serratia
E. Nagle	Patel	14/11/2003	16/12/2003	Migration	Surgical intervention - Died	side-ways	
P45	Patel	6/10/2003	18/11/2003	Impaired Outflow Drainage	Surgical intervention - Hernia repair performed privately	side-ways	nil to date

x6 Peritoneal Dialysis Catheter Placed 2003