Queensland Government
Queensland Health

SMB87

Noted – to Premier
via DG DPC
BDG
29/06/05

SPECIAL INVESTIGATION REPORT

ALLEGED INAPPROPRIATE RELEASE OF THE FINAL REPORT OF THE REVIEW OF CLINICAL SERVICES AT THE BUNDABERG HOSPITAL

Prepared for

THE DIRECTOR-GENERAL OF QUEENSLAND HEALTH

At the Request Of

DEPARTMENT OF THE PREMIER AND CABINET.

Investigating Officer: Ms Rebecca McMahon, A/Manager, Investigations, Audit and Operational Review Unit

29/6/05.

AUDIT-IN-CONFIDENCE

THIS IS A CONFIDENTIAL REPORT PREPARED BY THE AUDIT AND OPERATIONAL REVIEW BRANCH, QUEENSLAND HEALTH AT THE SPECIFIC REQUEST OF THE DIRECTOR-GENERAL.

THIS DOCUMENT IS "STRICTLY CONFIDENTIAL".

THE UNAUTHORISED POSSESSION, REPRODUCTION, AND/OR DISCUSSION OF THE INFORMATION CONTAINED IN THIS DOCUMENT IS PROHIBITED AND MAY RESULT IN PROSECUTION.

IF IN DOUBT AS TO THE DEALING WITH INFORMATION ARISING OUT OF THIS DOCUMENT, PLEASE CONTACT THE DIRECTOR, AUDIT AND OPERATIONAL REVIEW, QUEENSLAND HEALTH ON (07) 323 40835.

DICTIONARY

"Audit" or "AORU"	QH's Audit and Operational Review Unit
"the CM Act"	The *Crime and Misconduct Act 2001.*
"the CMC"	The Crime and Misconduct Commission.
"COI"	The Bundaberg Hospital Commission of Inquiry
"Crown Law"	Refers to relevant officers within Crown Law acting on behalf of QH during the COI.
"the Investigating Officer"	Ms Rebecca McMahon, A/Manager, Investigations, Audit and Operational Review Unit, Queensland Health.
"QH" or "the Department"	Queensland Health.
"the Review"	The Review of Clinical Services Bundaberg Base Hospital
"Review team"	The team appointed under Part 6 of the *Health Services Act 1991* to conduct the Review, comprising Dr Peter Woodruff, Dr Mark Mattiussi, Dr John Wakefield, Ms Leonie Hobbs and Ms Leanne Patton.

CONTENTS

1. TERMS OF REFERENCE 1

2. BACKGROUND 1

2.1 THE REVIEW 1

2.2 KEY DOCUMENTS PRODUCED BY THE REVIEW 1

3. SUMMARY OF KEY EVENTS/FINDINGS 2

3.1 INTERIM OR DRAFT REPORT 2

3.2 TWO PAGE SUMMARY PREPARED BY DR PETER WOODRUFF 2

3.3 COMMENTARY BY DR WOODRUFF 3

3.4 FINAL REPORT 4

1.0 TERMS OF REFERENCE

At 9.07am on 29 June 2005 Dr Leo Keliher, Director-General, Department of Premier and Cabinet, contacted Dr Steve Buckland, Director-General, Queensland Health, and requested an urgent investigation in relation to the alleged inappropriate disclosure, or "leaking' of the Final Report of the Review of Clinical Services at the Bundaberg Base Hospital, to Mr Hedley Thomas, Journalist, *Courier Mail*.

Dr Buckland subsequently instructed Audit to conduct an immediate review of the circumstances surrounding the handling of the final report between the time of finalisation on the afternoon of 28 June 2005 and the publication of the Courier Mail on 29 June 2005.

In conducting this review, in addition to reviewing the handling of the final report, the Investigating Officer has also considered the circumstances surrounding the handling of three other key documents produced by the Review Team prior to the finalisation of the final report (described further below in paragraph 2.0)

2.0 BACKGROUND

2.1 THE REVIEW

On 18 April 2005 the Director-General of Queensland Health appointed investigators (the Review Team) under Part 6 of the *Health Services Act 1991* to conduct an investigation entitled Review of Clinical Services Bundaberg Base Hospital (the review) in relation to issues surrounding the appointment and clinical skills of Dr Patel and other numerous issues relating to the clinical outcomes and care provided by the Bundaberg Base Hospital.

This review team is comprised of the following officers:

- Mark Mattiussi
- Dr John Wakefield
- Ms Leonie Hobbs
- Dr Peter Woodruff

The review team also receives administrative support from Ms Leanne Patton, Principal Project Officer, Central Zone.

Since the commencement of the review, in addition to conducting numerous site visits at the Bundaberg Hospital, the review team has also worked from and stored all review documentation in a locked room on Level 18 of the Queensland Health Building (QHB).

2.0 KEY DOCUMENTS PRODUCED BY REVIEW TEAM

Since its commencement the COI has been aware that the review was ongoing and on 11 May 2005 (received by QH on 13 May 2005) requested copies of all documents in relation to the review.

During the past two months the Review Team has produced four key documents in relation to its preliminary findings. These documents comprise:

- The Interim or Draft Report of the Review of Clinical Services Bundaberg Base Hospital (Annexure One)
- A two page summary document, prepared by Dr Peter Woodruff, entitled "Table: Summary of Charts Reviewed to Date" (Annexure Two)
- A 25 page commentary document prepared by Dr Peter Woodruff entitled "Appendix E Clinical Case Chart Review" (Annexure Three)
- Final Report of the Review of Clinical Services Bundaberg Base Hospital (Not annexed).

3.0 SUMMARY OF EVENTS/FINDINGS

The Investigating Officer spoke with all relevant officers who have had access to or otherwise dealt with each of the key documents and reviewed documentary evidence surrounding the communication of these documents (ie. email trails) in order to summarise the events surrounding the handling of each of these documents. These findings are summarised below.

3.1 INTERIM OR DRAFT REPORT (Annexure One)

During May 2005 and early June 2005 Crown Law had ongoing discussions with the Commission in relation to an expected completion date for the Review Team's draft or interim report. Throughout these discussions Crown Law had advised the COI that the review team expected to complete an interim or draft report by 3 June 2005.

On 6 June 2005 Mr Peter Dwyer, Principal Lawyer, Queensland Health-Bundaberg Hospital Inquiry Team, Crown Law, emailed Mr Peter Crofts, General Counsel, QH, to follow up on the status of the interim or draft report. On 7 June 2005 Mr Crofts advised Mr Dwyer that the draft report would likely be completed the following day (Annexure Four).

On 7 June 2005 Ms Patton sent an email version of the report to Mr Dwyer and Mr Crofts (Annexure Five).

Mr Crofts distributed the interim report via email to Ms Leisa Elder, Ms Catherine Flynn, Ms Geraldine Weld, Ms Jill Pfingst, Ms Katherine Curnow, Ms Leanne Chandler, Ms Penelope Eden and Mr Peter Brockett (Annexure Six).

On 7 June 2005 Mr Dwyer provided the interim report to Mr David Boddice Q.C. and formally sent the report under Crown Law cover letter to Mr Tony Stella (Annexure Seven).

3.2 TWO PAGE SUMMARY PREPARED BY DR PETER WOODRUFF (Annexure Two)

On 9 June 2005 Mr David Andrews, Senior Counsel assisting the COI, had a discussion with Mr Boddice wherein he requested a copy of a document summarising Dr Woodruff's findings in respect of the patients that had been reviewed up to that date.

On either 9 or 10 June 2005 Mr Dwyer contacted Ms Patton and requested a copy of Dr Woodruff's summary document.

At 8.26am on 10 June 2005 Ms Patton emailed a two page document entitled "Tables: Summary of Charts Reviewed to Date" to Mr Dwyer and Mr Crofts (Annexure Eight).

Mr Crofts subsequently emailed this document to Ms Weld, Ms Curnow, Ms Chandler, Ms Eden and Mr Brockett (Annexure Nine).

At 1.59pm Mr Andrews forwarded a letter to Mr Boddice (via email) stating that he understood that "a team of investigators engaged by Queensland Health (had) obtained some information from one of its members, Dr Woodruff about Dr Woodruff's findings in relation to a number of clinical notes which he (had) reviewed". Dr Andrews then requested details of "those findings of the patients reviewed to date by Dr Woodruff" and any "commentary" provided by Dr Woodruff to the review team in relation to the files he had completed reviewing (Annexure 10).

Also on 10 June 2005, during the meeting of the QH Steering Committee to Coordinate Queensland Health's Response to the Bundaberg Hospital Commission of Inquiry (Morris Inquiry), Queensland Health Systems Review (Forster Review) and CMC Queensland Health Investigation (the Steering Committee), Mr Crofts provided a copy of a two page document, summarising Dr Woodruff's preliminary findings, to Dr Keliher and Ms Uschi Schrieber, A/Deputy Director General, DPC. This document was discussed at the meeting in general terms but was not annexed to the minutes of the document.

On 14 June 2005 Mr Dwyer sent this document by facsimile to the COI.

On 16 June 2005 an article written by Mr Sean Parnell entitled "Dr Death's error rate 'within limits' appeared in *The Australian* newspaper. On the morning of 16 June 2005 Ms Schrieber contacted Ms Weld and had a discussion in relation to the circumstances surrounding the provision of the draft report and the two page summary to the COI. This discussion was followed with a subsequent email summarising the verbal advice provided during this discussion. (Annexure 11).

On 17 June 2005 Ms Weld provided a briefing for the Director-General entitled "Provision of the Bundaberg Review Team Draft Report – "Review of Clinical Services Bundaberg Base Hospital" – to the Commission of Inquiry (Annexure 12).

3.3 COMMENTARY BY DR WOODRUFF (Annexure Three)

On 23 June 2005 Dr Woodruff was scheduled to meet with a committee established by the Queensland Police Service (QPS) in relation to the investigation of any potential criminal charges against Dr Patel. This committee comprised Mr Robert Atkinson, Commissioner of Police, Mr Michael Condon, Detective Superintendent (Homicide)(Assistant Commissioner of Police), Dr Woodruff, Dr David Thiele, Surgeon, Dr John Haynes, Anaesthetist, Ms Elizabeth Robertson, Registered Nurse.

Leading up to, and after this meeting, between 22 June 2005 and 27 June 2005, Dr Woodruff had continuously worked on a document summarising his preliminary findings in relation to the medical charts he had reviewed throughout the review. QH believes Dr Woodruff prepared this document partly so that he could refer to this document during his meeting with the QPS.

On 22 June 2005 Dr Woodruff asked Ms Patton to print this document for him so that he could take it to the meeting with the QPS the following morning. Mr Patton advised QH that Dr Woodruff took this document with him to the meeting with the QPS the following morning 23 June 2005) but did not provide copies of this document to the committee members during the meeting.

On 23 June 2005 Mr Dwyer contacted Ms Patton and asked for Dr Woodruff's commentary document, as the COI had asked for the document.

Given that Dr Woodruff was not present at this time, Ms Patton sought authorisation to release this document from Dr Mark Mattiussi. After Dr Mattiussi approved the release of this document Ms Patton emailed this document to Mr Dwyer, Mr Crofts and Mr Mattiussi (Annexure 13).

Mr Dwyer subsequently emailed this document to another lawyer at Crown Law, Mr Gordon Twigg. He also printed four hard copies of this document, kept one for himself and provided a copy to Mr Boddice, Mr Farr and Mr Fitzpatrick.

Mr Dwyer has advised that this document has not been provided to the COI to date.

However, QH is aware that the COI (through Mr Andrews) has had directly dealings with Dr Woodruff and cannot comment on the content of such discussions. At the time of this investigation Dr Woodruff was overseas and could not be contacted to comment on the handling of this document.

It should be noted that this document is essentially a "chapter" or section of the Final Report and essentially contains all of the information that Mr Thomas refers to in his article of 29 June 2005.

It should also be noted that in his article Mr Thomas makes various comments which could relate to this document, rather than the final report. Specifically, he states that "a chapter (of the report) has been sent in strict confidence to the department's Charlotte St headquarters in recent days" and that "the devil in the detail of the chapter comprising the first stage of the clinical audit could make or break the police case".

3.4 FINAL REPORT

The chronology of events surrounding the handling of the Review Team's report between the finalisation of the report on the 28 June 2005 and the publication of the article in the *Courier Mail* has been summarised in the following table:

Date	Time	Event
22 – 28 June 2005		Ms Patton and Dr Woodruff worked in Review Team's office on Level 18 of QHB to finalise sections of the final report.
28 June 2005	5.30pm – 5.45pm	A hard copy of the report was provided to the Chief Health Officer.
28 June 2005	5.50pm	Ms Patton handed two hard copies of the final report and four CD's, each containing an electronic (PDF) version of the report to Ms Trish Neilson, Senior Executive Support Officer to the Director-General.
		Ms Neilson immediately placed the two hard copies and CD's on the Director-General's desk.
	5.55pm	The Director-General took one hard copy

		of the report to the Minister's office to discuss the findings with him. The Minister indicated that he did not want to retain a copy of the report overnight and the Director-General took the copy with him when he left the Minster's office.
	6.00pm	The Director-General returned to his office and informed Ms Jill Pfingst, Executive Manager, Executive Services, that the Minister did not want a hard copy of the report. He then gave both copies of the report to Ms Pfingst to secure for the night.
	6.00pm	Ms Pfingst secured both copies of the report and four CDs in a locked filing cabinet in her office. Keys to this cabinet are only held by Ms Pfingst.
	6.30pm	Given that the Director-General had originally asked for three copies of the report, Ms Weld telephoned Ms Patton to inquire as to whether a third copy had been prepared. Ms Patton advised that she was still binding the third copy and would deliver it to the Director-General.
	7.30pm-8.00pm	Ms Leanne Chandler walked to the review team's office on Level 18 of the QHB to retrieve the third hard copy of the report.
		Ms Patton advised that she had four other hard copies of the report in her possession, which she intended to provide to the four members of the Review Team, Dr Woodruff, Dr Wakefield, Mr Mattiussi and Ms Hobbs.
	7.30pm-8.00pm	Ms Patton locked the office of the Review Team and handed the keys to Ms Chandler.
		Ms Chandler immediately returned to Level 19 of the QHB and handed the third hard copy of the report and the keys to the Review Team's office to Ms Weld.
		Ms Weld locked the copy of the report and the keys in the cupboard in her office.
29 June 2005		Article entitled "Question of murder not matter of intent" appeared in the *Courier Mail.*

	9.07am	Dr Keliher telephoned Dr Buckland to express concern that the final report appeared to have been "leaked" to Mr Hedley Thomas, prompting above newspaper article and requested a full investigation, to be completed by 5.00pm on 29 June 2005.
	8.30am	Ms Patton forwarded a hard copy of the report via express post to Mr Mattiussi. Ms Patton confirmed she still had possession of three further copies.
	9.45am	Mr Stuart Dignam, on behalf of the Department of Premier and Cabinet, collected a hard copy of the report.
	10.00am	Investigation commenced.
	10.20am	Hard copy of the report delivered to the Minister by Ms Pfingst.

In summary, the following people had access to a copy of the final report between the completion time on the afternoon of 28 June 2005 and the appearance of the article in the Courier Mail on 29 June 2005:

- Ms Leanne Patton, Review Team.
- Ms Trish Neilson, Executive Support Officer to the Director-General.
- Dr Steve Buckland, Director-General.
- Ms Jill Pfingst, Executive Manager, Executive Support Services.
- Ms Leisa Elder, Executive Director, Public Affairs.
- The Minister for Health.
- Mr Gerry Fitzgerald, Chief Health Officer.
- Ms Leanne Chandler, COI Team.
- Ms Geraldine Weld, COI Team.

All of the above officers have stated to the Investigating Officer during the course of this investigation that they did not provide a copy of this report and/or disclose any information from this final report to any person, outside the circumstances detailed in the above table.

All of the above officers have specifically stated that they did not disclose this document to Mr Hedley Thomas.

It is clear that limited copies of the final report were created and were carefully secured in a locked cabinet. There is no evidence to indicate that the report could have been inappropriately removed from this location from an unauthorised person.

Queensland Government
Queensland Health

REVIEW OF CLINICAL SERVICES BUNDABERG BASE HOSPITAL

CONFIDENTIAL REVIEW REPORT

THIS REPORT IS STILL IN PROGRESS- THE CONTENTS OF THIS REPORT WILL ALTER AND CONSEQUENTLY ARE NOT FOR OFFICIAL RELEASE AT THIS TIME

CONFIDENTIAL REVIEW REPORT

Investigation Team:

Team Leader	**Name: Dr Mark Mattiussi**
	Title: District Manager & District Director of Medical Services Logan & Beaudesert District Health Service District
Member	**Name: Dr John Wakefield**
	Title: *Executive Director Patient Safety*
Member	**Name: Associate Professor Peter Woodruff**
	Title: Vascular Surgeon Princess Alexandra Hospital Vice President Royal Australasian College of Surgeons (Until May 31st 2005) President Elect Australian & New Zealand College of Vascular Surgeons
Member	**Name: Adjunct Associate Professor Leonie Hobbs**
	Title: Acting Executive Director Women's & Newborn Services, Royal Brisbane & Women's Hospital

Date Review Commenced: Monday 18th April 2005

Date Review Completed: Thursday 30th June 2005

Controlled Document Number:

TABLE OF CONTENTS

EXECUTIVE SUMMARY 1

Introduction.....

Findings & Analysis.....

Recommendations.....

1.0 BACKGROUND 2

1.1 Emphasis on Elective Surgery..... 3

1.2 History of Key Positions..... 3

1.3 Nursing Services..... 5

1.4 Medical Services..... 7

1.5 Industrial Environment..... 9

1.6 Allegations of Failure of Executive to Manage Concerns..... 9

2.0 METHODOLOGY 11

3.0 FINDING & ANALYSIS 18

3.1 Credentialing & Priviledges 18

3.1.1 Dr Patel Appointment Process..... 19

3.1.2 Dr Patel Credentials and Clinical Privileges..... 21

3.1.3 Management of Dr Patel..... 22

a) Concerns raised with management about Dr Patel..... 22

b) Further concerns raised about Dr Patel by Dr Joiner..... 23

c) Further concerns raised about Dr Patel by Dr Miach..... 23

d) Concerns raised regarding wound dehiscence rates..... 24

e) Sentinel event report from Ms Hoffmann..... 24

f) Serious concerns raised 26

g) Other relevant management details....28

h) Employee of the Month Awards....29

i) Sexual Harassment....29

j) Lack of Feedback from Tertiary Facilities....30

3.1.4 Why did this happen?....31

3.2 Clinical Case Review Dr Patel....36

3.2.1 Clinical Chart Review....37

3.2.2 Interview Feedback on Patel's Clinical Performance....38

3.3 Analysis of Clinical Outcomes & Quality of Care....39

3.3.1 Surgery....39

3.3.2 Intensive Care Unit....41

3.3.3 Integrated Mental Health Unit....41

3.3.4 Paediatrics....42

3.3.5 Emergency....42

3.3.6 Internal Medicine....42

3.3.7 Obstetrics & Gynaecology....43

3.3.8 Other Medical Issues....46

3.3.9 Other Nursing Issues....48

3.4 Risk Management Framework....54

3.4.1 Risk management....54

3.4.2 Guidance provided by Queensland Health to districts....54

3.4.3 Resources provided to Bundaberg Health Service District....54

3.4.4 Clinical Governance committees....55

3.4.5 Clinical Risk Management Policies and Procedures.....59

3.5 Service Capability Framework.....68

3.6 Other Clinical Service Matters.....71

3.7 Other Areas of Concern 72

4.0 CONCLUSION.....78

APPENDICES

A. Flowchart of Events.....76

B. Interview Schedule 84

C. Dr Patel Patients Lists – Deceased & Transferred.....86

D. Dr Patel potential adverse outcome patient list and other doctors' potential adverse outcome list.....94

E. Communication Strategies Map.....99

F. Copy of the Service Capability Framework Clinical Services and Levels of Complexity – Bundaberg Health Service District – Bundaberg Base Hospital.....101

EXECUTIVE SUMMARY

Introduction

The attached flow chart (Appendix A) provides a comprehensive chronological record of key facts identified by the Review Team during Dr Patel's tenure at Bundaberg.

Findings & Analysis

Recommendations

1.0 Background

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

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

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

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

data was said to be available but as it wasn't validated it was not thought to be reliable or accurate.

1.1 Emphasis on Elective Surgery

Many staff spoke of the emphasis on elective surgery and that it was the major focus of the Health Service. Nurses stated that despite increasing Operating Room workloads, elective surgery was never cancelled with elective lists running over, after which time the emergency cases would commence. This led to increased nursing overtime. There is a view amongst staff that in putting so much resource into meeting elective surgery targets other aspects of health service delivery have been compromised. There is a perception amongst some that there is an inequitable budget allocation with an emphasis on reducing surgical waiting lists. Examples provided include inadequate allied health resources to meet both the current demand and the requirements of the Clinical Services Capability Framework (CSCF) as it applies to Bundaberg Hospital. The definitions within the CSCF are inclusive of the allied health professions. They are very broad and neither outline the specific expertise required nor numbers of staff.

1.2 History of Key Positions

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

Following the resignation of the previous Director of Nursing in 2003 after sixteen (16) years service it took seven (7) months until the current incumbent was appointed and took up the position of District Director of Nursing Services. During this time there were a number of nurses acting in this role (including Ms Ms Hoffmann). This was also at a time when there were two significant state wide nursing matters being progressed; the first being the restructure of Levels 3/4/5 and the second the Accelerated Advancement Qualification Allowance. There was a need for strong nursing leadership during this challenging period.

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

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

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

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

- Strong focus on budget and staff were continually struggling to maintain budget integrity and still provide quality of care and services
- Intimidating and bullying behaviours by staff at various levels (including union representatives) across Bundaberg Hospital
- Strong friendships and family linkages between staff which some staff believed led to some behaviours being tolerated
- Lack of support from Executive akin to an 'us and them' mentality
- New people with fresh ideas often not welcomed
- Resistance to change
- District Manager described as the 'game breaker' – the person who made the final decision
- Expectation that managers will juggle multiple roles without adequate resourcing

1.3 Nursing Services

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

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

During this review, a number of nurses made reference to the Judy March Review, predominantly to express an opinion about the change in structure, which in their view, has resulted in the loss of support for middle managers and incongruent reporting relationships. At the time there were two Assistant Directors of Nursing and a recommendation was to reduce the number to one upon the retirement of one of the incumbents. The Review Team could not identify at which time the decision was made to remove the remaining ADON from line management and to implement the direct reporting to the District Director of Nursing. It was however following the retirement of the former Director of Nursing, Mrs Glennis Goodman in September 2003 but prior to Mrs Mulligan taking up the position in 2004.

A significant number of nurses were interviewed throughout the review either individually or as part of a group. What became apparent to the Review Team was that many of these nurses expressed a sense of powerlessness. There were several examples provided of nurses not being given feedback from senior line managers including the District Quality and Decision Support Unit

and therefore they had made an assumption that their information was not valued or acted upon. They were frequently asked to provide reasons for budget overruns even in areas for which they had no control such as pathology. Nurses described having every nursing hour scrutinised whereas the doctors did not plan leave and used locums at significant cost to cover shortfalls. Nurses saw this as unfair and an inconsistent standard being applied across the hospital. They hold a view that whereas nurses are micro managed, doctors are not accountable for the management of their clinical service. This has led to a strong sense of resentment between nursing and medical colleagues. There does not appear to be great respect for Dr Keating within the nursing service.

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

Several of those nurses interviewed spoke of the differences between the previous Director of Nursing (Mrs Goodman) and the new District Director of Nursing Services (Mrs Mulligan). The overwhelming feeling was that with Mrs Mulligan they felt micro-managed and that they generally felt unsupported. They hold a belief that Mrs Mulligan's allegiance is more toward 'Executive' rather than with nursing.

They describe that when they cannot progress issues with Mrs Mulligan then they have nowhere else to go and they are powerless to do anything else. It was clear to the Review Team that the Nursing Middle Managers as a group were generally supportive of each other, were keen to speak to the reviewers on issues and had a shared view on what they saw as management not responding to their issues effectively. This group believe there is a lack of

trust, supporting the view with allegations that Executive were allegedly stating that 'there were no decent middle managers'.

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

1.4 Medical Services

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

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

It is usual for these directors, in addition to managing administrative component of their own departments, to undertake leadership roles in other areas such as chairmanship of meetings and the management of service groups. It is also usual for these directors to be utilised by the Director of Medical Services as expert advisors in their specialty areas to assist with organisational decision making. It is the opinion of the Review Team that different directors displayed different level of leadership in the management of their departments and related services. It has been reported on many occasions to the Review Team that Dr Patel took an active role in the

operating theatre management and drove the team to improved levels of efficiency. It has also been reported to the Review Team that some of these directors were consulted, in their expert advisory capacity, prior to some of the more complex cases being undertaken by Dr Patel and that they provided reassuring comment.

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

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

operate on their family. It seems that, amongst the medical staff, here is general acceptance of mediocrity of performance.

1.5 *Industrial Environment*

The Review Team were advised that there is a strong industrial influence at Bundaberg Hospital and that unionism is entrenched. It has been suggested that change has been difficult and protracted as some of the larger unions fought with the District over a number of issues. During the Review, the team heard allegations of management bullying staff, and also that there is bullying by some unions who bully other staff to ensure the view of the few union delegates and organisers were adhered to. The Review Team were advised that a number of union representatives hold positions as middle managers and this, at times, has produced a conflict of interest. Within the minutes of the District Consultative Forum, whilst there is reference to workload management issues, there is little or no reference to issues pertaining to a culture of bullying and intimidation, service capability issues or other matters arising relevant to this Review.

1.6 Allegations of Failure of Executive to manage concerns

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

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

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

2.0 Methodology

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

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

a. That Dr Patel appeared to practice outside the scope of practice of Bundaberg Hospital. Specifically he undertook operations which the hospital was not in a position to support. Some of these patients did not survive. In addition he appeared to retain patients whose condition deteriorated when they would best be transferred to a hospital with higher capacity
b. That Dr Patel appeared to have a higher complication rate that other hospital of similar standing.
c. That there appeared to be a lack or failure of systems and structures that would support the quality and safety of health care.
d. That as a result of these issues, there is considerable disharmony at the Bundaberg Hospital.

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

1. Examine the circumstances surrounding the appointment, credentialing and management of Dr Patel.
2. Review the clinical cases of Dr Patel where there has been an identified adverse outcome or where issues related to his clinical practice have been raised.
3. Analyse the clinical outcomes and quality of care across all services at Bundaberg Hospital. Compare with benchmarks from other states or

other like hospitals and identify areas requiring further review or improvement.

4. Review the Risk Management framework as it relates to the provision of direct services at Bundaberg Hospital to determine its effectiveness. Make recommendations in relation to improvements to these systems.
5. Examine the way in which the Service Capability Framework has been applied at Bundaberg Hospital to determine that the scope of practice is appropriately supported by clinical services.
6. Consider any other matters concerning clinical services at Bundaberg that may be referred to the review by the Director-General.
7. Should the Review Team identify other areas of concern outside the scope of these Terms of Reference, the Director-General is to be consulted to extend the Terms of Reference if considered appropriate.

In order to undertake the review to comply with these Terms of Reference the review team first reviewed the Clinical Audit Report undertaken by the office of the Chief Health Officer. This report highlighted a number of areas of concern from both staff interviews and within the data sources identified. The Clinical Audit Report highlighted areas for further review around complication of procedure codes from data provided by the Client Services Unit (CSU) of the Queensland Health Information Centre (HIC), provided some interpretation of relevant ACHS clinical indicators and provided some conclusions and recommendations primarily around system modification. There were no conclusive statements made around the clinical competence of Dr Patel though attention was drawn to complication rates which the report advises required further in-depth statistical analysis and if indicated, a review of the clinical records in those cases. The report doesn't appear to cover this analysis. The Review Team having read the report and believing that CSU HIC complication code data is typically not validated by clinicians in some districts decided to conduct their own independent review from scratch to ensure integrity of the review. Incidentally, following discussion, on site, with the Health Information Unit at Bundaberg Hospital it was confirmed that there

is no process in place wherein clinicians in Bundaberg Hospital regularly validate complication codes.

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

During the first site visit an open staff forum was conducted to advise staff of the mechanism to confidentially communicate with the Review Team so that those who wished to provide information confidentially to the team could. This was also aimed to capture those who had not been included on the interview schedule who felt they had information to contribute to the investigation. All staff were issued with notification forms and confidentiality information at the forum. They were invited to circulate the information and photocopy the forms if any colleagues were interested in submitted their concerns. A locked box was used to collect these forms and was provided outside the rooms which the Review Team were using. These rooms used were not near the Executive Suite and were not in a main thoroughfare, so that staff would feel comfortable to post their concerns. Fifteen (15) Confidential Staff Notification forms were received.

As the terms of reference specify that the Review Team were to "review the clinical cases of Dr Patel where there has been an identified adverse outcome or where issues related to his clinical practice have been raised", it was decided that an initial way to screen for adverse events was to review the Dr Patel patients from HBCIS. The Review Team considered that a reasonable screening tool would be to look at a sample of deceased and transferred

patients. A report was requested to be generated from the Health Information Unit of Bundaberg Hospital which included all patients who were discharged during Dr Patel's tenure and had an admission or discharge consultant or surgeon with the consultant code for Dr Patel who had either a discharge code of transfer or deceased. There were some difficulties experienced by the Review Team in obtaining this information as an initial report which was produced by the Transition II team at Bundaberg Hospital only included those patients with a principal surgeon code for Dr Patel. Once it was realised that there may be other patients operated on by Dr Patel who was not listed under the Principal Surgeon category a further report was generated by the Transition II team and provided to the Review Team.

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

Further, the Review Team formed a link with the recently formed Patient Liaison Service and the temporary Medical Services Executive and District Manager to obtain patient details that, in their opinion, the Review Team should be aware of. This link was also utilised by the Review Team to ensure that any patients identified during the course of the investigation by team

members who needed ongoing clinical care could be appropriately referred. All the additional patients are included in the attached lists.

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

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

- Leadership and Management
- Improving Performance
- Clinical Services Forums (Paediatrics, Medicine, ASPIC, Family Unit)
- Safe Practice and the Environment
- Infection Control
- District Consultative Forum
- Local Consultative Forum
- District Health Council
- EDON/ADON/NMs
- EDON, ADON, AHNM & Bed Management Meeting
- Nursing 3,5,6 Nursing Services Committee
- Medical Staff Advisory Committee
- Erromed meetings
- Theatre Management Group
- Continuum of Care
- Executive Council
- Workload Management Committee

- Nursing HOD

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

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

The Review Team experienced difficulties with some of these documents as there were many loose leaf documents such as File Notes and Letters from staff raising concerns and some containing crucial information which were undated and some even unsigned. This included many of the statements reportedly attached to the letter of complaint dated 22nd October 2004. In these circumstances it was virtually impossible for the Review Team to absolutely verify when these documents were created and, at times, by whom. In addition, it became quite apparent that printed copies of emails contain dates that are reported in both European and American format (default American though user definable) and depending on the settings of the individual and at time the computer from which they are printed the date 05/10/03 could be the 5th October or the 10th May 2003 and it was impossible to determine from the printed document or profile of the individual GroupWise account which date it was. The Review Team where ever possible has used other collateral information to validate dates where ambiguity has occurred. However this identified anomaly has the potential to affect the chronology of reported events.

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

This report is a compilation of all of the above information and the interpretation of the Review Team as to the facts and matters as they occurred. It is based on a combination of documents and information provided during interview. As much as possible the events reported by staff and community members have been verified with documentation though there was no compulsion on those interviewed to tell the truth and none could be compelled to provide information if they declined. This should be remembered when considering the information contained within this report.

Recommendations

1. **A process be established to ensure that coded data (particularly complication codes) at Bundaberg Hospital are audited with input from clinicians.**
2. **Queensland Health adopts the European style of date format or sets as" long date" and removes the user definable characteristic of this field in GroupWise to reduce confusion in the future**
3. **All documents raising complaints or concerns need to be dated and signed by the staff member raising the complaint or concern or returned to them for signing and date at the time the document is first presented.**

3.0 Findings & Analysis

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

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

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

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

3.1.1 Dr Patel Appointment Process:

What happened? From the information contained within Dr Jayant Patel's Bundaberg Hospital Personnel Files (medical staff have a file in the office of the Director of Medical Services, which appears more detailed, and in the Human Resource Department, neither of which is complete in its entirety) and interviews with relevant persons it appears his Curriculum Vitae was presented by Wavelength Consulting to the Bundaberg Hospital A/Director of Medical Services, Dr Nydam on the 13th December 2002 when Dr Nydam was looking to fill vacant and impending vacant staff surgeon positions.

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

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

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

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

There were other references provided with these which included:-

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

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

From the interview with Dr Nydam the Review Team were advised that no further checks were undertaken of Dr Patel by the hospital management at that time as Dr Nydam felt he could rely on the information provided by Wavelength Consulting. In December 2002 Dr Patel was offered the position of Senior Medical Officer, Bundaberg Hospital for twelve (12) months, on a Temporary Full Time basis, subject to Medical board of Queensland and Immigration Department approval. Wavelength Consulting undertook the liaison with the Medical Board (QLD MB) and Department of Immigration (DIMIA) on behalf of Bundaberg Hospital to ensure deadlines were being met and that the hospital administration was updated of progress. Dr Patel was subsequently registered under Section 135 of the Medical Practitioners Registration Act 2001 from 1st April 2003 to 31st March 2004, registration number 1030450 by the Medical Board of Queensland. There were was no reference to any concerns raised with previous registration in other countries. Dr Patel was subsequently appointed as the Director of Surgery by Dr Nydam as the position remained unfilled and out of the two (2) Full Time Surgeons, Dr Nydam felt Dr Patel would be the most suitable.

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

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

3.1.2 Dr Patel Credentials and Clinical Privileges:

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

Opportunity for intervention: It is usual practice for the District Manager or if more appropriate, to delegate to the Director of Medical Services determination of clinical privileges for temporary medical staff. However, it is likely under current procedure that this would have specified 'general surgery' which would not exclude the complex surgical procedures such as oesphagectomy which have raised concerns.

3.1.3 Management of Dr Patel:

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

a) Concerns first raised with management about Dr Patel:

What happened? On 19th May 2003, Mrs Glennis Goodman (former DDON) and Ms Hoffman met with Dr Darren Keating regarding a patient Phillips UR 034546. This patient had died following an oesophagectomy, and concerns were raised about the three issues. 1) Dr Patel had allegedly written that the patient was stable when in fact they were on maximum inotrope therapy and support. 2) Dr Patel was rude, loud and allegedly did not work collaboratively with the ICU medical and nursing staff. 3) That the ICU in Bundaberg was Level 1 and was not capable of providing the level of care that was required to support such surgery.

Dr Keating agreed to speak to Dr Patel and Dr Carter. Dr Keating raised the issue with Dr Carter who indicated that the ICU should be able to cope with this surgery with good patient choice. Dr Carter also indicated that the patient was not a good candidate for surgery and had been refused surgery in Brisbane. Dr Keating discussed the issue with Dr Patel and it is not clear what the outcome of this discussion. It appeared to be considered an interpersonal issue between Dr Patel and Ms Hoffman. No file notes were available of these discussions.

Opportunity for intervention: A multidisciplinary meeting to address the issue of the adverse patient event would have highlighted the Service Capability issue. A decision could have been made at this point to specify surgical capacity in relation to the ICU. Communication of outcome to staff that raised concerns.

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

What happened? Around the 5th June 2003, Dr Joiner met with Dr Keating to raise concerns regarding the care of patient Mr Grave UR 130224. This patient was the second oesophagectomy under Dr Patel and had had complications requiring prolonged ICU stay. Dr Joiner questioned Dr Keating about whether these cases should be done in Bundaberg. Dr Joiner had suggested transfer of the patient to Brisbane but Dr Patel who had refused. Dr Carter was away and Dr Keating asked the acting Director, Dr Yunus, to see the patient. He indicated that the patient could stay in Bundaberg. Two days later, the patient was transferred to the Mater Hospital. On Dr Carters return, Dr Keating met with him to discuss concerns raised by Ms Hoffman that the Bundaberg ICU should only electively ventilate patients for 24 to 48 hours. Dr Carter indicated that this was variable and could be extended for 3 to 5 days depending on circumstances. No specific outcomes were documented from the complaint.

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

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

What happened? On 6th February 2004, Dr Miach provided to Mr Martin (Acting DDON) and Dr Keating, an unsigned and undated complication report. The report had been compiled by Dr Miach and outlined a 100% complication rate (six out of six patients), that had undergone Tenkhoff catheter insertion by Dr Patel. Mr Leck found the complication report on his desk and requested Dr Keating to follow up. As a result of this, Dr Miach refused to have Dr Patel operate on his patients and Dr Patel refused to visit the renal unit. Dr Miach arranged for this access surgery to be provided under an outsourced contract arrangement at no cost to the hospital, through

Baxter. Mr Leck requested advice from Dr Keating and he was supportive of this arrangement. This contract was signed off by Mr Leck.

Opportunity for intervention: Given that several senior clinicians had expressed concerns regarding patient outcomes from Dr Patel, consideration could have been given at this stage to obtaining formal external peer review. However, there is currently no standard Queensland Health process to assist administrators determine how this should be conducted.

d) Concerns raised regarding wound dehiscence rates:

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

Opportunity for intervention: This information in addition to the previous concerns would have suggested external peer review of the cases and limit to privileges.

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

What happened? On 27th July 2004, Ms Hoffman reported the death of Mr Bramich UR 086644 as a Sentinel Event. This was consistent with the Queensland Health definition of an *unexpected death*. This was delivered to Mr Leck, Mrs Mulligan and Dr Keating. The allegations of the staff against Dr Patel in this case included delayed transfer, verbally abusing Mrs Bramich in ICU and grossly inappropriate attempts at pericardial drainage when the patient was in extremis. The ICU staff were allegedly shocked by this event and tried to access the hospital Employee Assistance Service for counselling.

This was not available and several staff accessed counselling services external to the hospital. The staff were further devastated when they 'heard' that the sentinel event was not reported to the Director General as per the new Queensland Health policy of June 2004. The event was considered by Dr Keating, not to be a sentinel event. He commenced investigation. It was alleged that no feedback was ever given to the ICU regarding what was to be done about the incident report, or the result of any investigation. Ms Hoffman met with Mrs Mulligan on the 26th August 2004 to discuss several issues. These included the fact that Dr Patel was planning a thoracotomy operation for the following Friday, and she was concerned that this was beyond their capability to manage in ICU. Secondly that she was concerned that nothing had happened on the Mr Bramich case. Ms Hoffman, being concerned at the apparent lack of management action, proceeded to raise the issue with the Queensland Nurses Union in August 2004 and Ms Barry from the QNU met with her on 3rd September 2004. On 20th September 2004, Bundaberg Hospital received a Ministerial complaint about the Mr Bramich case and a Section 9A PIPA Notice was served on Queensland Health, at which point Dr Keating's investigation ceased. At a meeting between Mrs Mulligan and Ms Barry on 6th October 2004, the possibility of mediation was discussed for Dr Patel and Ms Hoffman. The problem still appeared to be being managed as a personality conflict between the two.

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

Opportunity for intervention: A multidisciplinary team review of the death would have been appropriate. Once again, given the previous issues, external peer review would have been appropriate.

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

What happened? After a meeting between Ms Hoffman and Mrs Mulligan on 20th October 2004 regarding Patel, they immediately went to meet with Mr Leck. He requested that she put the concerns in writing. This was detailed in a letter dated 22nd October 2004. Following this, Mr Leck arranged to meet with Dr Keating and three other medical staff to assess the allegations made by Ms Hoffman. He met with Drs Berens, Rissom and Strahan around 29th October 2004. Following these three (3) meetings, Mr Leck made a decision to obtain external peer review of Dr Patel. During interviews he indicated that he did not believe he had sufficient evidence to remove Dr Patel or to limit his privileges. Over the next few days, he attempted to secure a reviewer. The Tilt Train incident occurred on 16th November 2004 and this created two weeks of major disruption and the issue was not further addressed during this period. Dr Patel contributed to the significant local efforts to treat the injured. After contacting a number of colleagues for the names of potential reviewers, Mr Leck was advised that he should consider progressing the matter with the assistance of the Audit Branch and sent a Fax on 16th December 2004. He was advised in writing, via email, the next day that *this was a clinical matter and did not appear to constitute misconduct.* The recommendation was to contact the Chief Health Officer, Dr Fitzgerald where a copy of the email had also been sent. Mr Leck contacted his office and was advised that he was going on leave and would not be able to attend to this matter until he returned in January 2005.

On the 24th December 2004, the Director of Medical Services, Dr Keating wrote to Dr Patel offering a further extension of his contract from 1st April 2005 until 31st March 2009 under the terms and conditions of the previous

extension. The Review Team are unable to find any documentation of a merit based process to support such an extended period of contract extension for Dr Patel. Dr Patel advised in correspondence dated the 14th January 2005 that he was "not renewing my (his) contract as Director of Surgery with Bundaberg Base Hospital beginning April 1 2005", and this was acknowledged by Dr Keating on the 18th January 2005. Further discussion ensued and correspondence from Dr Keating dated 2nd February 2005 confirms an offer under the provisions of the District Health Services – Senior Medical Officers' and Resident Medical Officers' Award – State 2003 for a salary of $1,150.00 per day (includes all call ins) and weekends were to be paid at the above rate when placed on call for weekends. This correspondence also detailed that it was Dr Patel's responsibility to obtain an ABN number and to submit an account to Accounts Payable for payment upon completion of the locum appointment. The Review Team are not aware of any provision under the District Health Services – Senior Medical Officers' and Resident Medical Officers' Award – State 2003 which allows for locums to be employed in this way. Dr Patel wrote accepting this locum position on the 7th February 2005.

It should be noted that on 21st December 2004, Dr Patel undertook another oesophagectomy (Mr Kemps UR 007900) who died and allegedly grossly mismanaged a young trauma victim (Mr Mobbs UR 038213) on the 24th December 2004. In January 2005, letters of concern regarding these patients were raised by staff working in theatre and Intensive Care Unit.

On the 2nd February 2005 the Director of Medical Services, Dr Keating completed a Special Purpose Registrants – Section 135 Area of Need – Qld assessment for Dr Patel for the period December 2003 – January 2005 and rated Dr Patel's performance primarily "better than expected" though rated Emergency skills, Procedural skills and teamwork and colleagues as "consistent with level of experience" and Professional Responsibility and Teaching as "Performance exceptional".

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

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

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

g) Other relevant management details:

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

On the 25th November 2003 Dr Patel's contract of employment was extended for a further 12 months from 1st April, 2004 until 31st March 2005. It is noted in his extension of employment that the rental subsidy which was initially $150 per week for the first 12 month period had been increased to $300 per week. On the 2nd December 2003 the Director of Medical Services, Dr Keating, completed a Special purpose Registrants – Section 135 Area of Need – Qld assessment on Dr Patel for the period April – November 2003 indicating that

his performance was "better than expected" for most of the criteria and "consistent with level of experience" for the others (Emergency Skills and Medical Records/Clinical Documentation).

On the 5th January 2004, Dr Patel was appointed as the Surgery Academic Coordinator (0.5 FTE) in the Rural Clinical Division – Central Queensland (RCD-CQ), School of Medicine, University of Queensland. Dr Patel continued to be employed by Bundaberg Hospital and part of his position was funded by the RCD-CQ under this appointment.

h) Employee of the Month Awards

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

i) Sexual Harassment

The Review Team were provided with information surrounding allegations of sexual harassment involving Dr Patel and a number of nursing and medical staff. Whilst some of the information was hearsay, one female staff member who made serious allegations against Dr Patel did speak with the Review Team. The staff member concerned accessed support and advice in accordance with the Sexual Harassment Policy and was in the process of pursuing her complaint further when Dr Patel left Queensland. Given the confidential nature of the allegation and the inability to speak with Dr Patel, the issues raised and actions taken have not been documented within this

report. However there is clear indication from the statements made by the complainant that this matter would have required immediate investigation.

Statements made by other staff members in relation to this incident include:

- Dr Patel asked interns to perform surgical procedures beyond their level of expertise.
- Dr Patel paid more attention to females than males.
- The performance assessment of the staff member concerned was bartered as a tool for personal favours. When the staff member refused, the performance assessment was graded as unsatisfactory.

j) Lack of feedback from tertiary facilities

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

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

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

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

3.1.4 Why did this happen?

This section summarises the key underlying system issues identified by the Review Team that contributed to the events as they unfolded in relation to Dr Patel. This is based on the James Reason *'Swiss Cheese'* error chain model.

The major contributing factors were found to be:

Organisation level:

- There appears to be a **single point weakness in the registration** process for Area of Need temporary resident doctors that allowed for a doctor to be registered without independent checks to verify the veracity of the application. *(It is not within scope of this Review to comment further on this matter).*
- The **severe medical workforce shortages in Queensland** and challenges faced by provincial/rural practice, has led to a situation where services are under constant threat, which leads to recruitment of overseas trained medical staff that are often not suited to the local culture, practice and expectations. This leads to decreased safety and quality of care.
- There is **an emphasis on production within health service delivery.** Some of the hospital funding is linked to activity and waiting list performance which leads to a focus on finance. This can sometimes be at the expense of safety and quality.
- The Queensland Health **Clinical Service Capability Framework (CSCF)** discussed later in this report lacks clarity in relation to specific surgical procedures. The Credentials and Privileges process would require significant change to allow for specific procedures to be excluded based on CSCF.
- There is **no Queensland Health orientation process** for executives particularly for out-of-state appointments. This leads to a situation where executives are often unfamiliar with organisational legislation,

policy, procedure and practice and lack the necessary networks and contacts to ensure compliance with expectations.

- There is **no objective mechanism for monitoring the ongoing technical ability** of a medical practitioner to determine whether their practice is within acceptable standards. The absence of any formal guidance to help senior clinical staff and executives determine the appropriate process when concerns are raised about a clinician's performance, causes confusion and uncertainty in dealing with this situation.

Health Service District (Workplace) level:

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

Team level:

- There is **no established process for the multidisciplinary review and management of clinical incidents.** The executive are charged with investigating events and this lacks openness and transparency, which led to a lack of trust between staff and management.

- There is **no standard process and expectation of multidisciplinary peer review, audit and quality improvement** at clinical unit level (paediatric Erromed is a notable exception)
- There was a **perception that executive management did not listen** to clinician concerns. This was made worse as they were rarely seen in the clinical areas.

Individual level:

- Dr Keating was from inter-state and was **unfamiliar with the Queensland legislative, policy and administrative processes.**
- Dr Patel's **behaviour gave rise to fear and polarised staff groups.** There was no local capacity to facilitate the multidisciplinary review of adverse patient outcomes which reduced the opportunity to exclude personality issues.
- There appeared to be a **culture of tolerating problems** rather than addressing them. Several doctors withdrew, did nothing, hid patients, or arranged alternative surgical support rather than formally addressing the problem together with their nursing colleagues.
- Dr Patel was **not provided with written advice regarding his clinical privileges.**

How could this be prevented?

Recommendations:

1. **Queensland Health ensure there are rigorous processes for recruitment and assessment of Overseas Trained Doctors prior to commencing work in Health Service Districts.**
2. **Queensland Health must develop a comprehensive strategy to address the serious medical workforce issues affecting safety and quality of health services. This must deliver practical assistance to Health Service Districts.**

3. Bundaberg Health Service District should ensure that safety and quality is afforded priority. This will require Queensland Health to examine health funding incentives.
4. The Clinical Service Capability Framework (CSCF) should be developed to include specification of key groups of elective surgical procedures that are CSCF dependant.
5. Bundaberg Health Service District to ensure that all medical staff receive adequate orientation to the district on commencement. Queensland Health develop and implement an orientation process for key executives.
6. Objective mechanisms for monitoring the ongoing technical ability of medical practitioners needs to be developed to determine whether their practice is within acceptable standards.
7. The Bundaberg Health Service District review the committee structure and Terms of Reference to minimise duplication and to establish clear accountability for safety and quality. That a single multidisciplinary committee be established to address patient safety and quality issues, monitor and evaluate actions and provide feedback to staff.
8. Within the Bundaberg Health Service District, there should be a designated complaints coordinator and patient safety officer to support the district in implementing safety processes.
9. The Bundaberg Health Service District establishes a clear process for the multidisciplinary review and management of clinical incidents.
10. That Queensland Health work with Bundaberg Health Service District to develop peer clinical networks with a focus on clinical performance, service improvement, benchmarking and shared learning.
11. Human Resource Department Bundaberg Health Service District to provide oversight of Medical Staff Employment to ensure that there is consistency with recent Queensland Health policy, awards and industrial agreements.

12. One complete Personnel File to be maintained by the Human Resources Department Bundaberg Health Service District.
13. That Queensland Health develop and implement a state-wide clinical governance framework which effectively tracks accountabilities for clinical performance, and is subject to regular compliance monitoring.
14. That Bundaberg Health Service District ensure that all medical staff are provided with written clinical privileges upon appointment, consistent with the service capability and credentials.

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

3.2.1 Clinical Case Chart Review

This section needs Peter W to complete the chart reviews and then we will need to provide some interpretation of the table in a few paragraphs. PW should be able to assist with the wording

Table: Summary of Charts Reviewed to Date

Status	Deceased – Patel Admit or discharged or treated	Deceased treated by Patel - not under care of Dr Patel +/- elsewhere at time of death	Transferred Patients	Other Deceased non-Patel	Other Patel Patients- Adverse Outcomes	Other Hosp	Other Non-Patel	Total
Number of Charts reviewed to date	31	29	51	4	14	1	20	150
Number of Patients with Expected Level of Care to date								
Number of Patients Identified as Outside Scope of Practice to date								
Questionable Practice								
Referred to Coroner by Review Team	3							
Total Number of Charts to be Reviewed	32	55	60	5	67	1	29	249

3.2.2 Interview Feedback Relating to Dr Patel Clinical Performance

During the interviews with staff the Review Team sought information regarding their observations about Dr Patel's surgical technique and performance. Many provided some very insightful comments and the common themes have been drawn from these by the Review Team. **PW will need to provide some commentary if these themes are reinforced from review of the clinical records.**

The common themes include that Dr Patel had issues with wound closure, infection control practices and the attentiveness he paid to his operating technique. These include comment that he didn't close wounds in layers and opted for "mass closures" and he sutured too "tight". Bowel anastomosis was performed with suture material rather than using stapling equipment which in itself isn't an issue though it has been reported to the Review Team that some believed his sutures were spaced "too far apart".

When considering infection control practices Dr Patel is alleged to have coughed and wiped his nose with a gloved hand and be operating whilst suffering from active dermatitis of his arms.

Dr Patel is said by many to have been a fast surgeon and have reasonable technique with some of the "basic stuff" though from the information gathered during interviews by the Review Team it was reported that he didn't "protect the bowel" nor was he as meticulous in his dissection of vital structures as other surgeons have been though he was better than others. Some report that he undertook dissection with his fingers.

Many report that Dr Patel was not receptive to feedback regarding his performance and he is said to have denied responsibility for complications.

Others pointed out instances when during teaching he allowed very junior staff to operate under his supervision. In one instance he supervised an intern performing a bowel anastomosis. A number of the more senior resident medical officer staff found this very unusual. It was a common theme that he allegedly taught at people and was reported to use his own curriculum rather than that of the university and reportedly often yelled when things weren't as he would like.

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

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

The major data sources analysed were:

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

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

3.3.1 Surgery

The surgical service includes general surgery, including management of emergencies and trauma, general orthopaedics, and urology performed by a

visiting general surgeon. Public vascular surgery has now ceased due to the resignation of Dr Theile, the previous Director of Medical Services. Upper and lower GI endoscopy are provided by both surgeons and physicians.

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

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

ACHS Indicator	Definition	Rate 03	Rate 04
4.1	Unplanned patient admission to ICU within 24 hours of a procedure	Double expected	Double expected
1.3	Cancellation of procedure after arrival due to acute medical condition	Double expected	Double expected
3.1	Unplanned overnight admission	Double expected	Double expected
3.4	Haematemesis and/or malaena with blood transfusion with operation during same admission	75% patients (9/12)	13.6% patients (3/22)

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

Adverse event reporting was reported in trended graphs. These reports were produced by the DQDSU and were not well developed, having only been recently commenced. It is notable that the surgical ward reported much higher numbers of incidents than other clinical areas and medical ward (with the exception of mental health). This could be either due to a better reporting culture in the area, heightened awareness due to concerns about Dr Patel, or

more actual incidents. It is not possible to draw valid conclusions from comparison of *reported incident numbers.*

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

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

3.3.2 Intensive Care Unit

Intensive care was reviewed as part of the Critical Care Review of 2002 commissioned by the Central Zone. No further analysis of this data was undertaken. Unplanned admissions to ICU were higher than expected but not statistically significant. The number of readmissions to ICU within 72 hours of discharge from ICU decreased 2003 (2.9%) to 2004 (0.3%).

3.3.3 Integrated Mental Health Service

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

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

3.3.4 Paediatrics

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

3.3.5 Emergency Department

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

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

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

3.3.6 Internal Medicine

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

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

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

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

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

3.3.7 Obstetrics and Gynaecology

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

Two Staff Specialists are employed Dr Stumer and Dr Wijeratne. Dr Stumer, who is a long standing staff member of Bundaberg Hospital is the Director and has been employed in this capacity since the 1st July 1997. The Bundaberg Family Unit has had stable nursing leadership with the Nurse Unit Manager having been in the position for a number of years.

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

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

There is also significant and ongoing conflict between the Director of Obstetrics and Gynaecology and midwives surrounding clinical practice protocols, the reported obsessive and repetitious behaviours of the Director and the responsibility for the management of the unit. The last of these,

relating to the lack of engagement of the Medical Directors in issues such as the management of service budgets and quality agenda, is not only relevant to the Family Care Unit and is dealt with in other areas of the report.

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

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

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

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

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

noted behaviours, the details contained within these incident reports further confirm the ongoing theme of urinalysis for antenatal patients.

Following interviews and reviewing the after hours nurse manager reports the Review Team became aware of a number of patients, including those with undifferentiated chest pain, being admitted to BFU and, to a lesser extent, the paediatric unit. This raised concerns about the appropriateness of admissions to these areas considering the skill set of the staff and resources available. In the instance of BFU the geographic dislocation from the acute wards poses additional potential risk. It is not unusual to outlie patients in these areas though parameters need to be agreed upon to ensure only appropriate patients are admitted to these areas.

3.3.8 Other Medical Issues

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

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

Another anomaly which was identified whilst reviewing the Personnel Files of the Senior Medical Staff was that one of the specialists, the Director of Medicine, Dr Miach holds General Registration, Reg No. 924595 in the State of Queensland. He was, and the Review Team believes currently is, employed as a specialist with right of private practice by Queensland Health and appears to hold the relevant qualifications (MB BS Melbourne 1968 and FRACP, MRACP Australia). At the time of the Review he did not hold Specialist Medical Registration in Queensland. Upon enquiry with the Medical Board of Queensland the Review Team were advised that Dr Miach only applied for General Registration in Queensland on the prescribed General Registration application form. The Review Team were advised that Dr Miach had never applied for specialist registration in Queensland. It appeared from Dr Miach's Personnel File that he was previously registered as a specialist in Victoria prior to taking up his appointment at Bundaberg Hospital. Further, even though Dr Miach didn't hold Specialist Registration with the Medical Board of Qld he was in possession of a provider number for specialist billing No 0222115X for the Bundaberg Hospital in Queensland.

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

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

- Poor structure to the ED assessment of many of the patients reviewed. Some patients had significant pathology which appeared to be missed at initial presentation because a thorough assessment was not undertaken at initial presentation and admission in the Emergency Department or on the ward when the patient was admitted
- There was evidence that the supervision of junior doctors during business hours was appropriate. After Hours and on weekends, this was not necessarily the case, with inexperienced junior doctors required to provide unsupervised care. This was hard to avoid given the difficulties in recruiting suitably trained medical staff. In addition, junior medical staff are not as well supported by consultants as they could be. There was an instance of a patient who was transferred from one of the local private hospitals because they needed Intensive Care. This patient was admitted publicly under the same consultant they were cared for privately and was quite unwell. One of the junior staff was left to care for this deteriorating patient after hours and even though the consultant was informed of the criticality of the case they did not attend the hospital to care directly for their patient. This patient was subsequently transferred to a Brisbane Intensive Care Unit the following day.
- Obstetrics & Gynaecology is of concern – complaints about practitioners, practitioners not being available to provide clinical support to others as allegedly off site, doctors deliberating too much as asking others (less junior and less skilled for treatment advice, outdated practices

Will need to provide more details here once MM finishes reviewing the other Non Patel records if any other common themes are found

3.3.9 Other Nursing Issues

A number of nurses interviewed raised the issue surrounding line management, stating that they are no longer clear as to the role of the ADON and further that the current reporting relationship is most unsatisfactory.

Reasons for their dissatisfaction are primarily that with so many nurse managers reporting to the District Director of Nursing there is difficulty accessing her in a timely manner. Some nursing middle managers report that whilst the District Director of Nursing espouses an 'open door' policy that in fact this is not the case and at times had to wait weeks to get an appointment to see her.

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

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

The Bed Manager/After Hours Nurse Managers are required to provide a written report to the Executive which is completed three times a day at 0700, 1500 and 2300 hours. This report is intended to communicate staffing issues, ward occupancies and activity within Peri-operative Services and the Department of Emergency Medicine. There is also a section to report significant events that have occurred and that may be of interest to the Executive. The Review Team requested and reviewed these reports from 2003-2005. On reviewing this large number of reports it became obvious that these reports do not always provide key information. Significant events such as the sentinel events (Mr Bramich 27th July 2004) and another after-hours adverse event (Mr Kemps 21st Dec 2004) were not documented. If the purpose of the report is to inform Executive of significant issues that may

prompt further investigation then the report needs to be completed accurately and comprehensively.

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

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

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

perceived to be unresolved at District Manager level. At this point the matter would require escalation to the Zonal Manager.

As a consequence, when staff are reluctant to report upward they may tend to opt toward the seeking of support from their union i.e. Queensland Nursing Union (QNU). It has been suggested that the QNU have a strong presence and are very active within Bundaberg Hospital. This is not an unusual phenomenon and is common practice in some hospitals especially those where flat structures exist and wherein nurses may seek industrial advocacy rather than a more direct and less threatening approach with senior management.

Recommendations

1. **Queensland Health suggest to ACHS changes to current clinical indicator reporting and benchmarking to enhance validity and clinician acceptability.**
2. **Queensland Health to further develop Measured Quality Program to provide risk-adjusted and statistically valid performance data for key clinical outcomes.**
3. **That the Bundaberg Health Service District and the Measured Quality Program Team follow up these indicators once 2004/5 data is available.**
4. **Queensland Health to develop, implement and support statistical process control and cusum methodologies to assist with monitoring individual clinician performance in key clinical areas of practice.**
5. **That Bundaberg Health Service District assess progress against the previous Critical Care Review findings.**
6. **Consideration to undertake a more comprehensive review of the issues highlighted, particularly those surrounding the medical**

leadership and clinical practice, within the Bundaberg Family Unit.

7. Reinforce to staff that incident reports need to be completed and submitted with evidence of analysis and any corrective action taken in a timely manner.
8. Protocols need to be developed to determine which patients are clinically appropriate to be admitted as outliers to the Bundaberg Family Unit.
9. Human Resource Department to provide oversight of Medical Staff employment to ensure that there is consistency with recent Queensland Health policy, awards and industrial agreements.
10. One complete Personnel File be maintained by the Human Resources Department.
11. The anomaly of a medical officer with General Registration being employed as a staff specialist with right of private practice should be corrected.
12. The anomaly of a Medical Board of Queensland general (non specialist) registrant with specialist level billing Provider Number requires further review.
13. Training, support and supervision should be provided to ensure that the assessment of patients undertaken within the Emergency Department is thorough. Structures need to be put in place to ensure adequate supervision of junior medical staff after hours and on weekends.
14. The format of the After Hours Nurse Managers' Bed Status Report must be reviewed to ensure that all Nurse Managers provide accurate, pertinent and timely advice to the Executive in a consistent way.
15. That reporting relationships for the Nursing Service be reviewed to incorporate the existing Assistant Director of Nursing position and also to provide a reporting relationship for Clinical Nurses who are sole practitioners. For example, the

Stomaltherapist could report to the NUM-Surgical Ward rather than DDON.

16. The Position Description for the Assistant Director of Nursing position must be reviewed as a matter of priority.

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

3.4.1 What is risk management?

Risk Management is the "systematic application of management policies, procedures and practices to the task of identifying, analysing, assessing, treating and monitoring risk"

REF(Management Advisory Board's Management Improvement Advisory Committee (MAB/MAC), *Guidelines for managing risk in the Australian Public Service*, Report No. 22, Canberra, October 1996, p3.)

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

3.4.2 What guidance did Queensland Health provide to assist districts develop effective clinical risk management?

Queensland Health has had a state-wide policy in Integrated Risk Management since 2002 (No. 13355, February 2002; superseded by 13355, June 2004). This Policy was followed by the Incident Management Policy (23360: 10th June 2004) and the Complaints Management Policy (15184: 23rd July 2003).

3.4.3 What resources were provided to Bundaberg Health Service District to implement clinical risk management?

Training was provided by the Queensland Health Risk Management Coordinator to Bundaberg Health Service District to assist Bundaberg staff comply with the policies. However, training was not provided in Root Cause Analysis methodology. There were no additional human or fiscal resources provided to Bundaberg Hospital to support the additional work required to

effectively implement and sustain the policies. The District Manager for Bundaberg Health Service District was responsible for ensuring that the Risk Management Policy was implemented. The District Quality and Decision Support Unit (DQDSU) in conjunction with the Director of Medical Services (DMS), was delegated the responsibility of leading the implementation and providing ongoing support for clinical risk management systems in Bundaberg Hospital. Staff in this office raised concerns with District Executive that they did not have sufficient resources to effectively support these activities. A business case was submitted for additional staff, but no extra resources were provided.

3.4.4 What clinical governance committees were in place?

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

The peak decision-making and accountability committee in the district is the Leadership and Management (L&M). All of the Bundaberg Health Service District Executives are members of this committee. All information in the form of committee minutes is then filtered through to the Leadership and Management committee. There is no single committee that has been delegated responsibility for clinical safety and quality issues. These issues are covered in the terms of reference of the following committees directly

reporting to L&M: Safe Practice and Environment; Improving Performance; Executive Council; Improving Performance; Continuum of Care. Subcommittees included the Clinical Service Forums, Workplace Health and Safety, Infection Control, Falls, Pressure Ulcers and Erromed, which all reported through separate committees. The Medical Staff Advisory Committee was not represented on the Communication Map, despite also being a forum where safety and quality issues were raised.

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

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

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

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

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

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

Table: Example of poor follow through and poor documentation

Meeting	Minute Number	Issue	Action
ASPIC 19th May 2004	04/04-6	Wound Dehiscence	NUM to check on definition and collect data
9th June 2004			Ongoing- still defining terminology
14th July 2004			Report tabled.
18th August 2004			M Carter, J Patel to meet to discuss indicators
13th October 2004			No discussion. Wards to report as Adverse Event. **Item closed**

Exec Council 2nd July 2004 4th August 2004 3rd Sept 2004	0704-1.1	Wound Dehiscence	Nil Action documented Report by next mtg ASPIC will continue to progress. **Item closed.**
Leadership & Management Jun 7th, 15th, 21st and 28th 2004 Jul 5th, 19th and 26th 2004 Aug 9th, 16th, 23rd, and 30th 2004 Sept 6th, 13thand 27th 2004 October 4th, 11th and 18th 2004	**No record on minutes that Executive Council have referred the minutes or discussed items raised**		

This example demonstrates the lack of follow through despite common committee membership and the existence of a communication strategies map that outlines the flow of information. There is also no evidence of feedback to staff or ongoing evaluation, such as further reported cases of wound dehiscence identified through Adverse Event Forms; even though a further episode of wound dehiscence was reported on 20th August 04 after release of the initial wound dehiscence report.

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

3.4.5 Clinical risk management policies and procedures:

Incident reporting systems:

Bundaberg Health Service District had local procedures in place for incident management and sentinel event reporting. These were initially approved in November 2004. Risk Management procedures were initially approved in February 2002 and revised in November 2004 to be consistent with changes to the Queensland Health policy. The complaints handling procedure that the Review Team obtained was approved in March 2000 and apparently had been changed by the incumbent District Director of Nursing (DDON) shortly after commencing at Bundaberg Hospital. These procedures were consistent with the Queensland Health policies, and outlined:

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

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

- Workload issues – They were unable to maintain effective support for the process due to inadequate staff. They had been unable to get approval for further support until concern was raised about possible failure of the ACHS mandatory criteria.

- Inadequate training and support – Training provided to support roll-out of the Queensland Health incident management policy did not provide standardised Root Cause Analysis (RCA) methodology.
- Failure to close the loop – Referral of high, very high and extreme risks to the relevant Executive Director rarely led to documented investigation findings, approved actions or feedback to DQDSU or reporting staff.
- Executive and clinical directors were not clear on what aggregated data reports they required to monitor safety and quality performance.
- There was a tendency to have an individual and punitive approach to staff that reported incidents, rather than a system-focussed approach which encouraged reporting and used incidents as an opportunity to learn.
- Reluctance to report incidents – It was reported by many staff that there was no point in reporting incidents as nothing happened and the culture did not support reporting.

Incident recording information system:

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

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

Are Bundaberg Health Service District clinical risk management practices effective? JW to review this heading so the report flows

Are staff able to identify clinical incidents when they occur?

There appeared to be varied understanding of what was a reportable clinical incident amongst staff. The Bundaberg Health Service District procedure was titled *Adverse Event Management Policy* (QHEPS No. 21906: 1st June 2004) and did not provide clear definitions for incident, near-miss, adverse event and sentinel event. This was highlighted in relation to an unexpected death of one of Dr Patel's patients. A sentinel event form was submitted by the NUM of Intensive Care and this was 'downgraded' by a member of the Executive on the grounds that it did not meet the criteria. Under the Queensland Health Incident Management Policy, sentinel events are subject to mandatory reporting to the Director General and require an RCA to be conducted into the event.

Are there barriers to reporting clinical incidents?

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

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

What other methods of identification of clinical incidents were used?

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

Complaints management process

There appeared to be no link between the complaints process and clinical incident management process. The complaints procedure at Bundaberg had

been changed with the DDON assuming responsibility for complaints management since her arrival. It was not clear to the Review team that the complaints process was adequately resourced, and consistent with the principles of 'open disclosure'.

There were many examples of complaints that had not been reported through the incident management system, including two incorrect surgeries by Dr Patel. These would be reportable as sentinel events.

Mortality and morbidity reviews and clinical audits

There was no evidence of a hospital-wide death audit process. There was a history of clinical audit occurring within the clinical units at Bundaberg. Hospital Documentation around these activities was variable. Whilst these can be a very useful way to share information and learning, it is unclear how clinical incidents identified at these forums were reported.

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

Are incidents risk rated?

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

Are high-risk incidents investigated?

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

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

Are low risk incidents investigated?

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

What is the evidence that changes occur in response to incident investigation?

In the absence of any formal investigation process of high risk incidents, there is no opportunity to develop and approve action plans, and monitor effectiveness of interventions.

Pro-active clinical risk management strategies at Bundaberg

In addition to the clinical risk management systems aimed at responding to and learning from incidents *after they occur*, clinical risk management incorporates key strategies aimed at minimising the risk of adverse outcomes. These include:

Recruitment, retention, credentialing and privileges, performance management

Review team noted that there were significant medical workforce shortages in Bundaberg which are consistent with state and national shortages. Seventy per cent (70%) of the medical staff were Overseas Trained Doctors (BBH Medical Staff Establishment).

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

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

The credentialing system for senior medical staff was being reviewed at the time of the appointment of Dr Patel. Privileges for temporary consultant staff

were not outlined at appointment. There had been problems encountered in getting the involvement of the RACS on the credentialing committee.

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

Orientation for new medical staff was limited due to lack of resources and many staff identified this as a serious deficit.

It is important to note that the DMS was recruited after almost two years of the position being vacant. The new DMS was from interstate and received limited orientation both to the Hospital and to the Queensland Health system. The significant medical workforce shortages created an environment where recruiting and retaining appropriately trained medical staff was a major problem. Queensland Health focussed on production and Dr Patel was reportedly certainly production focussed, quickly reducing waiting lists, bringing in much needed revenue for the hospital and achieving activity targets.

Clinical pharmacy services:

Provision of clinical pharmacy services to ward areas provides significant benefits in risk reduction from medication related adverse events. The Pharmacy Department at the Bundaberg Base Hospital is unable to provide ward based clinical pharmacy services. This is in part due to significant state-wide workforce shortages and also due to insufficient resources available within the department to be able to provide this service.

Recommendations:

1. **Queensland Health provide sufficient resources to Bundaberg Health Service District to support effective management of**

clinical incidents and complaints consistent with Queensland Health policy, including implementation of the incident management information system PRIME.

2. Queensland Health provide comprehensive training and support for patient safety and incident management at the Bundaberg Health Service District, including standardised Root Cause Analysis (RCA) methodology.
3. Queensland Health provide comprehensive state-wide training and support to Executives and clinical leaders to facilitate improvement in safety culture.
4. Queensland Health develop and implement a state-wide clinical governance framework which effectively tracks accountabilities for clinical performance, and is subject to regular compliance monitoring.
5. Bundaberg Health Service District to ensure that all medical staff receive adequate orientation to the district on commencement. Queensland Health develop and implement an orientation process for key executives.
6. Bundaberg Health Service District should ensure that safety and quality is afforded priority. This will require Queensland Health to examine health funding incentives.
7. Queensland Health should ensure that there is development of a minimum data-set for patient safety and state-wide analysis of incident data with the emphasis on *learning* rather than *performance*.
8. Queensland Health develop strategies to address the medical workforce shortages that provide practical assistance to Health Service Districts.
9. Bundaberg Health Service District ensure that all medical staff are provided with written clinical privileges upon appointment, consistent with the service capability and credentials.
10. Objective mechanisms for monitoring the ongoing technical ability of medical practitioners needs to be developed to

determine whether their practice is within acceptable standards

11. Queensland Health ensure that Overseas Trained Doctors are adequately assessed prior to commencing work in Health Service Districts.

12. That the District Communications Strategy Map & Terms of Reference for committees be reviewed to minimise duplication and to reduce the number of committees attended by individual staff.

13. That all minutes of meetings clearly document key points of discussion, agreed action, accountable officers and timeframes.

14. That items remain on meeting agendas until there is documented completion of agreed action by the accountable officer.

15. That feedback to referring committees or staff occurs and that this is clearly documented in the action sheet

16. That the pharmacy department at Bundaberg Health Service District be reviewed with a view to providing sufficient staff to deliver ward-based clinical pharmacy services.

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

Clinical Services Capability Framework

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

Summary - Clinical Service Capability Framework - Bundaberg Hospital

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

Further discussion during an interview with the Director of Medical Services, Dr Keating revealed that the Health Service District Executive had

subsequently reviewed the scoring and had decided that the anaesthetic service at Bundaberg Hospital should have been scored as a Level 3 service when considering the proper application of the Clinical Services Capability Framework.

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

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

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

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

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

Recommendation

1. **Clinical Services Capability Framework should only be used as a guide to decision making. There is a need for Management within a hospital to take a holistic view of the services when applying the framework in specific instances**
2. **The decisions regarding service profile to be clearly communicated to hospital Staff so as to clearly define scope of service**
3. **The indicative range of procedures described within the Surgical Complexity section of the Clinical Services Capability Framework document needs to be reviewed to ensure greater homogeneity of complexity of the listed procedures.**

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

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

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

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

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

4.0 Conclusion

APPENDICES

APPENDICES

A. Flowchart of Events.....84

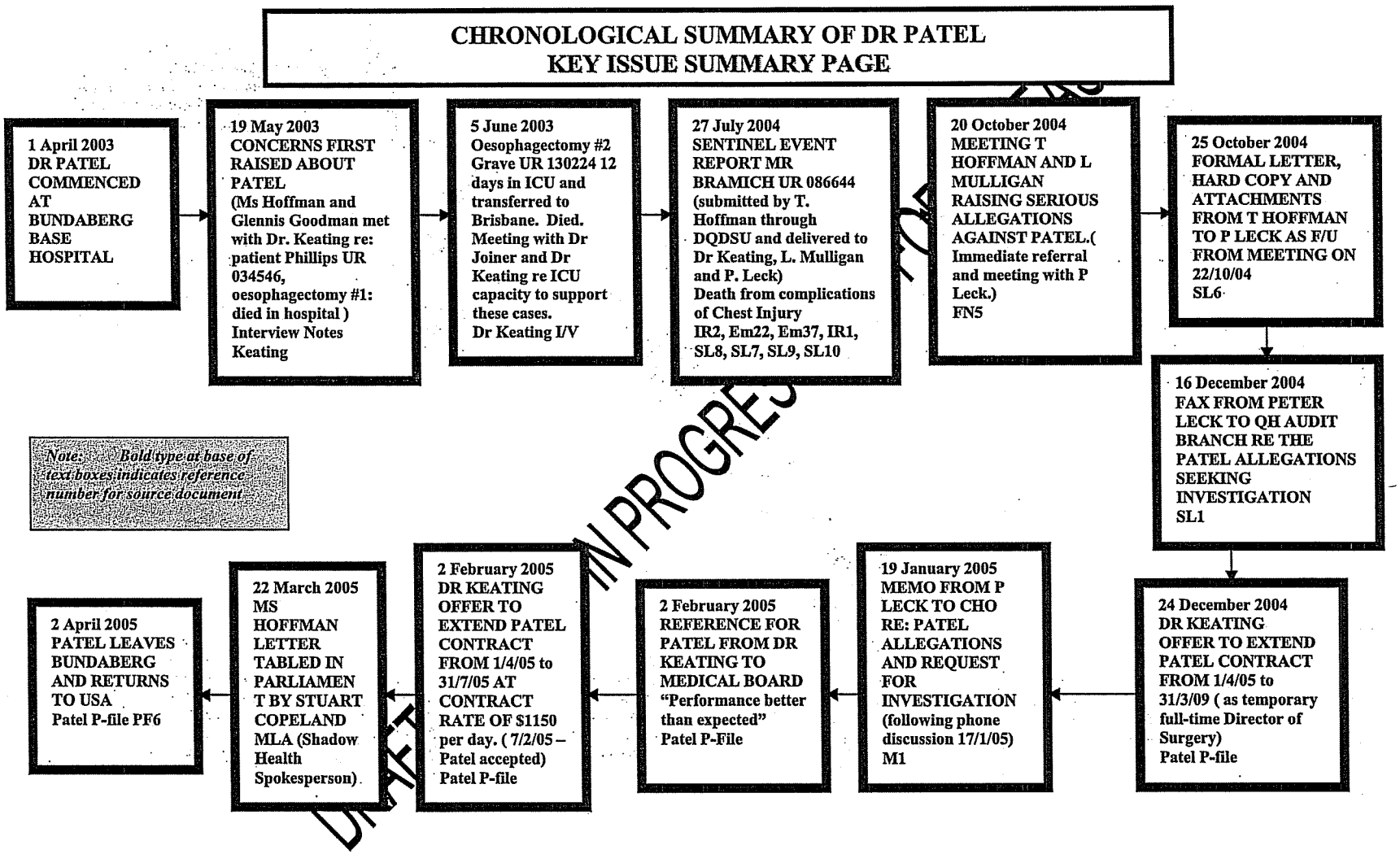
B. Interview Schedule 92

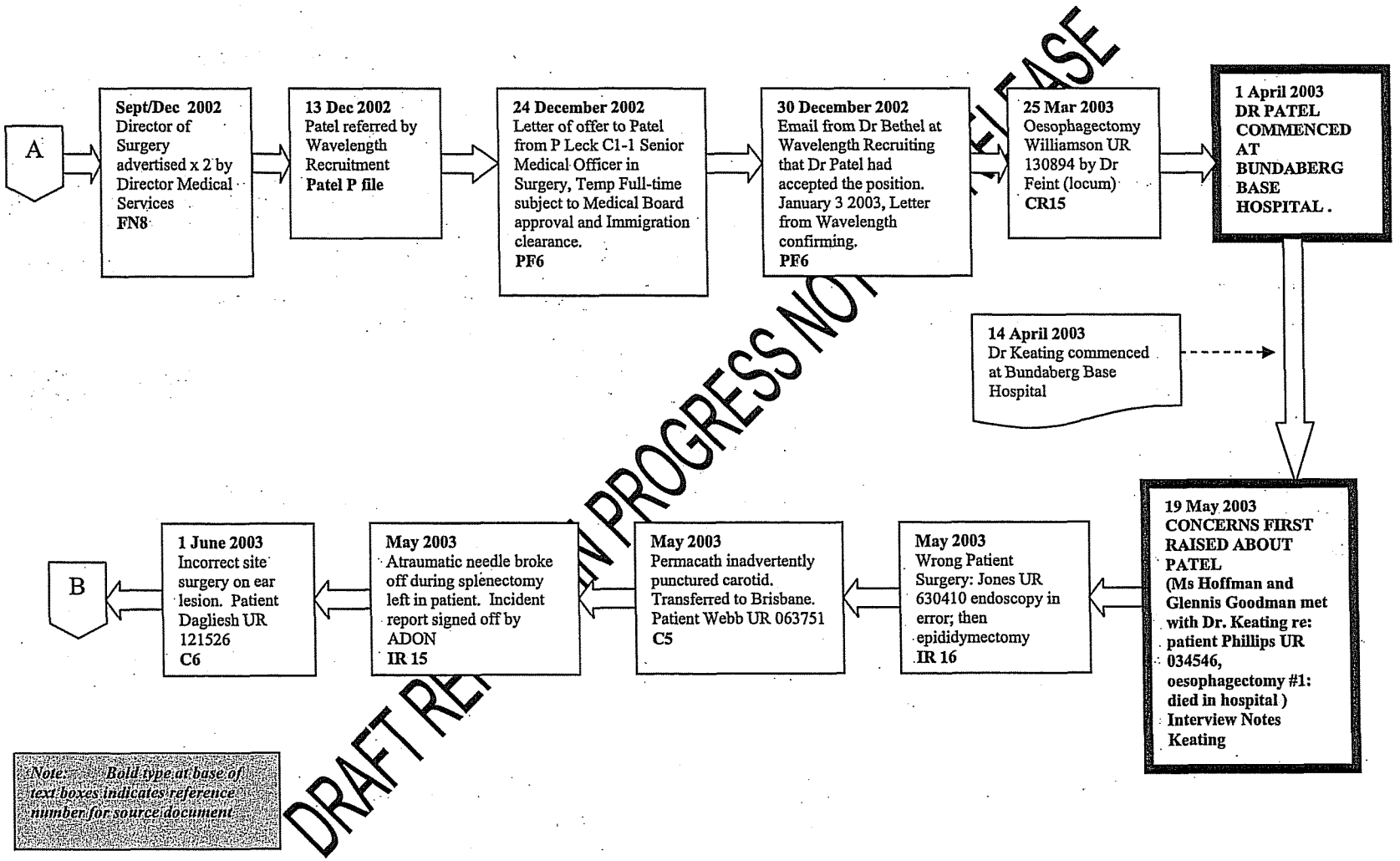
C. Dr Patel Patients Lists – Deceased &Transferred.....94

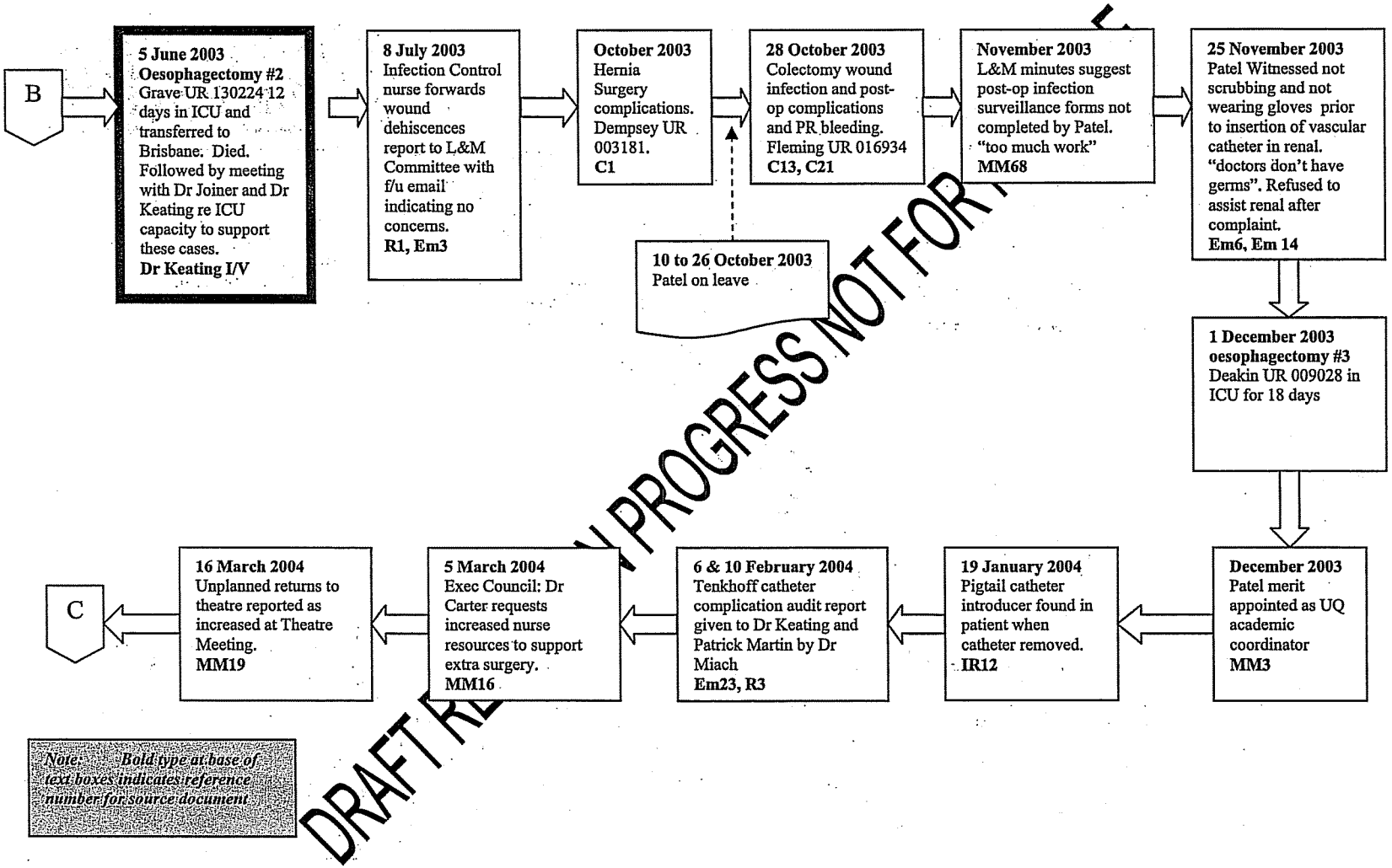
D. Dr Patel potential adverse outcome patient list and other doctors' potential adverse outcome list.....102

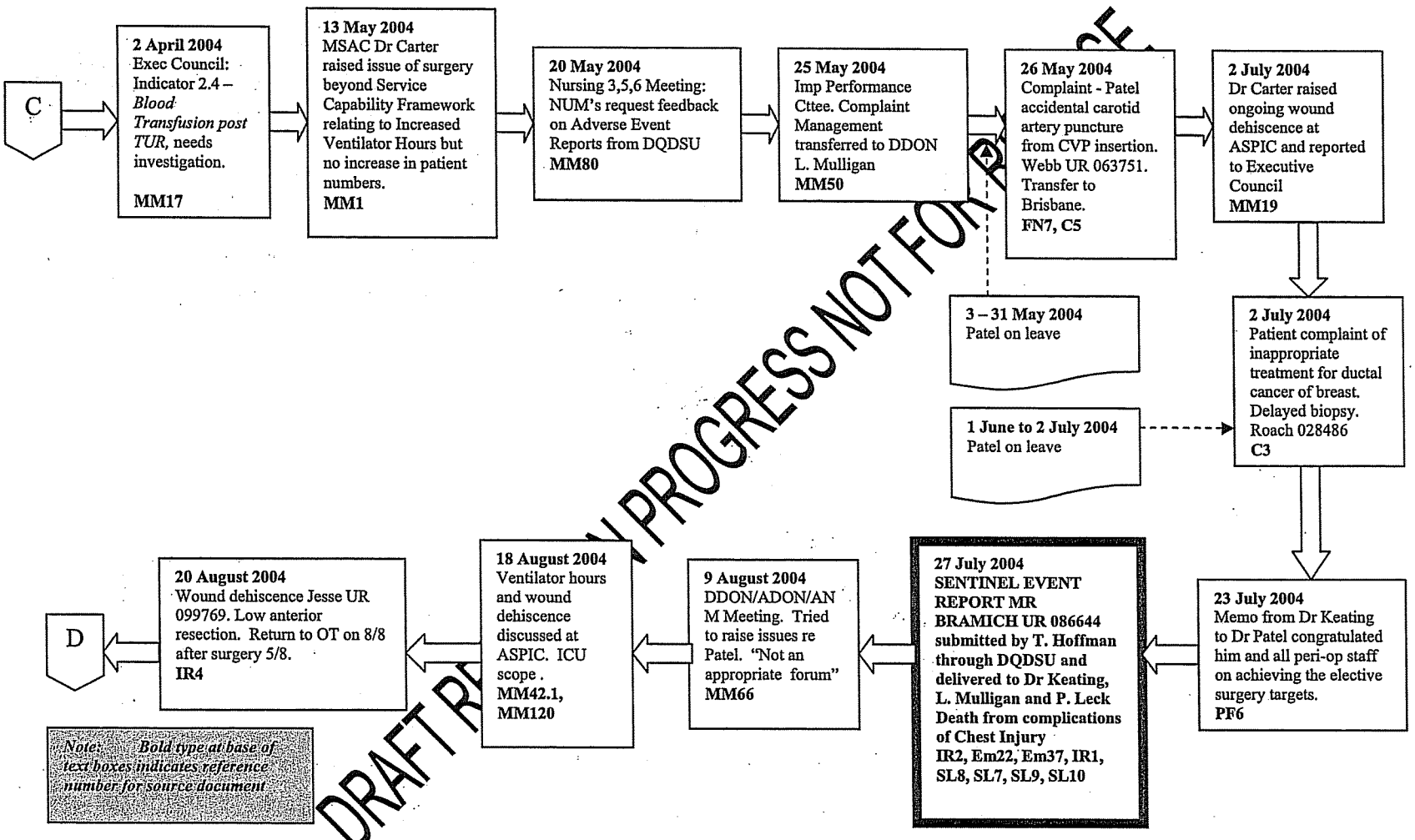
E. Communication Strategies Map.....107

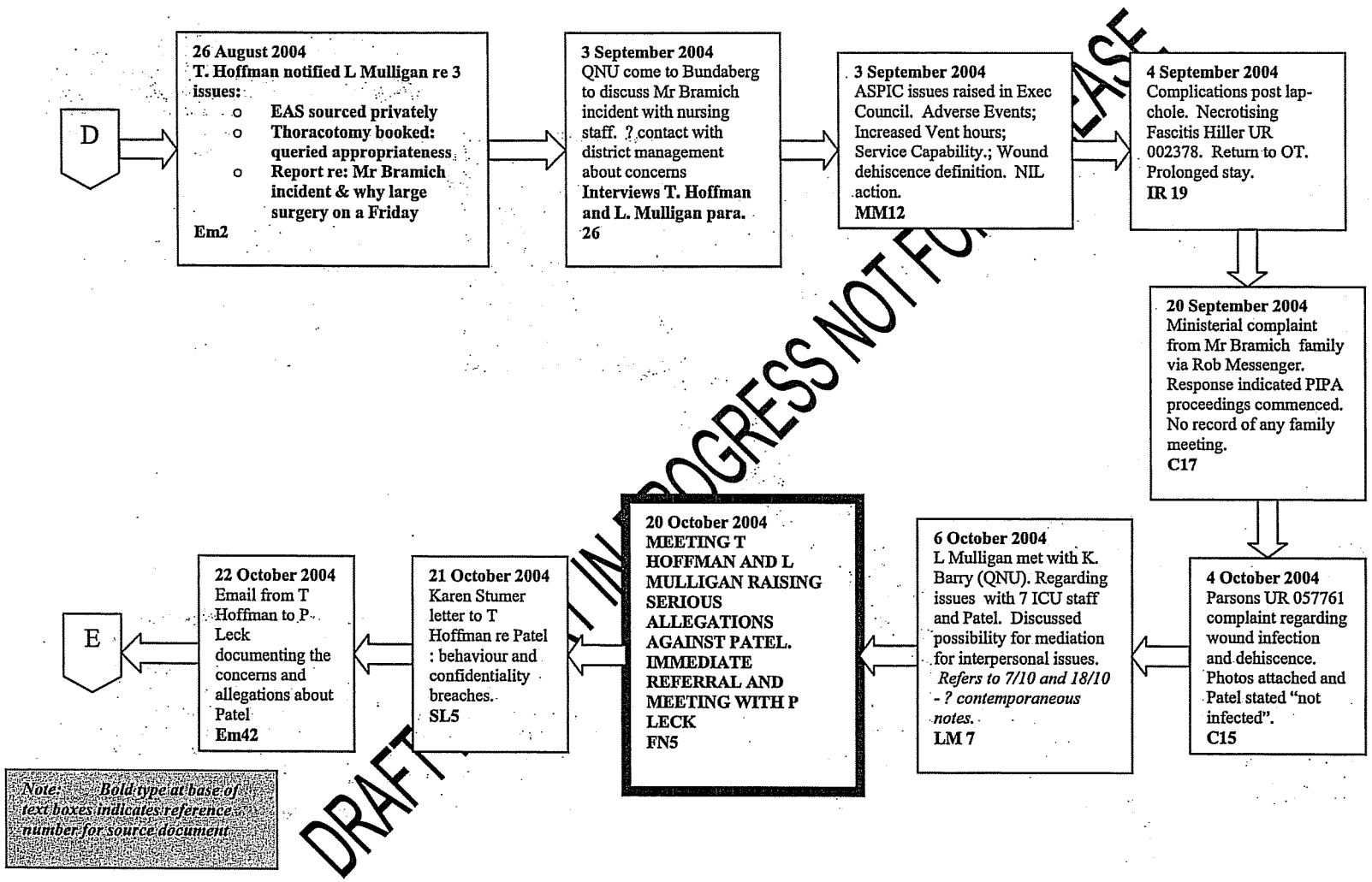
F. Copy of the Service Capability Framework Clinical Services and Levels of Complexity – Bundaberg Health Service District – Bundaberg Base Hospital.....109

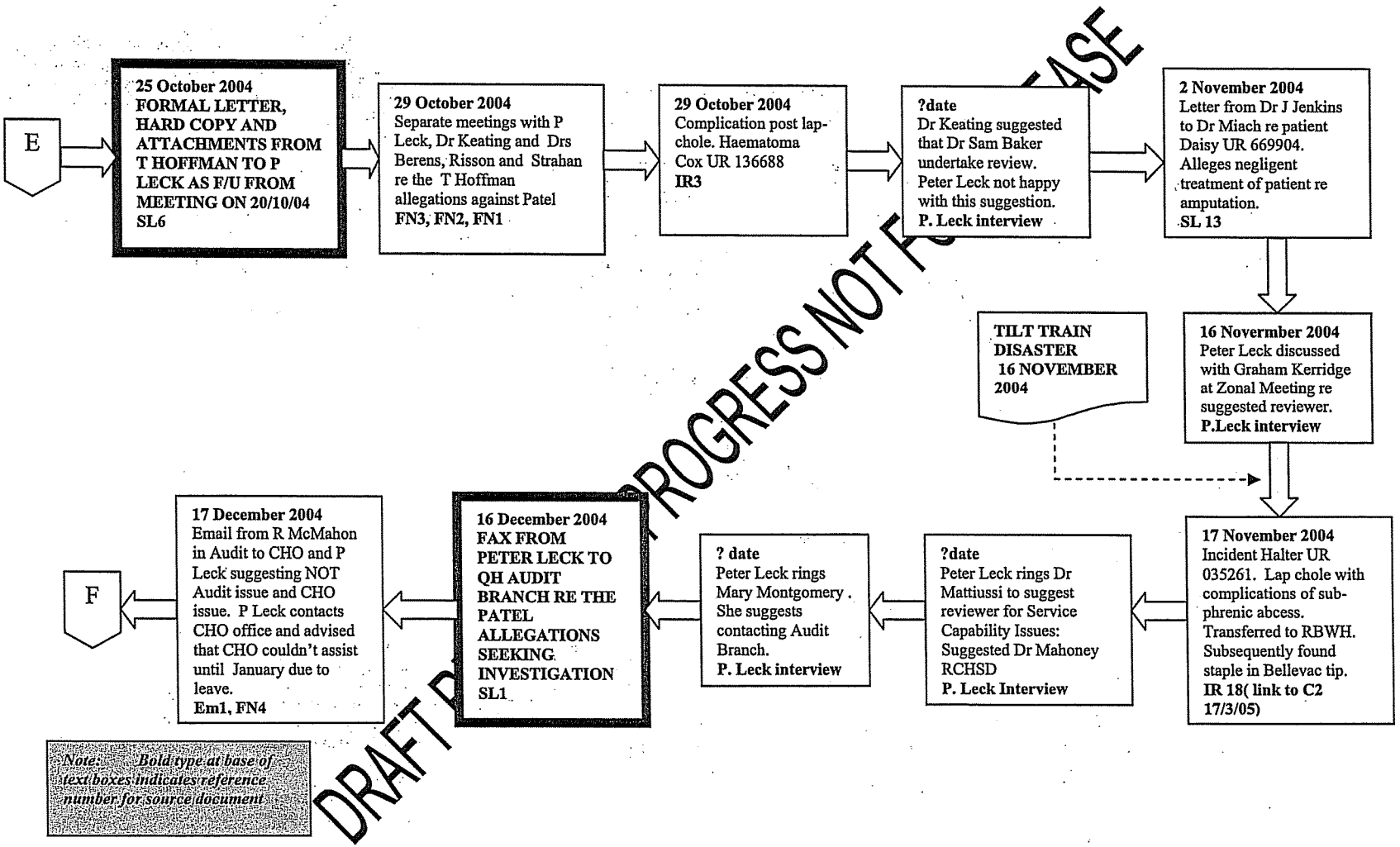

CHRONOLOGICAL SUMMARY OF DR PATEL
KEY ISSUE SUMMARY PAGE
1 April 2003 DR PATEL COMMENCED AT BUNDABERG BASE HOSPITAL
19 May 2003 CONCERNS FIRST RAISED ABOUT PATEL (Ms Hoffman and Glennis Goodman met with Dr. Keating re: patient Phillips UR 034546, oesophagectomy #1: died in hospital) Interview Notes Keating
5 June 2003 Oesophagectomy #2 Grave UR 130224 12 days in ICU and transferred to Brisbane. Died. Meeting with Dr Joiner and Dr Keating re ICU capacity to support these cases. Dr Keating I/V
27 July 2004 SENTINEL EVENT REPORT MR BRAMICH UR 086644 (submitted by T. Hoffman through DQDSU and delivered to Dr Keating, L. Mulligan and P. Leck) Death from complications of Chest Injury IR2, Em22, Em37, IR1, SL8, SL7, SL9, SL10
20 October 2004 MEETING T HOFFMAN AND L MULLIGAN RAISING SERIOUS ALLEGATIONS AGAINST PATEL.(Immediate referral and meeting with P Leck.) FN5
25 October 2004 FORMAL LETTER, HARD COPY AND ATTACHMENTS FROM T HOFFMAN TO P LECK AS F/U FROM MEETING ON 22/10/04 SL6
16 December 2004 FAX FROM PETER LECK TO QH AUDIT BRANCH RE THE PATEL ALLEGATIONS SEEKING INVESTIGATION SL1
24 December 2004 DR KEATING OFFER TO EXTEND PATEL CONTRACT FROM 1/4/05 to 31/3/09 (as temporary full-time Director of Surgery) Patel P-file
19 January 2005 MEMO FROM P LECK TO CHO RE: PATEL ALLEGATIONS AND REQUEST FOR INVESTIGATION (following phone discussion 17/1/05) M1
2 February 2005 REFERENCE FOR PATEL FROM DR KEATING TO MEDICAL BOARD "Performance better than expected" Patel P-File
2 February 2005 DR KEATING OFFER TO EXTEND PATEL CONTRACT FROM 1/4/05 to 31/7/05 AT CONTRACT RATE OF $1150 per day. (7/2/05 – Patel accepted) Patel P-file
22 March 2005 MS HOFFMAN LETTER TABLED IN PARLIAMENT BY STUART COPELAND MLA (Shadow Health Spokesperson)
2 April 2005 PATEL LEAVES BUNDABERG AND RETURNS TO USA Patel P-file PF6
Note: Bold type at base of text boxes indicates reference number for source document
DRAFT
IN PROGRESS

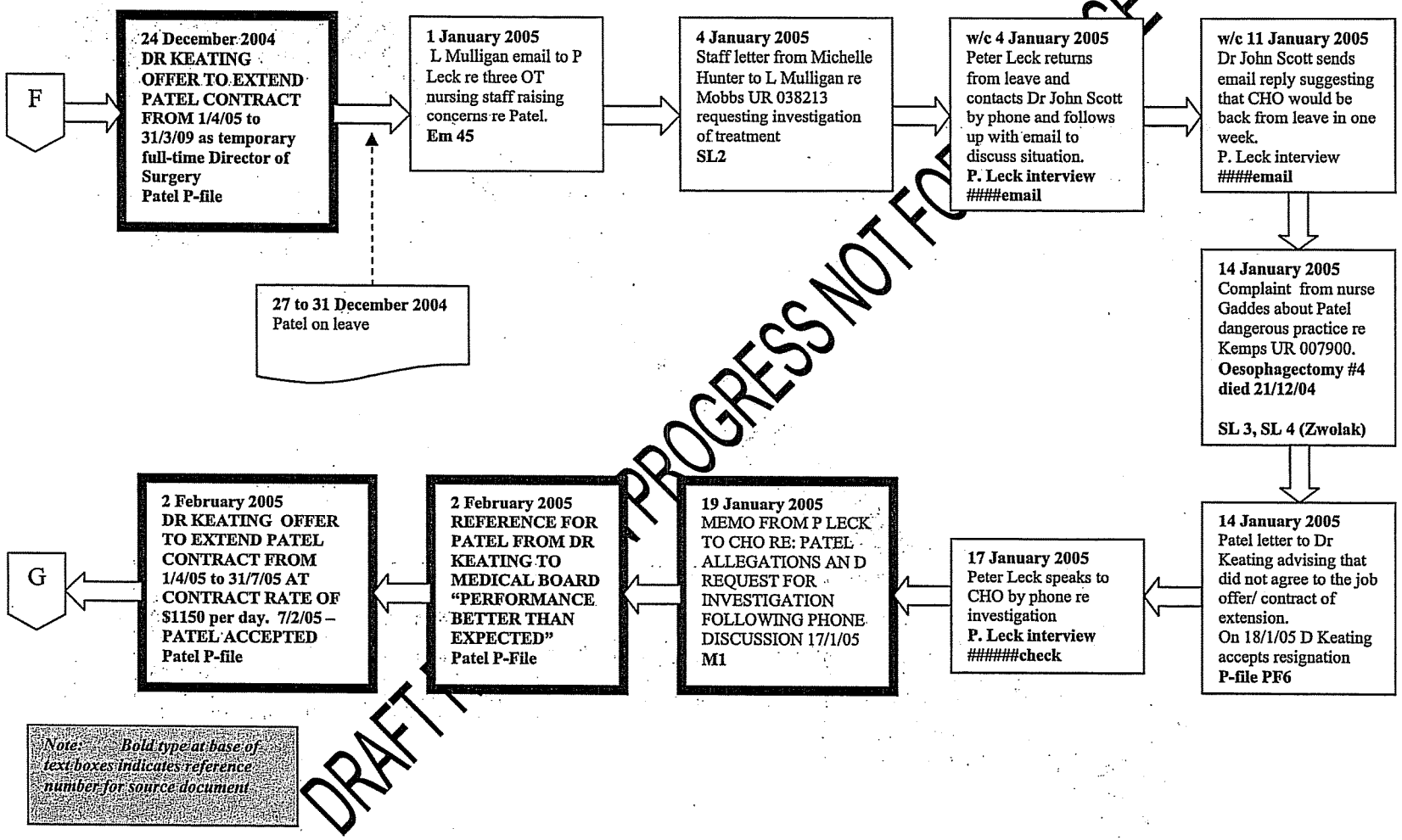


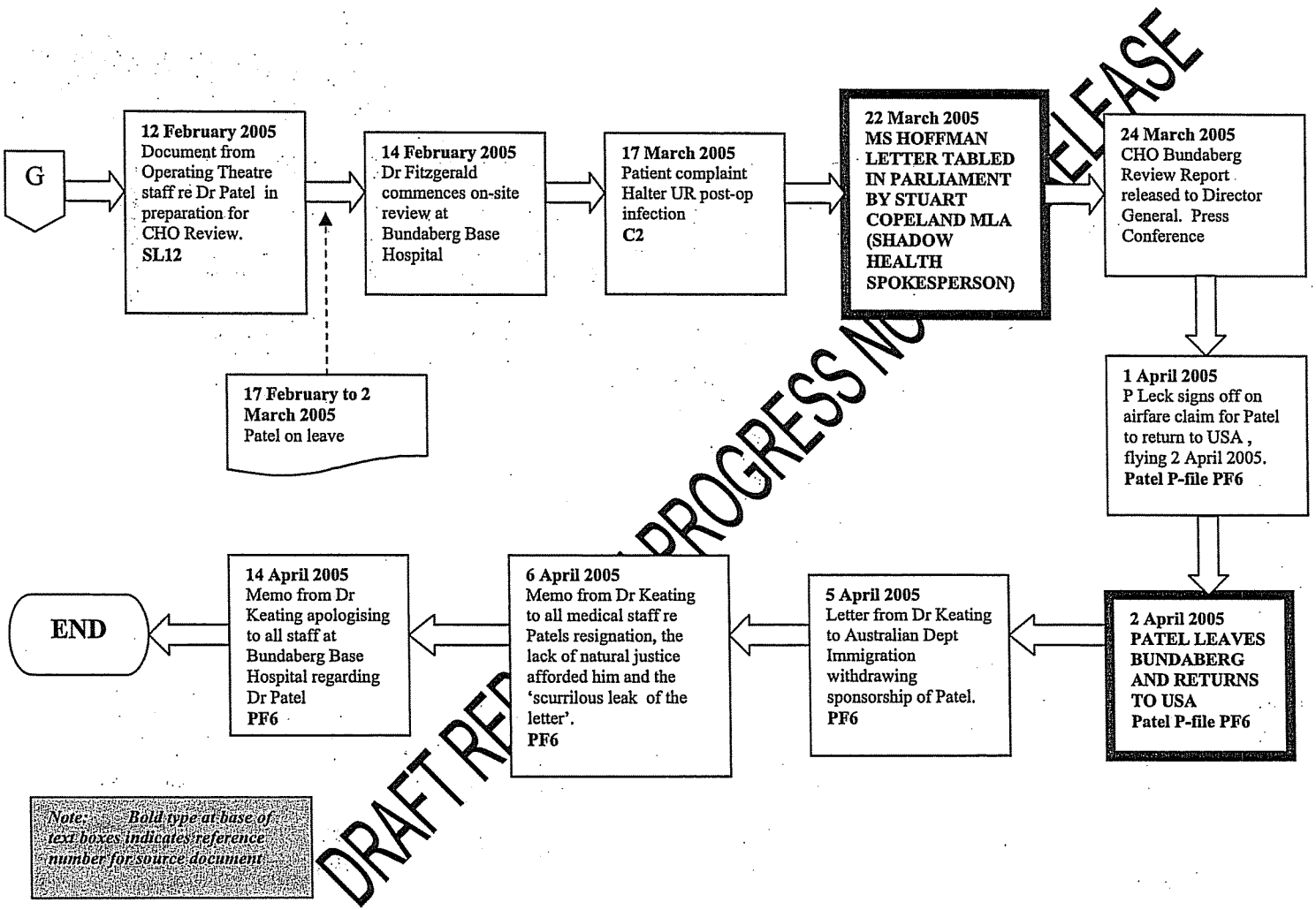



C
2 April 2004
Exec Council: Indicator 2.4 – *Blood Transfusion post TUR*, needs investigation.
MM17
13 May 2004
MSAC Dr Carter raised issue of surgery beyond Service Capability Framework relating to Increased Ventilator Hours but no increase in patient numbers.
MM1
20 May 2004
Nursing 3,5,6 Meeting: NUM's request feedback on Adverse Event Reports from DQDSU
MM80
25 May 2004
Imp Performance Cttee. Complaint Management transferred to DDON L. Mulligan
MM50
26 May 2004
Complaint - Patel accidental carotid artery puncture from CVP insertion. Webb UR 063751. Transfer to Brisbane.
FN7, C5
2 July 2004
Dr Carter raised ongoing wound dehiscence at ASPIC and reported to Executive Council
MM19
3 – 31 May 2004
Patel on leave
1 June to 2 July 2004
Patel on leave
2 July 2004
Patient complaint of inappropriate treatment for ductal cancer of breast. Delayed biopsy. Roach 028486
C3
23 July 2004
Memo from Dr Keating to Dr Patel congratulated him and all peri-op staff on achieving the elective surgery targets.
PF6
27 July 2004
SENTINEL EVENT REPORT MR BRAMICH UR 086644 submitted by T. Hoffman through DQDSU and delivered to Dr Keating, L. Mulligan and P. Leck Death from complications of Chest Injury
IR2, Em22, Em37, IR1, SL8, SL7, SL9, SL10
9 August 2004
DDON/ADON/AN M Meeting. Tried to raise issues re Patel. "Not an appropriate forum"
MM66
18 August 2004
Ventilator hours and wound dehiscence discussed at ASPIC. ICU scope .
MM42.1, MM120
20 August 2004
Wound dehiscence Jesse UR 099769. Low anterior resection. Return to OT on 8/8 after surgery 5/8.
IR4
D
Note: Bold type at base of text boxes indicates reference number for source document
DRAFT REVIEW IN PROGRESS NOT FOR RELEASE


D
26 August 2004
T. Hoffman notified L Mulligan re 3 issues:
EAS sourced privately
Thoracotomy booked: queried appropriateness
Report re: Mr Bramich incident & why large surgery on a Friday
Em2
3 September 2004
QNU come to Bundaberg to discuss Mr Bramich incident with nursing staff. ? contact with district management about concerns
Interviews T. Hoffman and L. Mulligan para. 26
3 September 2004
ASPIC issues raised in Exec Council. Adverse Events; Increased Vent hours; Service Capability.; Wound dehiscence definition. NIL action.
MM12
4 September 2004
Complications post lap-chole. Necrotising Fascitis Hiller UR 002378. Return to OT. Prolonged stay.
IR 19
20 September 2004
Ministerial complaint from Mr Bramich family via Rob Messenger. Response indicated PIPA proceedings commenced. No record of any family meeting.
C17
4 October 2004
Parsons UR 057761 complaint regarding wound infection and dehiscence. Photos attached and Patel stated "not infected".
C15
6 October 2004
L Mulligan met with K. Barry (QNU). Regarding issues with 7 ICU staff and Patel. Discussed possibility for mediation for interpersonal issues.
Refers to 7/10 and 18/10 - ? contemporaneous notes.
LM 7
20 October 2004
MEETING T HOFFMAN AND L MULLIGAN RAISING SERIOUS ALLEGATIONS AGAINST PATEL. IMMEDIATE REFERRAL AND MEETING WITH P LECK
FN5
21 October 2004
Karen Stumer letter to T Hoffman re Patel : behaviour and confidentiality breaches.
SL5
22 October 2004
Email from T Hoffman to P Leck documenting the concerns and allegations about Patel
Em42
E
Note: Bold type at base of text boxes indicates reference number for source document
DRAFT
IN PROGRESS NOT FOR RELEASE




F
24 December 2004
DR KEATING OFFER TO EXTEND PATEL CONTRACT FROM 1/4/05 to 31/3/09 as temporary full-time Director of Surgery
Patel P-file
1 January 2005
L Mulligan email to P Leck re three OT nursing staff raising concerns re Patel.
Em 45
4 January 2005
Staff letter from Michelle Hunter to L Mulligan re Mobbs UR 038213 requesting investigation of treatment
SL2
w/c 4 January 2005
Peter Leck returns from leave and contacts Dr John Scott by phone and follows up with email to discuss situation.
P. Leck interview
####email
w/c 11 January 2005
Dr John Scott sends email reply suggesting that CHO would be back from leave in one week.
P. Leck interview
####email
27 to 31 December 2004
Patel on leave
14 January 2005
Complaint from nurse Gaddes about Patel dangerous practice re Kemps UR 007900.
Oesophagectomy #4 died 21/12/04
SL 3, SL 4 (Zwolak)
14 January 2005
Patel letter to Dr Keating advising that did not agree to the job offer/ contract of extension.
On 18/1/05 D Keating accepts resignation
P-file PF6
17 January 2005
Peter Leck speaks to CHO by phone re investigation
P. Leck interview
######check
19 January 2005
MEMO FROM P LECK TO CHO RE: PATEL ALLEGATIONS AN D REQUEST FOR INVESTIGATION FOLLOWING PHONE DISCUSSION 17/1/05
M1
2 February 2005
REFERENCE FOR PATEL FROM DR KEATING TO MEDICAL BOARD "PERFORMANCE BETTER THAN EXPECTED"
Patel P-File
2 February 2005
DR KEATING OFFER TO EXTEND PATEL CONTRACT FROM 1/4/05 to 31/7/05 AT CONTRACT RATE OF $1150 per day. 7/2/05 – PATEL ACCEPTED
Patel P-file
G
Note: Bold type at base of text boxes indicates reference number for source document
DRAFT
PROGRESS
NOT FOR


G
12 February 2005
Document from Operating Theatre staff re Dr Patel in preparation for CHO Review.
SL12
14 February 2005
Dr Fitzgerald commences on-site review at Bundaberg Base Hospital
17 March 2005
Patient complaint Halter UR post-op infection
C2
22 March 2005
MS HOFFMAN LETTER TABLED IN PARLIAMENT BY STUART COPELAND MLA (SHADOW HEALTH SPOKESPERSON)
24 March 2005
CHO Bundaberg Review Report released to Director General. Press Conference
17 February to 2 March 2005
Patel on leave
1 April 2005
P Leck signs off on airfare claim for Patel to return to USA , flying 2 April 2005.
Patel P-file PF6
2 April 2005
PATEL LEAVES BUNDABERG AND RETURNS TO USA
Patel P-file PF6
5 April 2005
Letter from Dr Keating to Australian Dept Immigration withdrawing sponsorship of Patel.
PF6
6 April 2005
Memo from Dr Keating to all medical staff re Patels resignation, the lack of natural justice afforded him and the 'scurrilous leak of the letter'.
PF6
14 April 2005
Memo from Dr Keating apologising to all staff at Bundaberg Base Hospital regarding Dr Patel
PF6
END
Note: Bold type at base of text boxes indicates reference number for source document
DRAFT RE
PROGRESS NO
RELEASE

APPENDIX B INTERVIEW SCHEDULE

Name	Date	Time	Interviewers
Mr Leck	18/04/2005		MM, JW, LH
Kees Nydam	19/04/2005	1500-1530	MM, PW
District Health Council	19/04/2005	1600-1700	All
Ms Hoffman & QNU Rep	20/04/2005	1015-1200	All
Bundaberg Hospital All Staff Forum	20/04/2005	1200-1300	All
Allied Health Heads of Department	20/04/2005	1300-1400	LH
QLD Police Services- Graham Walker, David Nicoll, Terry Borland	20/04/2005	1315-1345	MM
ICU Staff	20/04/2005	1400-1500	LH, JW
Theatre Nursing Staff	20/04/2005	1500-1600	LH, PW, JW
Director of Anaesthetics, Martin Carter	20/04/2005	1600-1700	MM, PW, JW
Senior Medical Staff	20/04/2005	1700-1800	MM, PW, JW
Brian Johnston ACHS Phone Call	20/04/2005		LH
SMOs- Malcolm Stumer, Naldo Kiel & Scott Jenkins	21/04/2005	0800-0900	MM, PW
Darren Keating DMS	21/04/2005	0900-1030	All
Directors of Nursing, A/DDON & ADON	21/04/2005	1030-1130	LH, MM
Di Jenkins, NUM Surgical Ward	21/04/2005	1030-1130	PW, JW
Mr Miach, Director of Medicine	21/04/2005	1330-1430	PW, MM, JW
Other Nurse Managers	21/04/2005	1430-1530	LH, MM
Damien Gaddes, Theatre RN	21/04/2005	1530-1600	LH, JW
Dr Ben Davidson, PHO	21/04/2005	1500-1600	PW, MM JW PW
Dr Dieter Beirens	21/04/2005	1600-1700	
Jenny White, ex-NUM Theatre	21/04/2005	1630-1730	LH, MM
Phone Call to Gerry Costello Medical Director RPDS	21/04/2005	1230	LH
Phone Call to Steve Rashford Clinical Coordinator	21/04/2005		LP
Email from Steve Rashford re phone call	21/04/2005		
Denise Powell Local Medical Association	22/04/2005	0830-0930	JW, MM
Gail Aylmer Infection Control CN, Lindsey Druce Renal, V Smythe QNU	22/04/2005	0930-1030	PW, LH
Lyn McKean, Administration Officer	22/04/2005	0930-1030	MM
Sue Hutchins, Administration Officer, Specialists Secretary/Med Ed	22/04/2005	1030-1000	JW
Mr Connelly (patient & husband of deceased patient, Non-Patel)	22/04/2005	1100-1200	MM, LH
Judy O'Connor, Medical Education	22/04/2005	1100-1200	PW
David Nicoll & others QLD Police Service	22/04/2005	1230-1345	MM, PW
Karen Smith, Elective Surg Coordinator & Gail Doherty A/NUM Theatre	22/04/2005	1400-1500	MM, LH
Phone Call to Dr Michael Whitby Re Bundaberg CHRISP data	22/04/2005	1200	MM
Email via Kim Howe from Michael Whitby in relation to phone call	22/04/2005	1500	
Dr Heike Kath- previous JHO BBH	29/04/2005	1045-1145	JW
Dr Ayesha Curtis-previous JHO BBH	3/05/2005	1300-1400	LH, JW
LALU	3/05/2005	1600	All
Mr Leck Phone Call	3/05/2005	1800	MM
Dr Andrew Chang- Registrar - previously at BBH	5/05/2005	0800-0900	LH, JW

Name	Date	Time	Interviewers
Dr David Risson Phone Interview from Dalby	6/05/2005	1230-1330	PW, JW
Jenny Kirby & Leonie Raven DSU & DQDSU	9/05/2005	1030-1130	JW, LH
Coroner's Office Michael Barnes	9/05/2005		MM
Ann Robinson, NUM Family Services	9/05/2005	1200-1300	MM, LH
Dr Stumer		1330-1500	
Dr Wimal Wijeratne	9/05/2005	1530-1700	MM, LH
After Hours NUMs & QNU	10/05/2005	0800-0900	LH, MM
Linda Parsons -Patient with infection & dehiscence problems		1030-1130	
Dr Colin Lye, PHO	10/05/2005	1330-1430	MM, LH
Judith McDonnell, Director of Mental Health	10/05/2005	1430-1530	MM, JW
Mr & Mrs Stuart-Sutherland (Mrs Stuart-Sutherland inpatient)		1600-1700	
Margie Mears, Pre-Admission Clinic Coordinator	11/05/2005	0830-0900	LH, MM
Carol McMullen, NUM Nursing Informatics	11/05/2005	0915-1015	MM, LH
Jane Truscott, Cancer Care Project Officer		1100-1200	MM, JW
Sue Hutchins, AO Med Specialists Secretary/Med Ed	11/05/2005	1400-1500	JW
Darren Keating, DMS	11/05/2005	1500-1530	MM, JW
Judy Rayner- daughter of deceased patient Greg Cupitt	11/05/2005	1600-1700	JW, MM
Paddy Martin ex A/DDON Project Manager Comm Health	12/05/2005	0900-1000	MM, LH
Beryl Crosby & Ian Fleming (BBH Support Group)	12/05/2005	1030-1130	MM, JW, LH
Cathy Fritz, HRM Manager	12/05/2005	1430-1530	JW, MM
Dr Jim Gaffield Phone Interview to Sydney with Solicitor Edward Sooner	13/05/2005	0830-0930	JW, MM
Commission of Inquiry Solicitor Damian Atkinson & Angus Scott	13/05/2005	0930-1030	JW, MM, LH
Rita Haines Radiology	13/05/2005	1030-1130	MM
Judy O'Connor	13/05/2005	1130-1200	JW
Mr Leck District Manager BHHSD & solicitor	16/05/2005	1300-1500	JW, MM, LH, PW
Dr Michael Beckmann, O&G Registrar	16/05/2005	1600-1700	MM, LH
Mrs Mulligan, DDON BBHSHSD	17/05/2005	1300-1500	JW,MM,LH, PW
Beryl Callanan ex A/DDON BHHSD	18/05/2005	0900-1000	LH, MM
Glennis Goodman, ex DDON BHHSD Phone Interview	20/05/2002	0900-1000	LH, MM

APPENDIX C

Deceased Patients - not in Bundaberg Hospital/whilst under care of Dr Patel — Treated by Patel Patients ONLY

UR	Name	DOB	ADMIT	SURG	ADMIT DATE	STATUS	D/C DATE	Current	DOD	Comment
002278-2	ATKINSON, PAUL	12/10/1964	MCAR	PAT	18/09/2003	01 - HOME/USUAL RESIDENCE	23/09/2003	deceased	23/02/2004	
133321-1	BATES, WILLIAM	09/09/1919	PAT		2/07/2003	01 - HOME/USUAL RESIDENCE	8/07/2003	Deceased	29/08/2003	
068788-1	BENT, TERRY	09/04/1984	PAT	PAT	19/04/2003	01 - HOME/USUAL RESIDENCE	20/04/2003	deceased	30/05/2003	
079609-3	BOWLER, WINIFRED	24/04/1919	PAT	PAT	29/12/2003	01 - HOME/USUAL RESIDENCE	29/12/2003	Deceased	15/03/2004	
129531-1	BODLOVIC, RODNEY	27/07/1965	PAT	PAT	27/11/2003	01 - HOME/USUAL RESIDENCE	27/11/2003	deceased	15/08/2004	
132961-1	BRYEN, DOROTHY	22/02/1927	PAT	PAT	8/06/2003	01 - HOME/USUAL RESIDENCE	15/06/2003	deceased		
018605-714	CARTER, MATTHEW	08/10/1932	MIA	PAT	18/06/2003	01 - HOME/USUAL RESIDENCE	26/08/2003	Deceased	27/09/2003	
136704-5	CAYLEY, MITCHELL	28/06/2003	RYA	PAT	6/10/2004	01 - HOME/USUAL RESIDENCE	9/10/2004	deceased	6/11/2004	
017489-16	CORBETT, VICTOR	08/06/1925	PAT	PAT	14/01/2004	01 - HOME/USUAL RESIDENCE	19/01/2004	deceased	8/10/2004	
119561	DAVIES, NOELA	02/12/1944	PAT	PAT	07/10/2003	01 - HOME/USUAL RESIDENCE	07/10/2003	deceased		CR11 Complaint
006710-4	DEWIT, SUSAN	27/02/1956	PAT		4/03/2004	01 - HOME/USUAL RESIDENCE	4/03/2004	Deceased	31/03/2004	
057579-2	EGGMOLESSE, ARNOLD	25/09/1934	STR		14/11/2003	01 - HOME/USUAL RESIDENCE	15/12/2003	Deceased	23/04/2004	
035298-1	ELLACOTT, VALERIE	20/11/1931	KNAPP		15/06/2003	01 - HOME/USUAL RESIDENCE	20/06/2003	Deceased	13/09/2003	
135089-4	FENTON, EDWARD	14/04/1947	PAT	PAT	24/04/2004	01 - HOME/USUAL RESIDENCE	30/04/2004	deceased	9/06/2004	
138941-2	FOURRO, PETER	05/07/1959	PAT	PAT	8/09/2004	01 - HOME/USUAL RESIDENCE	11/09/2004	deceased	11/01/2005	
099036-8	GERRARD, GLORIA	20/04/1927	PAT	PAT	03/04/2003	02-OTHER HOSPITAL	3/04/2003	deceased	1/05/2003	
085460-2	GOOCH, MILTON	18/10/1947	MIA	PAT	17/11/2003	01 - HOME/USUAL RESIDENCE	21/11/2003	Deceased	6/12/2003	
138492-2	GRAMBOWER, JANICE	11/12/1947	PAT	PAT	30/07/2004	16 - TRANSFER TO ANOTHER HOSP	18/08/2004	Deceased	25/08/2004	BIGGENDEN HOSPITAL C7
130224-3	GRAVE, JAMES	22/12/1939	PAT		7/08/2003	01 - HOME/USUAL RESIDENCE	18/08/2003	Deceased	8/01/2004	R1-dehiscence,Em5,R6
039681-4	GREEN, LEONARD	28/08/1936	PAT	PAT	26/05/2003	01 - HOME/USUAL RESIDENCE	27/05/2003	Deceased	1/07/2003	
089388-3	HALLORAN, GORDON	19/03/1941	PAT		9/03/2004	01 - HOME/USUAL RESIDENCE	9/03/2004	Deceased	28/03/2004	
N033119	HAWKINS, MAVIS	17/10/1930		PAT	13/12/2004	01 - HOME/USUAL RESIDENCE	16/12/2004	Deceased	21/02/2005	
039181-3	HILLYARD, EDWARD	13/08/1927	MIA	PAT	12/12/2003	01 - HOME/USUAL RESIDENCE	12/12/2003	deceased	25/01/2004	R3, R7-Peritoneal catheter
060446-14	HUTTON, KENNETH	04/11/1945	STR	PAT	23/03/2004	EPISODE OF CARE CHANGE	24/03/2004	deceased	1/05/2004	
089103-16	JACKSON, HERBERT	03/07/1927	PAT	PAT	20/05/2003	01 - HOME/USUAL RESIDENCE	23/05/2003	deceased	4/06/2003	

UR	Name	DOB	ADMIT	SURG	ADMIT DATE	STATUS	D/C DATE	Current	DOD	Comment
035690-13	KEEN, GLORIA	17/11/1956	PAT	PAT	23/05/2003	01 - HOME/USUAL RESIDENCE	23/05/2003	Deceased	24/10/2003	
083173-18	KELLY, ELSIE	25/04/1924	PAT		17/02/2004	01 - HOME/USUAL RESIDENCE	19/02/2004	Deceased	22/11/2004	
053965-1	KERR, KATHLEEN	30/11/1930	PAT	PAT	30/10/2004	16 - TRANSFER TO ANOTHER HOSP	1/11/2004	Deceased	22/12/2004	WESLEY HOSP-A'FLOWR
093215-2	KERR, RENAI	08/02/1978	WIJE	PAT	30/06/2003	01 - HOME/USUAL RESIDENCE	6/07/2003	Deceased	10/04/2004	
103368-10	KRAUSE, GAIMAREE	07/02/1962	PAT	PAT	22/11/2004	01 - HOME/USUAL RESIDENCE	22/11/2004	Deceased	21/02/2005	
025795-4	LANDSBERG, JUDITH	04/07/1942	PAT		10/08/2004	01 - HOME/USUAL RESIDENCE	22/08/2004	Deceased	14/09/2004	
047508-6	LAWSON, VICTOR	25/12/1926	PAT	PAT	9/12/2004	06 - EPISODE CHANGE	16/12/2004	Deceased		
002558-5	LOVI, BERYL	10/10/1927	MCAR	PAT	8/07/2003	16 - TRANSFER TO ANOTHER HOSP	8/07/2003	Deceased	6/08/2003	ST ANDREWS WAR MEM
139925-3	MAISEY, SHIRLEY	13/09/1938	PAT		3/11/2004	01 - HOME/USUAL RESIDENCE	8/11/2004	Deceased	18/12/2004	
033696-3	MANDERSON, JOYCE	18/08/1933	MCAR	PAT	25/04/2004	16 - TRANSFER TO ANOTHER HOSP	10/05/2004	Deceased	30/05/2004	REDCLIFFE HOSPITAL
085721-6	MCMANUS, CEDRIC	09/12/1921	PAT		9/10/2003	01 - HOME/USUAL RESIDENCE	29/10/2003	Deceased	17/01/2004	
029817-2	MOFFAT, JOHN	12/03/1905	PAT	PAT	22/12/2004	01 - HOME/USUAL RESIDENCE	18/01/2005	Deceased	1/02/2005	
013431-5	O'DEA, JOHN	15/07/1953	PAT	PAT	23/06/2003	01 - HOME/USUAL RESIDENCE	23/06/2003	Deceased	14/02/2004	
067734-9	PANCHERI, MURIEL	13/08/1923	PAT	PAT	16/04/2003	01 - HOME/USUAL RESIDENCE	16/04/2003	Deceased	8/08/2003	
026824-3	PETERS, MARINUS	04/07/1950	PAT		8/03/2004	01 - HOME/USUAL RESIDENCE	22/03/2004	Deceased	10/06/2004	
057570-4	PETTITT, JUDITH	01/02/1942	PAT	PAT	21/04/2004	01 - HOME/USUAL RESIDENCE	25/04/2004	Deceased	28/11/2004	
N040278	RASMUSSEN, KENNETH	14/07/1940	PAT		11/12/2003	01 - HOME/USUAL RESIDENCE	12/12/2003	Deceased		CR5 nil issues id.
041571-2	ROLL, JEAN	03/02/1926	PAT	PAT	10/09/2003	01 - HOME/USUAL RESIDENCE	17/09/2003	Deceased	6/12/2003	
104490	RYAN, THOMAS	13/12/1941	PAT	KARS	04/11/2004	01 - HOME/USUAL RESIDENCE	10/11/2004	Deceased	13/01/2005	
135261-1	SCOPE, KATHLEEN	29/11/1921	SMZ	PAT/AND	2/12/2003	01 - HOME/USUAL RESIDENCE	2/01/2004	deceased	26/01/2004	
126538-5	SIMPKINS, LAUREN	25/02/1993	PAT	PAT	8/02/2004	01 - HOME/USUAL RESIDENCE	13/02/2004	Deceased	7/01/2005	
002736-7	SINGHO, KEVIN	07/04/1934	PAT	PAT	11/12/2003	01 - HOME/USUAL RESIDENCE	11/12/2003	deceased	31/08/2004	
019627-3	SONDERGELD, ERNEST	27/05/1914	PAT	PAT	17/01/2004	01 - HOME/USUAL RESIDENCE	20/01/2004	deceased	27/02/2004	
055819-7	STANTON, JOSEPH	25/07/1936	PAT	PAT	4/06/2003	01 - HOME/USUAL RESIDENCE	4/06/2003	Deceased	18/01/2004	
138813-1	THIELE, COLIN	30/06/1941	PAT	PAT	24/08/2004	01 - HOME/USUAL RESIDENCE	3/09/2004	Deceased	20/12/2004	
095018-5	WELLER, RONALD	27/12/1925	PAT	PAT	8/07/2003	01 - HOME/USUAL RESIDENCE	22/07/2003	deceased	25/01/2004	

UR	Name	DOB	ADMIT	SURG	ADMIT DATE	STATUS	D/C DATE	Current	DOD	Comment
055189-6	WHEELER, NOEL	23/04/1926	PAT	PAT	28/08/2004	01 - HOME/USUAL RESIDENCE	24/09/2004	deceased	21/10/2004	
120588-3	WHITNEY, BERYL	24/09/1920	PAT	PAT	20/09/2003	16 - TRANSFER TO ANOTHER HOSP	25/09/2003	deceased	18/11/2003	
027515-1	WILLIAMS, GRACE	15/03/1927	PAT	PAT	8/12/2003	01 - HOME/USUAL RESIDENCE	12/12/2003	Deceased	4/08/2004	
045187-9	WOMERSLEY, JOAN	09/10/1931	PAT	PAT	9/05/2003	01 - HOME/USUAL RESIDENCE	9/06/2003	Deceased	25/06/2004	

55 patients

Deceased Patients in Bundaberg Hospital

PATEL ONLY PATIENTS

UR	NAME	DOB	ADMIT	SURG	ADMIT DATE	STATUS	DC DATE	COMMENT
005751-3	AINSLIE, FRANCES	19/09/1936	MCAR	PAT	1/05/2003	05 - DIED IN HOSPITAL		
005153-41	COLEMAN, MARGARET	15/08/1942	PAT		19/04/2003	05 - DIED IN HOSPITAL	25/04/2003	
133218-1	CHRISTENSEN, WALTER	06/08/1924	PAT	PAT	27/06/2003	05 - DIED IN HOSPITAL	27/06/2003	
045211-1	DORRON, NOEL	15/11/1942	GAF	PAT	13/09/2004	05 - DIED IN HOSPITAL	14/09/2004	
104562-2	FINCH, RAYMOND	09/07/1925	PAT	KIN	19/08/2003	05 - DIED IN HOSPITAL	19/08/2003	
006765-13	FORD, LEANNE	09/03/1965	MIA	PAT	20/09/2003	05 - DIED IN HOSPITAL	21/09/2003	
057809-7	GAUTRAY, ANTOINE	07/07/1928	PAT	PAT	8/09/2004	05 - DIED IN HOSPITAL	22/09/2004	CR10 MM SL1
134333-2	JOHNSON, BARRY	08/09/1946	PAT	PAT	22/09/2003	05 - DIED IN HOSPITAL	1/10/2003	
080457-8	JONES, ANITA	20/12/1949	PAT	PAT	30/06/2003	05 - DIED IN HOSPITAL	2/07/2003	
007900-6	KEMPS, GERARD	14/08/1927	PAT	PAT	19/12/2004	05 - DIED IN HOSPITAL	21/12/2004	Em51, C9, SL2,3,4
063164-6	KIEHNE, BERNARD	18/06/1919	PAT	PAT	31/07/2004	05 - DIED IN HOSPITAL	17/08/2004	SL1-TH
031725-1	LAACK, FRANCES	06/04/1920	MCAR	PAT	21/04/2003	05 - DIED IN HOSPITAL	22/04/2003	
002443-8	MCDONALD, THELMA	11/09/1931	MCAR	PAT	29/09/2003	05 - DIED IN HOSPITAL	7/10/2003	
111085-1	MELLOR, HECTOR	14/08/1909	PAT	PAT	23/03/2004	05-DIED IN HOSPITAL	23/03/2004	
106639-16	MORONEY, ALICE	14/03/1925	MIA	PAT	11/09/2003	05 - DIED IN HOSPITAL	16/09/2003	
071453-6	MORRIS, MERVYN	30/10/1927	MCAR	PAT	20/05/2003	05 - DIED IN HOSPITAL	14/06/2003	R1- deh, IR10, Em5, R6

UR	NAME	DOB	ADMIT	SURG	ADMIT DATE	STATUS	DC DATE	COMMENT
130567-12	NAGLE, ERIC	22/11/1938	MIA	PAT	16/12/2003	05 - DIED IN HOSPITAL	17/12/2003	R3-Peri Catheter, R7
124218-3	PARK, GRAHAM	15/02/1932	GAF	PAT	25/10/2004	05 - DIED IN HOSPITAL	7/11/2004	
023142-5	PATTERSON, JAMES	02/01/1922	PAT	PAT	17/07/2004	05 - DIED IN HOSPITAL	25/07/2004	
034546-536	PHILLIPS, JAMES	27/03/1957	MCAR	PAT	19/05/2003	05 - DIED IN HOSPITAL	21/05/2003	SL14
134655-4	PORTER, ISOBELL	28/08/1938	KNAPP		4/02/2004	05 - DIED IN HOSPITAL	11/02/2004	
117965-9	POWELL, WILMA	17/12/1931	SML	PAT	9/02/2004	05 - DIED IN HOSPITAL	4/03/2004	
009677-8	SLATER, MONA	19/05/1915	PAT	PAT	12/12/2003	05 - DIED IN HOSPITAL	24/12/2003	CR13 LH, C11, CR17
000144-1061	SPANN, MERVYN	28/07/1935	MIA	MIA	29/03/2003	05-DIED IN HOSPITAL	04/04/2003	
122651-2	THORNE, LESLIE	23/04/1934	GAF	PAT	8/07/2004	05 - DIED IN HOSPITAL	13/07/2004	C12
132412-2	TUCKER, LAWRENCE	26/07/1932	CON	PAT	27/08/2004	05 - DIED IN HOSPITAL	12/10/2004	Em51, SL7
043441-5	TURTON, ROBYN	13/08/1941	PAT		18/12/2004	05 - DIED IN HOSPITAL	20/12/2004	
001697-15	WALES, IRENE	18/08/1930	MCAR	PAT	25/11/2003	05 - DIED IN HOSPITAL	28/11/2003	
135796-1	WALK, KEITH	19/11/1930	PAT	PAT	29/12/2003	05 - DIED IN HOSPITAL	30/12/2003	CR12 JW, LH Coroner
143944-1	WALKER, NEVILLE	17/04/1939	PAT	PAT	4/02/2005	05 - DIED IN HOSPITAL	4/02/2005	
124584-3	WHITCOMBE, DAVID	12/01/1927	PAT		7/10/2003	05 - DIED IN HOSPITAL	22/10/2003	
097482-2	WILLETTS, HENRY	03/06/1920	GAF	PAT	9/10/2004	05 - DIED IN HOSPITAL	28/10/2004	

32 Patients

PATIENTS OF DR PATEL
TRANSFERRED

URN	Name	DOB	Dr Discharge	Surgeon	Admit Date	Discharge Disposition	Discharge Date	Transfer Hospital	COMME
117791-1	ANDERSON, HELEN	02/02/1970	PAT		16/11/2004	16 - TRANSFER TO ANOTHER HOSP	18/11/2004	Royal Brisbane & Womens	
130228-13	BARNARD, ELSIE	26/10/1918	PAT	PAT	27/01/2004	16 - TRANSFER TO ANOTHER HOSP	22/02/2004	Monto	
001069-2	BARON, REON	12/12/1964	PAT		26/09/2004	16 - TRANSFER TO ANOTHER HOSP	26/09/2004	PRINCESS ALEXANDRA	
102414-6	BIGGS, VALMAE	31/08/1944	PAT	PAT	21/12/2004	16 - TRANSFER TO ANOTHER HOSP	24/12/2004	Biggenden	
001430-4	BREED, JOHN	17/06/1941	MCAR	PAT	6/07/2003	16 - TRANSFER TO ANOTHER HOSP	13/07/2003	Royal Brisbane & Womens	SL1-TH
137325-1	BRODIE, DANIEL	06/12/1972	PAT	PAT	24/04/2004	16 - TRANSFER TO ANOTHER HOSP	24/12/2004	Royal Bris	
008792-681	BROOME, PRISCILLA	09/04/1945	COCH	MCAR/GAF/PAT	17/02/2004	16 - TRANSFER TO ANOTHER HOSP	22/02/2004	Royal Bris	
N032332	CHADWICK, IRENE	11/04/1913	PAT		2/08/2004	16 - TRANSFER TO ANOTHER HOSP	3/08/2004	Royal Brisbane & Womens	
139750-1	COFFMAN, CLARK	23/07/1965	PAT		25/09/2004	16 - TRANSFER TO ANOTHER HOSP	25/09/2004	Royal Brisbane & Womens	
026387-5	COOPER, CAROL	05/06/1948	MIA	PAT	2/12/2003	16 - TRANSFER TO ANOTHER HOSP	17/12/2003	Royal Brisbane & Womens	
132929-1	CRAIG, HAZEL	04/07/1920	PAT	THI	8/07/2003	16 - TRANSFER TO ANOTHER HOSP	10/07/2003	GLADSTONE HOSPITAL	
045282-11	CULLEN, RONALD	07/01/1949	PAT		7/10/2003	16 - TRANSFER TO ANOTHER HOSP	10/10/2003	GAYNDAH HOSPITAL	
142693-1	DAVIS, PAT	09/04/1943	PAT	ROB	16/11/2004	16 - TRANSFER TO ANOTHER HOSP	17/11/2004	NAMBOUR HOSPITAL	
138339-1	DEAN, NASEEF	11/04/1986	PAT		9/07/2004	16 - TRANSFER TO ANOTHER HOSP	10/07/2004	Royal Brisbane & Womens	
135181-1	DELANEY, SYLVIA	29/04/1959	MIA	PAT	27/10/2003	16 - TRANSFER TO ANOTHER HOSP	2/12/2003	Royal Brisbane & Womens	
041083-1	DRIVER, MERVYN	07/12/1952	PAT		19/09/2003	16 - TRANSFER TO ANOTHER HOSP	23/09/2003	Royal Brisbane & Womens	
142699-1	FIELDING, CAROL	30/05/1944	CHAU		16/11/2004	16 - TRANSFER TO ANOTHER HOSP	17/11/2004	MARYBOROUGH HOSPITAL	
001597-4	FORMAN, HAROLD	05/03/1913	STR	PAT	28/11/2004	16 - TRANSFER TO ANOTHER HOSP	17/12/2004	GIN GIN HOSPITAL	
127514-1	FRAY, RICHARD	17/08/1940	PAT		20/04/2004	16 - TRANSFER TO ANOTHER HOSP	21/04/2004	Royal Brisbane & Womens	
143088-3	FREESTONE, SHARON	01/01/1961	PAT	PAT	13/12/2004	16 - TRANSFER TO ANOTHER HOSP	17/12/2004	CHILDERS HOSPITAL	
130408	GALLAGHER, GLADYS	22/09/1923	PAT	PAT	22/09/2004	16 - TRANSFER TO ANOTHER HOSP	24/09/2004	Royal Bris	
138492-2	GRAMBOWER, JANICE	01/12/1947	PAT	PAT	30/07/2004	16 - TRANSFER TO ANOTHER HOSP	18/08/2004	BIGGENDEN HOSPITAL	
004278-4	GRANGIOTTI, FERDINANDO	26/07/1908	PAT		16/01/2004	16 - TRANSFER TO ANOTHER HOSP	20/01/2004	FRIENDLY SOCIETY PVT	
139353-1	GREALISH, MOLLY	16/10/1938	PAT	PAT	1/10/2004	16 - TRANSFER TO ANOTHER HOSP	13/10/2004	BIGGENDEN HOSPITAL	

URN	Name	DOB	Dr Discharge	Surgeon	Admit Date	Discharge Disposition	Discharge Date	Transfer Hospital	COMME
104754-6	HALLEN, DESMOND	12/11/1936	PAT		27/07/2004	16 - TRANSFER TO ANOTHER HOSP	29/07/2004	GIN GIN HOSPITAL	
035261-2	HALTER, TREVOR	05/11/1947	PAT	PAT	19/11/2004	16 - TRANSFER TO ANOTHER HOSP	4/12/2004	Royal Brisbane & Womens	Em51 C staple
126237-3	HARVEY, GILBERT	20/09/1931	DELA	PAT	14/03/2005	16 - TRANSFER TO ANOTHER HOSP	16/03/2005	FRIENDLY SOCIETY PVT	
129039-1	HOWARD, NELSON	03/06/1930	PAT	PAT	28/08/2003	16 - TRANSFER TO ANOTHER HOSP	29/08/2003	Royal Brisbane & Womens	
128067-2	HUTCHEON, MAUREEN	22/06/1945	SML	PAT	9/02/2004	16 - TRANSFER TO ANOTHER HOSP	12/02/2004	GREENSLOPES PRIVATE	
002197-11	JOYCE, DARCY	12/05/1942	PAT	PAT	22/03/2005	16 - TRANSFER TO ANOTHER HOSP	25/03/2005	Hervey Bay	
142155-1	JUNG, BARRY	20/08/1940	PAT	PAT	24/09/2004	16 - TRANSFER TO ANOTHER HOSP	25/09/2004	Mater - Bundaberg	
053965-1	KERR, KATHLEEN	30/11/1930	PAT	PAT	30/10/2004	16 - TRANSFER TO ANOTHER HOSP	1/11/2004	WESLEY HOSP-A'FLOWER	
143698-3	KIRKLAND, GLEN	25/08/1983	PAT	PAT	6/02/2005	16 - TRANSFER TO ANOTHER HOSP	7/02/2005	Holy Spirit	Em24
002558-5	LOVI, BERYL	10/10/1927	MCAR	PAT	8/07/2003	16 - TRANSFER TO ANOTHER HOSP	8/07/2003	ST ANDREWS WAR MEMO	
115831-2	LUDCKE, SKYE	22/01/2001	PAT	PAT	10/11/2004	16 - TRANSFER TO ANOTHER HOSP	12/11/2004	Royal Childrens	
033696-3	MANDERSON, JOYCE	18/08/1933	MCAR	PAT	25/04/2004	16 - TRANSFER TO ANOTHER HOSP	10/05/2004	REDCLIFFE HOSPITAL	
010299-1	MARSDEN, HEATHER	20/05/1935	JEN	PAT	10/11/2003	16 - TRANSFER TO ANOTHER HOSP	8/12/2003	MATER ADULT PRIVATE	
144201-1	MCPHERSON, RUSSELL	18/10/1943	PAT		15/02/2005	16 - TRANSFER TO ANOTHER HOSP	17/02/2005	Royal Brisbane & Womens	
098782-6	MEIERS, LAURENCE	05/12/1933	PAT		17/09/2004	16 - TRANSFER TO ANOTHER HOSP	23/09/2004	GAYNDAH HOSPITAL	
129324-1	MINNS, PHILLIP	26/01/1923	PAT	PAT	12/08/2003	16 - TRANSFER TO ANOTHER HOSP	14/08/2003	ST ANDREWS WAR MEMO	R5-Gas biliary tre
038213-1	MOBBS, SHANNON	16/07/1989		PAT	23/12/2004	16 - TRANSFER TO ANOTHER HOSP	1/01/2005	Royal Brisbane & Womens	Em24, R SL2, Em
122960-2	MORSE, SIMONE	20/12/1966	PAT	PAT	3/03/2005	16 - TRANSFER TO ANOTHER HOSP	7/03/2005	Royal Bris	
053832-11	MURRAY, LIAM	05/05/1938	PAT	PAT	17/08/2004	16 - TRANSFER TO ANOTHER HOSP	18/08/2004	Royal Bris	
059257-2	PARSONS, JOHN	10/10/1937	PAT	PAT	2/03/2004	16 - TRANSFER TO ANOTHER HOSP	3/03/2004	Royal Bris	
083866-2	PEARSON, JOHN	07/10/1937	MCAR	PAT	7/02/2004	16 - TRANSFER TO ANOTHER HOSP	11/02/2004	Royal Brisbane & Womens	SL1-TH
139301-1	PEDERSON, RENE	13/11/1951	PAT	PAT	4/03/2005	16 - TRANSFER TO ANOTHER HOSP	4/03/2005	PAH	
110212-3	POUND, GWLADYS	21/09/1944	PAT	PAT	29/09/2003	16 - TRANSFER TO ANOTHER HOSP	30/09/2003	CHILDERS HOSPITAL	
041253-1	REIN, BARRY	27/10/1951	PAT	PAT	23/11/2004	16 - TRANSFER TO ANOTHER HOSP	25/11/2004	Royal Brisbane & Womens	
061490-2	REYNOLDS, PETER	11/05/1939	PAT		14/11/2003	16 - TRANSFER TO ANOTHER HOSP	15/11/2003	MATER ADULT PUBLIC	
111765-2	ROACH, HAROLD	12/04/1931	PAT	PAT	18/01/2005	16 - TRANSFER TO ANOTHER HOSP	14/02/2005	MATER ADULT PUBLIC	Em51
143888-1	ROBINSON, JAMES	19/02/1924	PAT	PAT	3/02/2005	16 - TRANSFER TO ANOTHER HOSP	5/02/2005	Royal Brisbane & Womens	

URN	Name	DOB	Dr Discharge	Surgeon	Admit Date	Discharge Disposition	Discharge Date	Transfer Hospital	COMME
775999-2	ROHDMANN, DOMINIC	24/10/2003	PAT	PAT	11/11/2003	16 - TRANSFER TO ANOTHER HOSP	13/11/2005	Royal Childrens	
120676-1	SMYTH, PATRICK	18/12/1950	PAT	PAT	23/09/2003	16 - TRANSFER TO ANOTHER HOSP	24/09/2003	Holy Spirit Northside	
075156-4	STEPHENSON, ALLEN	17/03/1926	PAT	PAT	23/12/2004	16 - TRANSFER TO ANOTHER HOSP	24/12/2004	Royal Brisbane & Womens	
117790-1	SULLOCK, VAL	19/09/1926	PAT	CHAU	16/11/2004	16 - TRANSFER TO ANOTHER HOSP	26/11/2004	CALVARY PRIVATE HOSP	Em25
075042-2	TEBBIT, GORDON	14/09/1952	ROB	PAT	9/09/2003	16 - TRANSFER TO ANOTHER HOSP	3/10/2003	Royal Brisbane & Womens	
039868-2	THOMPSON, LESLIE	28/10/1935	PAT		11/11/2003	16 - TRANSFER TO ANOTHER HOSP	12/11/2003	FRIENDLY SOCIETY PVT	
136902-1	TREMBLE, LOTTIE	16/11/1935	CON	PAT	5/03/2004	16 - TRANSFER TO ANOTHER HOSP	9/03/2004	Royal Brisbane & Womens	
037658-5	TURCAROLO, ANITA	02/05/1948	PAT		19/02/2004	16 - TRANSFER TO ANOTHER HOSP	22/02/2004	REDCLIFFE HOSPITAL	
063751-296	WEBB, ANNETTE	10/02/1945	MIA	PAT	10/12/2003	16 - TRANSFER TO ANOTHER HOSP	12/12/2003	Royal Brisbane & Womens	PL5, FN
005020-2	WEBB, VALMA	14/09/1924	PAT	AND	1/02/2005	16 - TRANSFER TO ANOTHER HOSP	10/02/2005	FRIENDLY SOCIETY PVT	
017316-2	WEINHOLZ, KEITH	03/11/1938	PAT		16/02/2005	16 - TRANSFER TO ANOTHER HOSP	23/02/2005	BIGGENDEN HOSPITAL	
142406-1	WELLS, FAYE	03/03/1978	PAT	PAT	29/11/2004	16 - TRANSFER TO ANOTHER HOSP	3/12/2004	GIN GIN HOSPITAL	
080692-13	WHALLEY, JAMES	30/11/1932	PAT	PAT	7/11/2003	16 - TRANSFER TO ANOTHER HOSP	11/11/2003	Royal Brisbane & Womens	
120588-3	WHITNEY, BERYL	24/09/1920	PAT	PAT	20/09/2003	16 - TRANSFER TO ANOTHER HOSP	23/09/2003		
108809-2	WILLIAMS, MAUREEN	19/04/1961	CON	PAT	20/09/2004	16 - TRANSFER TO ANOTHER HOSP	27/09/2004	Royal Brisbane & Womens	

66 WITH 6 DECEASED
(ALSO ON Deceased List)

Patient of Dr Patel Discharged to another hospital

URN	Name	DOB	Dr D/C	Surg	Admit Date	Discharge Disposition	Discharge Date	Transfer Hospital	Comment
130224-2	GRAVE, JAMES	22/12/1938	PAT	PAT	5/06/2003	02 - OTHER HOSPITAL	20/06/2003	MATER ADULT PUBLIC	
013936-13	JONES, ELWYN	11/11/1938	MCAR	PAT	9/05/2003	02 - OTHER HOSPITAL	14/05/2003	ROYAL BRIS & R'MOUNT	IR15

Patient Grave on Deceased Elsewhere list

APPENDIX D OTHER PATEL	ADVERSE OUTCOMES					
Patient Name	Ur No	DOB	DOA	D/C	Referral	COMMENT
Alexander, Noel	118657	06/07/1941	03/03/2005	11/03/2005	Complaint, interview & email	JW CR3, Em24
Ball, Albert E.	N035864	12/08/1942	19/09/2003	20/09/2003	R3- peritoneal dialysis cath	
Banks, John	N012769	13/09/1924	16/01/2004	28/01/2004		dehis R1 Em5, R6
Bellamy, Terry	N060881	05/02/1973	11/10/2004	12/10/2004	R6	
Bender, Vicki	N075042	18/06/1964	30/01/2004	30/01/2004	Liaison referral	
Benn, June	128142	127142	19/06/1925	3/07/2003	CR20	dehis R1, Em5
Black, Alan	N058253	24/09/1949	22/04/2003	22/04/2003	Liaison referral	
Blight, Darcy	N047221	19/11/1927	16/05/2003	19/05/2003	Liaison referral	LH- bladder punc CR7
BRAUND, KERRY	010380-2	08/06/1949	31/07/2004	02/08/2004	C3	
Buckley, Katherine	885616	29/06/1988	21/11/2004	25/11/2004	Liaison referral	
Casey, Kathleen	142351	4/04/1920	4/11/2004	22/11/2004	Liaison referral	
Christensen, Sarah	N094715	9/10/1937	8/08/2003	11/08/2003	Liaison referral	
Connolly, Reece	090307-3	30/07/1997	07/07/2003	07/07/2003	interview/email	
Connors, Una	134442	5/09/1930	19/10/2003	8/04/2004	radiology report, Ms Hoffman referral	SL1 R6
Cox, Nelson	136688-1	4/05/1941	25/10/2004	15/11/2004	post op haematoma incident report	R6, IR3
Dalgliesh, Peter	121526-1	2/07/1944	13/08/2003	22/08/2003	WS24, PL1, C6	
Daisy, Marilyn	005225	15/04/1961	16/09/2004	06/10/2004	SL13, 18	
Deakin, Phillip	N009028	21/09/1932	11/04/2003	11/04/2003	radiology report, Patient Complaint	SL1
Dempsey, Laurence	003181-12	18/04/1948	17/11/2003		Patient Complaint C1	
Eisel, Eric	N038663	10/06/1941	23/08/2004	24/08/2004	Ms Hoffman referral	
Fleming, Ian	N016934	12/01/1955	19/05/2003	23/05/2003	C13, 21	
Garland, Leslie	N003080	30/10/1928	27/09/2004	12/10/2004	Ms Hoffman referral	

Patient Name	Ur No	DOB	DOA	D/C	Referral	COMMENT
George, Clinton	N041276	3/06/1970	10/02/2005	10/02/2005	Ms Hoffman referral	
Goyns, Tony	134120	16/11/1931	3/09/2003	21/09/2003	Ms Hoffman referral	
Green, Doris	N037412	5/10/2020	29/05/2003	3/06/2003	infected hip wound Robinson surgery	IC Report
Hale, Julie	N017611	13/03/1953	13/09/2004	13/09/2004	Liaison Referral	
Hosler, Gary	020514-12	7/10/1943	23/09/2004	22/10/2004	Allied Health Referral	Em51
Holder, George	113808	02/02/1929	14/02/2005	23/02/2005	Allied Health Referral	Em51
Jesse, Terrence	136688-1	14/10/1937	3/08/2004	17/08/2004	wound dehisence 3/7 post op ?who closed the wound	R6,IR4
Knust, Alan	N097121	26/02/1931	5/08/2004	5/08/2004	Em24	
Lambert, Eleonor	N095623	26/12/1948	2/11/2004	4/11/2004	Website WS26	behaviour, hernia, infect
Langridge, Patrick	N069123	09/10/1935	27/08/2004	03/09/2004	thoracotomy 31/8/04	wedge resection Em38
Larsen, Christian	N024451	4/10/1967	18/03/2004	18/03/2004		
Lee, Coral	128583	23/07/1931	3/02/2005	4/02/2005	referral from A/HRs Nurse/email	JW, LH CR1 Em24
Lester, Vicki	034130-5	11/11/1962	20/09/2003	22/09/2003		
Lewis, Gwyneth	N099634	18/06/1967	21/03/2005	22/03/2005	Allied Health Referral	Em
MacPhail, Vaughan	142212	21/12/1969	31/10/2004	03/11/2004	chart not copied	completed JW CR6
Manthey, Suzanne	N064794	10/11/1942	28/05/2003	30/05/2003		
Marr, Raymond	130172-9	29/11/1943	30/09/2003		R3- Peritoneal Catheter, R7	
McNamara, Sylvia J	N084445	3/03/1945	27/10/2003	10/11/2003		WS1-OTD, infection
Monaghan, Brian	139830	1/11/194	10/11/2004	22/11/2004		
Moore, Trevor	880266	21/03/1956	27/1/04	30/1/2004	SL1-TH-issue with transfer Bris Dr Carter Patient	CR27
Mowbray, Lorraine	139985	15/04/1937	7/03/2005	14/03/2005	R6	
Noppe, Phillip	084654-4	29/09/1962	12/08/2003	23/08/2003	R3- Peritoneal Catheter, R7	
Parsons, Linda	N057761	21/08/1959	15/03/2004	15/03/2004	WS17 C15	
Perry, Mark	N091206	23/04/1968	14/03/2005	19/03/2005		

Patient Name	Ur No	DOB	DOA	D/C	Referral	COMMENT
Pirovano, Felica.	N025333	18/08/1943	16/11/2004	1/12/2004		
Prince, Cikala	103006	10/03/1999	19/03/2004	19/03/2004	Gail Aylmer referral Em28	CR7 LH
Pullin, Cheryl	131374-1	19/01/1951	4/07/2003	14/07/2003	C8	
Roach, Gwynneth	N028486				CR30 breast Carcinoma	PL3,4 FN6 & C3
Robinson, Carl	N049114	07/02/1931	14/04/2003	03/05/2003	R6	
Saroglia, Carsandra	N075841	22/06/1982	10/03/2005	10/03/2005		C4
Selten, Audrey	N017794	7/02/1932	10/08/2004	6/09/2004	radiology report	SL1-Ms Hoffman
Smith, Christopher	N086643	25/09/1952	22/03/2004	22/03/2004	Liaison Referral	
Smith, Mervyn	N032407	06/08/1930	29/08/2003	20/09/2003	Hoffman COI statement	
Sonter, Raymond	N023485	10/02/1944	6/07/2004	9/07/2004		
Stanaway, Warren	133338-5	26/09/1957	4/07/2003	13/07/2003	SL11, R6	
Stuart-Sutherland, Jean	130566	13/03/1943	11/02/2005	inpatient	C14, 20 R6	Allied Health Referral
Sullivan, Amanda	N029727		? Patel Patient		Hoffman COI statement IR22	inapprop admit to paeds
Svensson, Margaret	N013712	29/03/1945	14/07/2003	16/07/2003	Liaison Referral	
Swanson, Nancy	N020609	9/07/1942	18/10/2004	1/11/2004	SL1-TH R6	
Taratoa, Christian	772896	9/06/1999	? Patel Patient		Gail Aylmer referral- re appendicectomy Em28	
Taylor, Judith	N000910	25/03/1943	8/01/2004	16/03/2004	R6-WOUND DEHISCENCE	IR12
Thompson, Neil	135321	28/01/1955	27/12/2003	27/12/2003	Incident report-pigtail catheter introducer left insitu	
Turner, Christine	013422-4	29/12/1951	22/10/2004	22/10/2004	C10	
Warren, Kevin	112736-13	25/07/1948	3/10/2003	5/10/2003	Em51-Allied Health	
Weir, Alwyn	N083830	19/09/1926	06/10/2003	07/10/2003	Hoffman COI statement	R3, R7
Williams, Scott	N096063	17/04/1968	28/01/2004	30/01/2004		

68 Patients

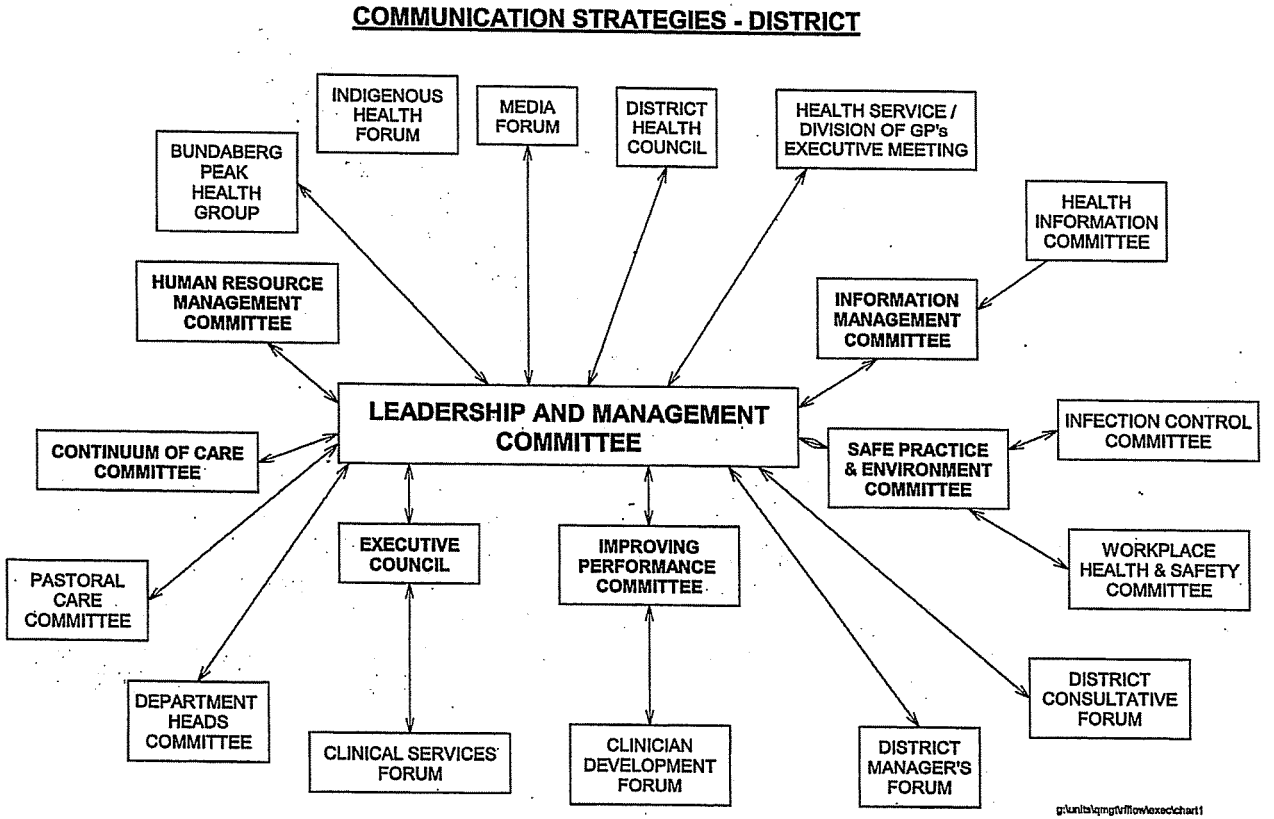
APPENDIX D ADVERSE OUTCOMES

Patient Name	Ur No	DOB	DOA	D/C	COMMENT	COMMENT
OTHER Not Patel						
Ball, Ernest	104530	1/08/1945			Not admitted, not correct patient	diabetic neuropathy CR25
Bos, Antoon	131458	4/09/1930			chart not copied	CR9MM
Brown, Siobhann Linda	880116	25/11/1971	26/04/2002	28/04/2002	website	CR33
Cameron, Leesa	139512	16/01/1963	16/01/2003	episode change	referred ICU staff	PAH BIU
Crook, Phillip E	N084640	29/10/1952	9/08/2004	10/08/2004	complaint, website & letter	Ortho WS32 Scar, soreness
Dean, Kevin	112571	19/05/1949	22/12/2003			
Duggan, Debbie	1121000	29/07/1966	28/09/2002		Legal Report	CR14 JW
Eaves, John	138803	16/12/1983				CR2 JW- no issues id.
Ebdon, Susan	N086425	4/04/1954			Allied Health Referral	Em51
Friedrich, Dakota-Lee	885453	24/04/2002	24/04/2002	28/04/2002	website child of siobhann brown	CR33
Green, Robert	N034526	31/01/1953	21/01/2004	21/01/2004	Liaison Referral	
Hannah, James	122858	19/01/1940	15/03/2002	20/03/2002	Liaison Referral DOD 15/3/2002	
Hickton, Jack	108821	2/02/1922			chart not copied	CR8 MM, C30
Hillier, Doris	N002378	27/04/1948	28/08/2004	11/09/2004	R6, IR10 necrotising fascitis	
Huihsmann, Hans	N069289	27/01/1943	1/02/2002	5/03/2002	Em54, C28	incident report-necrotizing fascitis
Jenkin, David	N017654				R6-Rectal Bleeding not reviewed for 6 days	
Johnston, Donna					WS10 follow up post surgery	
Kadletz, Julia	N072512	27/12/1960	29/10/2002	5/11/2002	Website, Letter Wij/Stumer	Post op haematoma CR24, PL7, WS35
Larsen, Nicholas	N020669	23/06/1981			??? Correct patient, never an inpatient	
Lawton, Harley Robert	144187	22/01/2005	21/01/2005	25/01/2005		CR23, WS25
Mellish, Angela	144296	15/08/1980	14/03/2005	17/03/2005		Patel/Stumer op- appendix- no histology CR29
Novacsek, Lajos	N029893	21/05/1916	21/08/2003	4/09/2003		MI/Acute abdo Gaffield op issue with xray reports CR26
Punch, Tori	775009	8/05/2002	6/08/2004			
Ward, Leigh	N036315	20/03/1958	18/11/2004	18/11/2004		Ovarian cyst spontaneously resolved CR21
Weschel, Shane	144847	18/08/1964	16/04/2005	19/04/2005	StrachanTransfer to St Andrew's ICU	Strachan-Junior doctor to care for sick patient CR28
Williamson, Neville	130894	28/04/1938	24/03/2003	9/04/2003		CR15 JW & CR22MM WS7 ?WRONG RESULTS
Wurth, Berendina C.H	137431	14/03/1942	22/04/2004	23/04/2004	Dates on pathology & op notes vary, histo track path original request done CR22	
Zunker, Gwenda	N022513	28/01/1950	13/08/2004	19/08/2004		28 Patients (2 incorrect patients)

APPENDIX D Patients non-Patel Deceased ADVERSE OUTCOMES

NAME	UR	DOB	ADMIT	DOD	COMMENT	Review Code
Mr Bramich, Desmond	N043441	15/04/1948	25/07/2004	28/07/2004	legal file SL 1,6,7,9, 10,14,25 IR2 Em22,35,39	C17, IR1
CAMERON, JOAN	N003379	27/07/1928		21/03/2005	Patel R/V	Staff Interview
Cupitt, Gregory	N079614	24/09/1927	25/07/2004	27/07/2004	medical WS 15 Em12	
Duggan, Sean	N099225	26/04/1980	9/11/2003	11/11/2003	Carter/Patel ICU no surg -chart not copied	JW-? Breach T&A Act CR4
Bradley, Maryse	N057253	1/9/1914	18/2/2003	21/3/2003	Family complaint- previously inv by police	

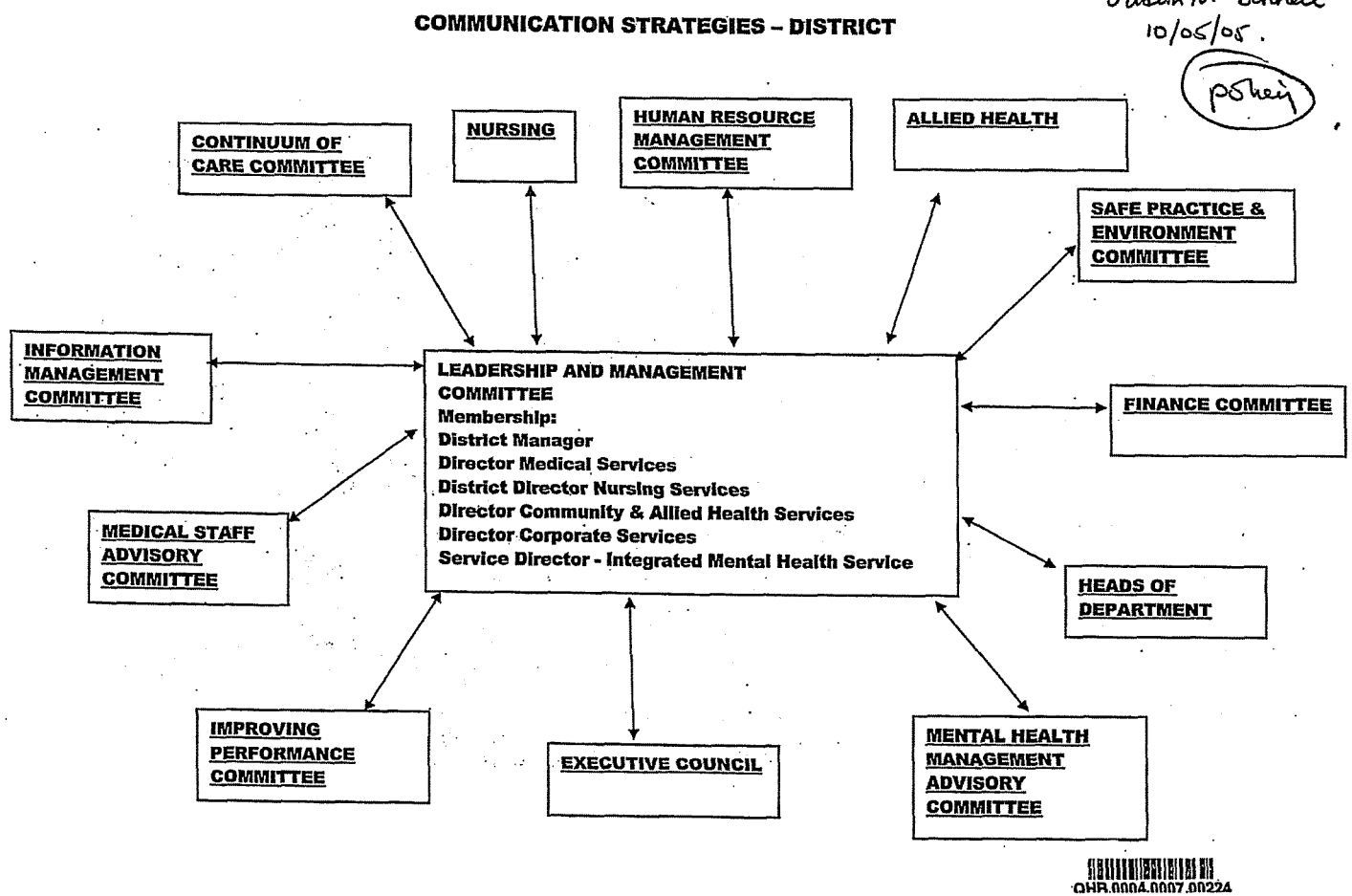
APPENDIX E



APPENDIX E

developed last 2 weeks

provided by Justin McDonnell 10/05/05.



QHR.0004.0007.00224

APPENDIX F

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

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

5/05/2005

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

APPENDIX F

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

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

5/05/2005

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

APPENDIX F

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

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

5/05/2005

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

APPENDIX F

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

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

5/05/2005

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

APPENDIX F

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

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

5/05/2005

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

APPENDIX F

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

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

5/05/2005

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

APPENDIX F

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

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

5/05/2005

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

APPENDIX F

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

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

5/05/2005

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

APPENDIX F

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

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

5/05/2005

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

Tables: Summary of Charts Reviewed to Date

Patients Referred to the Coroner: Kemps (Bundaberg), Walk (Brisbane)

Patients where Chart Review requested by the Coroner: Dorron, Gautray

Did Patel Contribute to Adverse Outcome

Selection Value	Count
Total	124
Maybe	13
No	98
Yes	13

Yes: Bellamy, Blight, Bramich, Connors, Cox, Fleming, Grave, Johnson, Paul Jones, Kemps, Mobbs, Nagle, Phillips

Maybe: Daisey, Delaney, Dorron, Gautray, Grealish, Leonard Green, Anita Jones, McDonald, Pancheri, Parsons, Harold Roach, Slater, Walk

Was Patel Outside of Expertise Scope

Selection Value	Count
Total	124
Maybe	4
No	116
Yes	4

Yes: Grave, Kemps, Phillips, Tebbit

Maybe: Deakin, Gautray, Leonard Green, Slater

Was Patient Management Reasonable

Selection Value	Count
Total	124
Maybe	14
No	11
Yes	99

No: Bellamy, Bramich, Cox, Dewitt, Grave, Anita Jones, Paul Jones, Kemps, Mobbs, Nagle, Phillips

Maybe: Blight, Connors, Daisey, Deakin, Dorron, Fleming, Gautray, Leonard Green, Barry Johnson, Mc Donald, Pancheri, Harold Roach, Slater, Walk

APPENDIX E CLINICAL CASE CHART REVIEW

1. List those patients with a brief clinical summary in whom Dr Patel was considered to have contributed to an adverse outcome.

Mr Terry Bellamy 5/2/73 Ur 060881
11/10/04 Repair of an incarcerated right inguinal hernia. The vas deferens was divided inadvertently, a scrotal haematoma became infected which was reoperated upon on 3/12/04 and a further re-operation on 10/12/04. The cultured organism was a staphylococcus aureus. The patient's son of 10 years age was admitted as an inpatient around this time for staphyloccal infection of both lungs and kidneys.

Mr Darcy Blight 19/11/27 Ur 047221
Underwent a completion thyroidectomy on 16/5/03 and associated neck dissection for a tall cell variant papillary thyroid cancer. During this dissection, an inadvertent jugular venotomy was repaired. Post operatively, he was considered to have a residual metastatic node. This was excised and shown histologically to be the right submandibular gland. Following this excision, a salivary fistula resulted.

Mr Desmond Bramich 15/4/48 Ur 043441
Mr Bramich was admitted under the care of Dr Gaffield on 25/7/04 following blunt chest trauma. The CT scan revealed contusions of both lungs and fractured ribs. He remained clinically well for two days but deteriorated noticeably at 1300hrs 27/5/04, his blood pressure falling to 50mm and his haemoglobin at the time being 77 gdl. He was noted to be in acute respiratory distress and his right under water seal drain was non-functional at this time. He was transferred to the Intensive Care Unit. A second intercostal drain, endotracheal intubation and ventilation were performed. The Flight Coordinator was contacted at 1620hrs. A CT scan at this time showed a right haemothorax under tension with no evidence of pericardial collection. The underwater seal drain was recorded as being patent with minimal drainage at 2315hrs on 26/7/04. He remained stable throughout the night with no complaint of pain. Statement of Dr Patel and Dr Carter document the rapid deterioration of the patient's condition. Following a provisional diagnosis of pericardial tamponade attempts made to drain the pericardial sac by Dr Patel. The patient in extremis was considered too ill for transfer which was cancelled at that time. He succumbed and at autopsy was found to have three (3) litres of clotted blood in his right chest under tension with displacement of the mediastinum to the left. There was no pericardial effusion nor damage to the myocardium.

Mrs Dorothy Bryen 22/2/27 Ur 132961
This patient was admitted on 8/6/03 with a five (5) day history involving constipation and abdominal distention, past history of hypertension and a cardiac arrhythmia.
The x-ray revealed multiple fluid levels. Dr Patel's notes of 8/6/03 at 1930hrs were an example of a comprehensive and lucid assessment. The patient underwent surgery on 9/6/03 at the Bundaberg Base Hospital. An incarcerated epigastric hernia was repaired and an inadvertent enterostomy was oversewn. The patient was discharged home on 15/6/03, the incision clean and dry. Readmitted on 20/6/03 with shortness of breath and confusion. Considered to be possibly suffering pulmonary embolism.

Transferred to the Mater Private Hospital Intensive Care Unit in Brisbane and ventilated until 30/6/03.

Mrs Una Connors 5/9/30 Ur 134442
Underwent removal of an ovarian carcinoma and a sigmoid colectomy on 29/3/04. Discharged home but brought in by the ambulance on 8/4/03 with a dehiscence of the wound. Radiology of 29/7/04 suggests obstruction of the left kidney.

Mr Nelson Cox 4/5/41 Ur 136688
Admitted 25/10/04 following his fourth attack of acute cholecystitis. Underwent a laparoscopic cholecystectomy that day. Developed a post operative haematoma and bile leak which was further washed out on 26/10/04. A further abdominal wall haematoma resulted in open re-operation on 29/10/04. He was discharged home on 15/11/04. On 23/11/04 was noted to have an incisional hernia and booked for a repair.

Mr Ian Fleming 12/1/55 Ur 106934
Following repeated rectal bleeding, Mr Fleming was seen by Dr Patel on 29/4/03. A recent CT scan showed no phlegmon or abscess. There was some left abdominal tenderness and a localised segment of sigmoid colon was noted to be abnormal on the CT scan. The pros and cons of management were considered. Dr Patel records that the patient wanted to proceed with surgical resection. The procedure, alternatives and risks were discussed, consent was obtained and sigmoid colectomy booked. Mr Fleming was admitted on 19/5/03 and discharged 23/5/03. He attended the hospital on 29/5/03 with a sero-sanguinous discharge from the wound and was admitted. Initially this was managed conservatively by Dr Patel but following continuing purulent discharge, the wound was opened completely. He was discharged home on 4/6/03. He continued to suffer PR bleeding post operatively. A colonoscopy on 20/1/04 reports multiple and large diverticula seen about 30cms from the anal verge. A review of the histology of the resected specimen describes a 70 x30 x 30 mm segment of colon with diverticula extending to resection margins.

Mr James Grave 22/12/39 Ur 130224
Underwent a trans-hiatal oesphagectomy and a partial gastrectomy on 6/6/03. He was noted to have metastases in the pericardium and nine (9) of fourteen (14) lymph nodes were positive and liver metastases were present. He suffered a vocal cord paralysis and respiratory failure post operatively. Developed an AMI and peritonitis and was transferred to the Mater Intensive Care Unit. He had a past history of a coronary artery bypass graft and of an occluded left internal carotid artery. The paralysed vocal cord contributed to post operative aspiration. There were two (2) wound dehiscences- one 12/6/03 and the other on 16/6/03, both requiring suturing in the operating theatre. Leakage was noted from the jejeunostomy site and this was oversewn in the operating theatre on 18/6/03. The patient was discharged home on 18/8/03.

Trevor Halter 5/11/47 Ur 035261
Following a laparoscopic cholecystectomy in Bundaberg by Dr Patel, the patient developed a subhepatic haematoma which became infected and was drained by Dr Patel on 26/11/04. A further laparotomy was performed on 28/11/04. The patient was transferred to the Royal Brisbane Hospital on 9/12/04 because of failure to wean from

the ventilator, continued sepsis and the development of ARDS. The patient was transferred back to Bundaberg Base Hospital and was seen by Dr Patel on 25/12/04 and noted to have a soft abdomen, non tender and the drain was removed. He was discharged home on 31/12/04

Barry Johnson 8/9/46 Ur 134333
Admitted with a pancreatic mass producing obstruction. At laparotomy the mass was considered unresectable. Cholecystojejeunostomy and gastrojejeunostomy was performed 22/9/03. The patient died on 1/10/03.

Anita Jones 20/12/49 Ur 080457
This patient admitted to the Royal Brisbane Hospital on 14/12/02 underwent partial removal of pancreas and stomach. A further procedure was performed at the Royal Brisbane Hospital in February 2003 for drainage of a pseudo cyst. This subsequently recurred. Cultures at that time grew pseudomonas. A further CT scan 3/6/03 reported a 5-6cm cyst in the lesser sac posterior to the stomach adherent to the gastric wall. On 24/7/03 Dr Patel records the proposed procedure and the alternatives. He explains the risks to the patient and records that all questions were answered and the consent signed. The patient was admitted on 30/6/03. Dr Patel's operative notes of that date describes the satisfactory drainage of the pseudo cyst into the stomach. The patient died on 2/7/03.

Mr Paul Jones 22/9/52 Ur 063404
Mr Jones attended the Day Surgery Unit for removal of skin lesions. Both he and the first patient on that morning's list had the Christian name Paul. The nurse just addressed the patient by just his first name. There was no formal nursing handover. The armband was not checked by nurse, Dr Patel or anaesthetist. An OGD was performed on Mr Jones prior to performing his planned procedure.

Mr Gerrard Kemps 14/8/27 Ur 007900
Mr Kemps underwent an Ivor Lewis Oesphagectomy for a tumour at the gastro oesphageal junction on 20/12/04. Unacceptable quantities of bright blood accumulated in the drains post operatively. He was returned to the Operating Theatre for a further exploratory laparotomy and right thoracotomy. A splenectomy was performed during this second procedure. Despite thirty-nine (39) units of blood products, the patient exsanguinated. His previous history had included the repair of an abdominal aortic aneurysm in 2002 with had been accompanied by renal failure and on the fourth post operative day he'd required transfer to the Royal Brisbane Hospital. A CT scan preceding his oesophagectomy described ectasia of his thoracic aorta and loss of tissue definition between the oesophagus and aorta.

Mr Shannon Mobbs 16/7/89 Ur 038213
Shannon Mobbs was transferred to Bundaberg by helicopter following a motorcycle accident. He sustained a deep extensive left groin laceration and lacerated femoral vein. When examined in Bundaberg at 1150hrs, he was peripherally shutdown with a heart rate of 150 and a blood pressure of 80 and pallor++. He was bleeding from the left groin oozing through the packs held in place by manual pressure. It was noted by the first aid team that massive blood loss had occurred at the scene. He was

resuscitated via 16 and 14 gauge cannulae in the right arm with 0 negative blood. He received eleven (11) units of red cells or fresh frozen plasma and was taken straight to the operating theatre.

Findings included a 1cm laceration in the left femoral vein at the saphenofemoral junction, completely transected rectus femorus with lacerated fascia and adductors and muscles. The femoral artery and nerve were considered intact. The pubic ramus periostium was exposed. An IDC was placed. The manual pressure pack was removed. The femoral vein was clamped to achieve haemostasis. The venous laceration was sutured with 5/0 prolene. The artery and nerve were explored. A thorough washout was performed. Dead tissue and foreign body debridement was performed. The adductor fascia was approximated and an 18 french bellovac drain was placed and the wound closed. He was sent to x-ray for a CT scan and other x-rays. The foot remained pulseless and cold.

The patient was returned to the operating theatre. Fasciotomies were performed. He was returned to the ICU at 1750hrs on the 23/12/04 but the pulse was still absent. Urine output was recorded at 130mls per hour but the urine was noted to be dark and considered to contain myoglobin. It tested positive for blood. Shock persisted despite adequate volume replacement. The left leg was considered threatened and the cause was questioned. It was noted that pulses were absent but that there was good supply to the tissues. It was considered that the ischaemia may be due to secondary venous obstruction. The comment was expressed "if no improvement may need to consider transfer to the Royal Brisbane Hospital".

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

The patient was transferred to the ward and reviewed with Dr Gaffield. A ward round with Dr Gaffield on 1/1/05, reported that the posterior tibial pulse was palpable but there was a discussion with Dr Gaffield re transfer of the patient to the Royal Brisbane Hospital. A comment is recorded by the vascular staff at the Royal Brisbane Hospital that the arterial reconstruction with PTFE performed by Dr Patel on the night of 23/12/04 was still functioning. The limb was gangrenous and amputated at the Royal Brisbane Hospital.

Mrs Lorraine Mowbray 15/2/37 Ur 139985
7/3/05 Symptomatic para oesophageal hernia repair and splenectomy
Wound dehiscence 8/3/05

Mr Eric Nagel 22/11/38 Ur 130567
Tenckhoff catheter placed on 12/11/03 but 'flipped under the liver'. The patient's clinical background included end stage renal failure, chronic peritoneal dialysis, haemoptysis and a positive d-dimer. On 17/12/03, Dr Patel attempted a permacath insertion. This proved difficult. The difficulty was attributed to previous catheter placements and radiotherapy. The patient died 17/12/03. A post mortem examination the cause of death was attributed to a haemopericardium associated with perforated thoracic veins, cardiac failure, end-stage renal failure, hypertension and chronic obstructive airways disease.

James Phillips 27/3/57 Ur 034546
Oesophageal biopsy 23.4.03- poorly differentiated invasive adenocarcinoma associated with Barrett's oesophagus. No evidence of metastases.
Mr Phillips underwent an oesophagectomy on 19/5/2003. He was in end-stage renal failure, on dialysis and suffering hyperkalaemia. Patient died 21/5/03 2215hrs.

Mr Carl Robinson 7/2/31 Ur 049114
Low anterior resection 14/4/03 Post op anastomotic leak. Treated with transverse colostomy and mucous fistula. Colostomy closed 18/7/03 Admitted with wound infection 3/8/03 Discharged home 11/8/03

Mrs Audrey Selten 7/2/32 Ur 017794
Mrs Selten admitted 10/8/04 with acute abdominal pain. Past history of AMI and coronary stent. At 0710hrs, 13/8/04, Dr Patel notes the patient continues to have abdominal pain. The CT scan confirms an incarcerated ventral abdominal wall hernia. On 23/8/04, 10 days post operatively, some wound breakdown is noted. CT scan reveals a mass, query collection. The original operative note records serosal tear with the diathermy. On 25/8/04, a formal evacuation of the haematoma is performed. No fascial defect evident.

Mr Warren Stanaway 26/9/57 Ur 133338
Mr Stanaway past history of sigmoid colectomy for diverticular disease on 24/11/01. On 4/7/03, he underwent a laparotomy where a rectosigmoid mass was considered

unresectable and therefore a transverse colostomy and mucous fistula was performed. Following closure of colostomy on 23/2/04, the patient developed significant post operative right iliac fossa pain and on the 27/2/04 at 2300hrs was noted by Dr Patel to be tachycardic and febrile. His abdomen was distended and tender. The presence of abdominal sepsis of questionable aetiology was raised by Dr Patel and on the 28/2/04, he performed an exploratory laparotomy. He drained two (2) litres of non purulent fluid and noted on testing the anastomosis a 2mm enterotomy. On 4/3/04, Dr P Andersen expressed concern regarding ongoing intra abdominal sepsis and recommended further laparotomy. Later that day, Dr Patel explored the abdomen, drained an abdominal abscess and performed a loop ileostomy. Although he comments that the colonic anastomosis was intact, he considered this the source of the sepsis. The patient was discharged on 15/3/04.

Mrs Nancy Swanson 9/7/42 Ur 020609

Mrs Swanson was noted on colonoscopy 4/3/04 to have two (2) large flat adenomas distal to the caecum. These were considered too large for endoscopic removal. Dr Patel performed a subtotal colectomy on 22/4/04. Histology revealed multiple adenocarcinoma with high grade dysplasia. No evidence of malignancy. A second procedure was performed by Dr Patel on 27/4/04 where a bowel leak was oversewn at the anastomosis and a covering ileostomy performed. The ileum was transected with a GAI80 stapler. A third procedure wasperformed by Dr Anderson on 8/5/04 following a wound dehiscence. A non STEMI MI occurred on 26/4/04 and during August 2004, the ileostomy was closed. A note is recorded on 24/11/04 from a clinic that the patient returned for review post drainage of abdominal wall collection which occurred following the closure of the ileostomy.

Mrs Judith Taylor 25/3/43 Ur 000910

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

2. Did Dr Patel contribute to adverse outcomes? Maybe

Mrs June Benn 19/6/25 Ur 127142
Sigmoid colectomy and high anterior resection 26/6/03 for colonic obstruction. Wound dehiscence 3/7/03 one day post discharge.

Mr Noel Alexander 6/7/41 Ur 118657
Following an abdominoperineal resection on 24/1/05, a suprapubic catheter was placed. A letter from Dr Anderson 18/4/05 states that the patient sustained a urethral injury while undergoing an AP resection performed by Dr Patel. Dr Patel's operative note of the abdominoperineal resection states a large anterior rectal carcinoma invading into the prostatic urethra and bladder, accidental tear of bladder neck while dissecting the tumour secondary to tumour invasion was repaired and drained. The sigmoid was divided with a GIA staple.

Master Reece Connolly 30/7/97 Ur 090307
Operation notes by Dr Patel on 7/7/03, left hydrocele requiring left herniotomy, hydrocele sac ligated. On 3/9/03, recurrent hydrocele post repair, aspirated 8mls of yellow fluid. On 10/9/03, a further 5mls of fluid aspirated. On 17/9/03, the swelling much smaller. On 12/10/03, the hydrocele returned- 13mls drained via 25 gauge needle. The parents anxious to have definitive treatment performed. Patient reviewed by Dr Patel on 29/10/03 with a note return in 6 weeks for possible sac excision.

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

Mrs Sylvia Delaney 29/4/59 years Ur 135181
12/11/04 Permacath insertion Dr Patel not working. Appropriate Transfer

Mr Noel Dorron 15/11/42 Ur 045211
Admitted 13/9/04 with a ruptured abdominal aortic aneurysm, crystalloid resuscitation produced free intraperitoneal rupture, troublesome juxtasuture line bleeding was encountered. The patient died.

Mr Lesley Garland 30/10/28 Ur 003080
Invasive adenocarcinoma of the rectum excised 27/9/04. A letter of 4/3/05 states that his principle complaint is of urinary incontinence. A post void bladder scan suggests that he empties his bladder normally and that the slight leakage may be due to nerve damage done at the time of his AP resection. He denies any new pains and is eating well. During the operation a GIA60 stapler was used. The histology revealed a rectlal

adenocarcinoma which infiltrated and well into the perirectal fat. Adenocarcinoma within 4 perirectal lymph nodes. On 23/10/04, there was drainage of pelvic abscess by perineal access performed by Dr Patel.

Mr Antoine Gautray 7/7/28 Ur 057809
Mr Gautray presented with jaundice, weight loss and anaemia. The CT scan revealed a 5cm lesion in the head of the pancreas with straining of the peri pancreatic fat planes, displacement and encasement of the SMA & V. The malignancy was closely applied to small bowel loops and was considered that there may be localised extension to small bowel mesentery. There was a suggestion in the bony mode of the scan- that of a few small lesions. A Whipples operation was performed in September 2004, surgery and early post operative care appears to have gone well. Histopathology reports focal soft tissue metastases to the soft tissues of the greater curvature area, the tumour extends to the surgical margin of the pancreas. There are comments in the progress notes of hypoxia, over sedation and pneumonia. The patient died 12 days post operatively of Klebsiella pneumoniae which was considered to have followed aspiration of vomitus.

Mr Clinton George 3/6/70 Ur 041276
Mr George referred to Dr Patel following a failed right sided vasectomy performed by his GP under local anaesthetic. He underwent a right redo vasectomy on 10/2/05. This was followed by vomiting. Infection was evident on 14/2/05 as was haematoma and swelling. When seen on 9/3/05, one month post vasectomy, it was noted the haematoma was still present and hadn't reduced in size. There was no pain in the testicle, occasional pain running up into the inguinal region, the suture line had not healed and palpation of the periwound area produced some ooze from the incision. Dr Patel reviewed the patient and commented on a residual haematoma, no sign of infection. Dr Patel reassured the patient the haematoma would resolve spontaneously.

Mrs Molly Grealish 15/10/38 Ur 139353
Seen by Dr Patel on 15/9/04, noted the CT findings of large left renal mass assessed as metastatic renal cell carcinoma. A left nephrectomy booked. The patient developed a pathological fracture of the left humerus. Gram positive cocci were cultured from the patient's subsequent nephrectomy wound. It was considered that the patient's malnutrition and anaemia and renal failure had a contributing role in the development of wound infection. Trauma and blood loss were considered as possible significant contributing factors.

Mr Leonard Green 28/8/36 Ur 039681
Admitted 26/5/03 with a history of carcinoma of the lung and thyroid cancer, poorly differentiated. A CT scan revealed a large thyroid mass displacing the trachea, with some retrosternal extension and partial obstruction of the left jugular vein which contained thrombus. The tumour was declared non resectable and an incisional biopsy was obtained, the trachea and tumour were inseparable. The carotid artery could not be identified. Died 1/7/2003.

Mr Terrence Jesse 14/10/37 Ur 099769
Surgery on 5/8/04 in which a segment of sigmoid and descending colon was excised revealing a moderately differentiated adenocarcinoma with invasion of pericolic fat.

Following passage of nasogastric tube, a gag reflex resulted and is claimed to have ruptured the suture. The consequent visceral dehiscence was repaired. The patient discharged home on 17/8/04 following an uneventful recovery. He represented 21/8/04 with abdominal pain and was assessed as suffering possible intraabdominal sepsis. By 28/8/04, he had markedly improved. He was discharged home on 2/9/04 but was reported to have a large hernia in the abdomen from the past surgery performed years ago.

Mr Glen Kirkland 25/8/83 Ur143698
Mr Kirkland fractured his femur jumping from the roof to the surrounds of a swimming pool on 9/1/05. He subsequently developed acute gangrenous appendicitis and underwent open appendectomy by Dr Patel on 26/1/05. A further collection occurred around the caecum which was drained through the sciatic notch by Dr Nathanson following transfer to the Wesley Hospital.

Ms Coral Lee 23/7/31 Ur 128583
Parathyroidectomy post Op DVT. Stockings but no chemical DVT prophylaxis.

Mrs Thelma McDonald 11/9/31 Ur 002443
Mrs McDonald was admitted on 29/9/03 with vomiting++ and a tender abdominal mass. The provisional diagnosis of partial bowel obstruction was made. Mrs McDonald had a complex past history having undergone an aorto-femoral bypass in 1993, an aorto-renal bypass in 1998. Despite COAD she was still smoking and in June of 2003 was being cared for by Dr Miach and Dr Kerswell for chronic renal failure. Initially managed conservatively. On 3/10/03, during the night her saturations reduced, urinary output likewise reduced. Temperature, rigors and rapid atrial fibrillation developed. Her state was discussed with Dr Gaffield and Dr Patel agreed to review the question of laparotomy. This was performed on 3/10/03. She was assessed by Dr Patel post operatively on 7am on 4/10/03 and noted on 5/10/03 at 0745hrs to remain drowsy but more awake than last night after narcain. At 7.20pm there was a sudden marked deterioration. At 7am the following day, Dr Patel notes that she was becoming progressively more acidotic and still had no urinary output. The patient died on 7/10/03.

Mrs Muriel Pancheri 13/8/23 Ur 067734
Mrs Pancheri with a long history of recurrent kidney infections and hypothyroidism was to undergo colonoscopy for investigation of iron deficiency anaemia. She had been on long term Brufen for septic arthritis and this was considered to be a possible factor in her anaemia although it was noted that there had been a 6kg weight loss recently and the development of colicky abdominal pain. Bowel prep had been arranged at home but an attempted colonoscopy on 16/4/03 was abandoned because of inadequate preparation. The patient was admitted on 21/5/03 very disorientated and confused and unable to state what procedure she was having or her date of birth. The performance of a colonoscopy raises questions of appropriateness of case selection. No biopsy was performed.

Mrs Linda Parsons 21/8/59 Ur 057761
Mrs Parsons admitted 15/3/04 for hernia repair. At operation, no hernia was found, there was excision of scar tissue from a paramedian wound. On 24/3/04, infection was

noted in the wound associated with burning pain. Examination revealed tenderness in the right iliac fossa and a 7cm wound with purulent discharge.

Miss Cikala Prince 10/3/1999 Ur 103006
History of hernia repair at Bundaberg Hospital 2/8/04 Mother noticed blood stained urine and thought the child was incontinent. There was a question of a bladder injury. Child passed urine satisfactorily and was discharged from hospital. A left inguinal hernia repair was performed 12/8/04

Mr Harold Roach 17/4/31 Ur 111765
This diabetic patient was admitted on 18/1/05 with a subacute bowel obstruction. On 21/1/05, Dr Patel records his observations and management plan. At operation on 22/1/05, 4 litre aspirate was removed from the stomach, a subtotal colectomy for an obstructive colonic carcinoma was performed. Post operatively the patient exhibited biventricular heart failure and cardiac ischaemia. Dr Patel's notes of 23/1/05 0930hrs suggested a third spacing, the patient was returned to theatre for abdominal decompression. Abdominal compartment syndrome was diagnosed, there was ischaemic colon just distal to the anastomosis which was treated by ileostomy. On 29/1/05, the patient developed atrial flutter which reverted to sinus rhythm. There was a collapse after aspiration requiring the patient to re-intubated and ventilated. The patient was transferred to the Mater Hospital Brisbane.

Mrs Mona Slater 19/5/15 Ur 009677
Mona Slater suffering chronic renal failure underwent a low anterior resection on 15/12/03. She died on 24/12/03 and in the clinical summary anuric renal failure was mentioned. Dr Patel's post operative statements show maturity and compassion. It is not possible on review of these notes to exclude the possibility of ureteric injury. The death certificate records respiratory failure, fluid overload for 7 days, chronic renal failure for years, hypertension, angina, gout and atrial fibrillation. This case raises questions of preoperative judgement.

Mr Chris Smith 25/9/52 Ur 086643
Mr Smith was seen at outpatients on 24/2/04 with bilateral inguinal hernia, reducible and symptomatic. He was also noted to have an umbilical hernia. Bilateral inguinal hernia repairs were planned. These were performed on 22/3/04 but when seen at outpatients on 21/4/04, it was noted he was well, the wounds were healed and he was discharged to the care of his GP. He was subsequently reviewed 28/4/05 by Dr Barry O'Loughlin Director of Surgery of the Royal Brisbane Hospital seconded to Bundaberg. He assessed Mr Smith noting that his main complaint was of pain preoperatively which still persists post operatively including pain in the left testicle. He recorded that slowly things are settling down. On examination, the wounds were healed, no hernia obvious, tenderness in the left inguinal region, the testicles were normal both left and right. He diagnosed ongoing neuralgia and suggested an injection of local anaesthetic and hydrocortisone or removal of the mesh used for the hernia repair. An ultrasound examination of 3/8/04 reported that the thickening and echogenicity of the spermatic cord associated with an elongated anechoic structure is

puzzling. No suggestion of flow. Possibly this represents a solitary thrombosed vessel or a thrombosed varicocele.

Mrs Jean Stuart-Sutherland 13/3/43 Ur130566

Mrs Jean Stuart-Sutherland underwent a completion colectomy on 11/2/05 with the formation of an ileorectal anastomosis. A second laparotomy performed by Dr Gaffield on 20/2/05 revealed 1200cc of bile stained fluid within the peritoneal cavity. He fashioned a loop ileostomy and left the drain insitu. Mrs Stuart-Sutherland's past history was complex having undergone resection of an appendiceal carcinoma in 2000 by right hemicolectomy. There was a history of uterine carcinoma in 2003.

Mr Keith Walk 19/11/30 Ur 135796

Mr Walk was admitted with painless jaundice, no history of fever or chills, the abdomen was non tender, there was no ascites, the liver was ++ and the gall bladder was palpable. An ultrasound revealed dilated intrahepatic ducts and gallbladder. A hypoechoic mass in a porto hepatis was noted and the distal common bile duct was normal. The CT scan confirmed the above findings and a provisional diagnosis of cholangiocarcinoma just distal to the cystic duct was made. This was explained to the patient. Surgery was undertaken on 29/12/03, metastatic adenocarcinoma of the gall bladder and omentum were found at operation. The patient died on 30/12/03. There was no obvious explanation of the mode of death. The case has been referred to the coroner.

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

Mr James Grave 22/12/39 Ur 130224
Oesophagectomy & partial gastrectomy

Mr Gerrard Kemps 14/8/27 Ur007900
Ivor Lewis Oesophagectomy and thoracic aortic disease

Mr James Phillips 27/357 Ur 034546
Oesophagectomy, the patient suffering end-stage renal failure on dialysis

4 List of patients where it was considered Dr Patel maybe operating outside of scope of either his expertise or that of the hospital

Mr Phillip Deakin 21/9/32 Ur 009028
Ivor Lewis Oesophagectomy 2/12/03 & splenectomy. Review 17/ 2/04 doing fine weighed 65kg. 18/8/04 no nausea, vomiting, pain or diarrhoea. Still smoking 10 cigarettes per day. 1/9/04 CT scan no metatases.

Mr Antoine Gautray 7/7/28 Ur 057809
Whipples operation for carcinoma head of the pancreas. In light of the CT findings indicating displacement and encasement of the superior mesenteric artery and vein

Mr Leonard Green 28/8/36 Ur039681
CT demonstration of a large thyroid mass displacing the trachea with some retrosternal extension and partial obstruction of left jugular vein which contained thrombus.

Mrs Anita Jones 20/12/49 Ur 080457
Drainage of a pseudocyst in a patient who had previously undergone two complex upper gastrointestinal procedures at the Royal Brisbane Hospital.

Mrs Mona Slater 19/5/15 Ur 009677
Low anterior resection in a patient with chronic renal failure, hypertension, angina and atrial fibrillation.

List of those patients where clinical patient management was considered

UR	DOB	Name	CLINICAL DIAGNOSIS
005751	19/9/36	AINSLIE, FRANCES	Died of peritonitis following steroid therapy
117791	2/2/70	ANDERSON, HELEN	Burns- appropriate transfer
002278-2	12/10/64	ATKINSON, PAUL	Self inflicted stab wound to the heart repaired. Discharged home
012769	13/9/24	BANKS, JOHN	Sigmoid colectomy for carcinoma May 03 Biliary drainage Jan 04
130228-13	26/10/18	BARNARD, ELSIE	Left above knee amputation for gangrene
001069-2	12/12/64	BARON, REON	Motor Vehicle accident suffering multi trauma appropriate transfer
133321-1	9/9/19	BATES, WILLIAM	Fractured skull following a fall, appropriate transfer
075042	18/6/64	BENDER, VICKI	Laparoscopic cholecystectomy for symptomatic cholelithiasis
068788-1	9/4/84	BENT, TERRY	Incision and drainage of perianal abscess April 2003 A further abscess developed on the posterior aspect of the left thigh in May 2003
102414-6	31/8/44	BIGGS, VALMAE	Metastatic bowel cancer palliative care Royal Brisbane Hospital
058253	24/9/49	BLACK, ALAN	Excision of multiple skin lesions
129531-1	27/7/65	BODLOVIC, RODNEY	Excision of multiple sebaceous cysts Nov 2003. Sustained a fatal unrelated cardiac arrest 15/8/04
079609-3	24/4/19	BOWLER, WINIFRED	Bleeding internal haemorrhoids normal colonoscopy
010380-2	8/6/49	BRAUND, KERRY	Anterior resection of poorly differentiated Duke's D tumour with multiple secondaries performed by Dr De Lacey at Mater Private Hospital. Post operative wound infection drained by Dr Patel.
001430-4	17/6/41	BREED, JOHN	Perforated duodenal ulcer oversewn with an omental patch July 2003 Slow post operative progress from a respiratory view point appropriate transfer
137325-1	6/12/72	BRODIE, DANIEL	Multi trauma appropriate transferr
008792	9/4/45	BROOME, PRISCILLA	Appropriate treatment of carbuncles. Following an apronectomy by Dr Gatfield in February 2004 developed a necrotic abdominal wall cavity with underlying calciphylaxis. Underwent a wide resection by Dr Patel. The wound was closed surgically. Initially the patient did well but later as an outpatient she developed several areas of foul smelling discharge. Exploratory laparotomy
003379	27/7/28	CAMERON, JOAN	Hyperemesis secondary to a duodenal tumour. Multiple co-morbidities appropriate transfer
018605	8/10/32	CARTER, MATTHEW	End stage renal failure, dysphagia, laparotomy 1/4/03 inoperable carcinoma, stent placed for inoperable oesophageal obstruction. Barium swallow revealed complete obstruction of a meshed oesophageal stent within the tumour No surgical option was considered available to relieve his oesophageal obstruction
142351	4/4/20	CASEY, KATHELEEN	Hemicolectomy for carcinoma of the caecum discharged home
136704-5	28/6/03	CAYLEY, MITCHELL	Referred via the Royal Children's Hospital with terminal acute myeloid leukaemia for palliative therapy. Left subclavian Hickmans line septic removed by Dr Patel on 7/10/04. Patient died 6/11/04
094715	9/10/37	CHRISTENSEN, SARAH	Open cholecystectomy 8/8/03
133218-1	6/8/24	CHRISTENSEN, WALTER	Fatal ruptured abdominal aortic aneurysm
139750-1	23/7/65	COFFMAN, CLARK	Motor vehicle accident head injury transferred from Biggenden to Royal Brisbane Hospital via Bundaberg
005153-41	15/8/42	COLEMAN, MARGARET	Carcinoma of the uterus 1998 Admitted for palliative care 19/4/03 Died 25/4/03
026387-5	5/6/48	COOPER, CAROL	Appropriate transfer with Respiratory failure
017489-16	8/6/25	CORBETT, VICTOR	Right direct inguinal hernia no operation
132929-1	4/7/20	CRAIG, HAZEL	Transfer from Gladstone for placement of a caval filter for VTE by Dr Theile
045282-11	7/1/49	CULLEN, RONALD	Appropriate transfer
121526-1	2/2/44	DALGLEISH, PETER	Total Hip replacement Dr Patel involvement satisfactory
119561	2/12/44	DAVIES, NOELA	Appropriate transfer
142693-1	9/4/43	DAVIS, PAT	Appropriate transfer

UR	DOB	Name	CLINICAL DIAGNOSIS
138339-1	11/4/86	DEAN, NASEEF	Motor Vehicle accident appropriate transfer
003181-12	18/4/48	DEMPSEY, LAURENCE	Repair of recurrent inguinal hernia
041083-1	7/12/52	DRIVER, MERVYN	Appropriate transfer
057579-2	25/9/34	EGGMOLESSE, ARNOLD	Liver cirrhosis, carcinoma of the lung, incarcerated epigastric hernia repair. Died 23/4/04
038663	10/8/41	EISEL, ERIC	Anal fistulotomy
035298-1	20/11/31	ELLACOTT, VALERIE	Disseminated malignancy Total gastrectomy 4/11/03 Admitted 24/4/04 end stage disseminated malignancy Died 30/6/04
142699-1	30/5/44	FIELDING, CAROL	Appropriate transfer
104562-2	9/7/25	FINCH, RAYMOND	Admitted 19/8/03 with superior mesenteric embolism. Laparotomy extensive necrotic bowel supportive treatment only Died 19/8/03
006765-13	9/3/65	FORD, LEANNE	Admitted 20/9/03 with multiple co-morbidities including gram negative sepsis and neutropaenia Underwent a left femoral embolectomy on 21/9/03 Died 21/9/03
001597-4	5/3/13	FORMAN, HAROLD	Appropriate transfer
138941-2	5/7/59	FOURRO, PETER	Admitted 8/9/04 cholangiocarcinoma with left lung metastasis. A percutaneous stent insitu. Appropriate transfer Died 11/1/05
127514-1	17/8/40	FRAY, RICHARD	Appropriate transfer
143088-3	1/1/61	FREESTONE, SHARON	Excision of angiomyolipoma involving right ureter discharged home
130408	22/9/33	GALLAGHER, GLADYS	Acute pancreatitis with an impacted stone in the ampullae Dilated ducts appropriate transfer
099036-8	20/4/27	GERRARD, GLORIA	Admitted 3/4/03 with gall stone pancreatitis. Previous cholecystectomy at RBWH. Appropriate transfer
085460-2	18/10/47	GOOCH, MILTON	Admitted 17/11/03 with metastatic pancreatic carcinoma Discharged home 21/11/03 Died 6/12/03
134120	16/11/31	GOYNS, TONY	Removal of portacath and insertion of permacath
138492-2	11/12/47	GRAMBOWER, JANICE	Admission 30/7/04 exploratory laparotomy a large necrotic mass in the region of the head of the pancreas Gastrojejeunostomy and T tube drainage of the bile duct. Discharged to Biggenden Hospital 18/8/04
004278	26/7/08	GRANGIOTTI, FERDINANDO	Appropriate transfer
037412	5/10/20	GREEN, DORIS	Fractured left neck of femur appropriate supervision
017611	13/3/53	HALE, JUNE	Complex recurrent breast cancer following previous surgery and radiotherapy
104754-6	12/11/36	HALLEN, DESMOND	Left below knee amputation. Appropriate transfer
089388-3	19/3/44	HALLORAN, GORDON	Admitted 9/3/04 with disseminated malignancy including liver metastasis and malignant ascites. Died 28/3/04
126237-3	20/9/31	HARVEY, GILBERT	Incision and drainage of perianal abscess Appropriate transfer
033119	17/10/30	HAWKINS, MAVIS	Admission 13/12/04 with abdominal and back pain weight loss and anaemia. Open gall bladder exploration 13/12/04 & liver biopsy. Findings carcinoma of the gall bladder with a mass involving the bowel and invading into the liver. Portal structures involved in the mass which was considered unresectable. Three core biopsies were taken of the liver. Referred to Gayndah Hospital for palliative care
002378	27/4/48	HILLIER, DORIS	Admitted 28/8/04 with cholecystitis. Laparoscopic Cholecystectomy Dr De Lacey 29/8/04 Developed necrotizing fasciitis CT findings included gas in the abdominal wall and the subcutaneous fat. The underlying tissue was oedematous and infected tracking back to the lateral edge of the extensor back muscles. Dr Patel performed an extensive debridement and fasciotomy Discharged home 11/9/04
039181-3	13/8/27	HILLYARD, EDWARD	Complex dialysis access in a frail patient involving Dr Patel on 13/12/03 and Dr Theile on 24/12/04 Patient deceased 25/1/04
113808	2/2/29	HOLDER, GEORGE	Nissen Fundoplication 14/2/05 Patient offered laparoscopic treatment in Brisbane but declined
020514-12	7/10/43	HOSLER, GARY	Debridement of diabetic foot
129039-1	3/6/30	HOWARD, NELSON	Appropriate transfer for treatment of a 10cm abdominal aortic aneurysm in August 03. Excision of a left hydrocele in August 04. Incisional hernia repair October 04

UR	DOB	Name	CLINICAL DIAGNOSIS
128067-2	22/6/45	HUTCHEON, MAUREEN	Removal of infected intrathecal catheter for chronic pain relief. Appropriate transfer
060446-14	1/11/45	HUTTON, KENNETH	Appropriate palliative care following laryngectomy and radiotherapy for carcinoma
089103-16	3/7/27	JACKSON, HERBERT	Excision of skin lesions
096867	13/9/76	JOHNSTON, DONNA	Resection for Crohns disease
013936-13	11/11/35	JONES, ELWYN	Admitted 9/5/03 underwent a splenectomy for a splenic tear which occurred secondary to a laparoscopic adrenalectomy by Professor Goughat the Royal Brisbane Hospital on 14/4/03. Patient was transferred back to the RBH on 14/5/03 –a portion of a "non cutting" suture needle broke and become embedded in the pancreas and was left insitu
002197-11	12/5/42	JOYCE, DARCY	Peripheral vascular disease with multiple co morbidities Appropriate transfer
142155-1	20/8/40	JUNG, BARRY	Palliative care of advanced lung cancer
035690-13	17/11/56	KEEN, GLORIA	Admitted 23/5/03 with metastatic breast carcinoma Deceased 24/10/03
083173-18	25/4/24	KELLY, ELSIE	Admission 17/2/04 Discharged 19/2/04 No surgery Deceased November 2004
053965-1	30/11/30	KERR, KATHLEEN	Admitted 30/10/04 to the Bundaberg Hospital with peritonitis and overwhelming sepsis as a consequence of a rectal polypectomy by colleague at the Mater Private Hospital on 28/10/04. Dr Patel's comment of 30/10/04 12MD recorded the extremely poor prognosis of the required laparotomy. The patient was transferred post operatively to the Wesley Hospital and died on 22/12/04
093215-2	8/2/78	KERR, RENAI	Laparoscopy revealing pelvic inflammatory disease plus the removal of a normal appendix
063164-6	18/6/10	KIEHNE, BERNARD	Admitted to the BBH from a nursing centre with a sigmoid volvulus with impending perforation Sub total colectomy with an ileostomy was performed on 31/7/04. Patient developed renal failure and died on 17/8/04
097121	26/2/31	KNUST, ALAN	Excision of skin lesions
103368-10	7/2/62	KRAUSE, GAIMAREE	Admitted 22/11/04 for palliation following right hemicolectomy in February 03 by Dr Baker at which time hepatic metastases were evident. Died 21/2/05
031725-1	6/4/20	LAACK, FRANCES	Respiratory arrest 6/4/03 following resection of haemorrhagic small bowel with areas of focal haemorrhage, mucosal infarction and perforation with localised peritonitis Patient died 22/4/03
025795-4	4/7/42	LANDSBERG, JUDITH	Palliative care for terminal carcinoma
069123	9/10/35	LANGRIDGE, PATRICK	Wedge resection left lung
024451	4/10/67	LARSEN, CHRISTEN	Excision of sebaceous cyst
047508-6	12/12/26	LAWSON, VICTOR	Palliative care of colonic cancer
034130-5	11/11/62	LESTER, VICKI	Perianal abscess
099634	18/6/67	LEWIS, GWENYTH	Waiting list for lap chole
002558-5	10/10/27	LOVI, BERYL	Transfer from SFPH with perforated colon following a colonoscopy by Dr Strahan Laparotomy and repair of perforated sigmoid colon Dr Patel 8/7/03 CT angiogram 6/8/03 extensive pulmonary embolus Patient died of Pulmonary embolus 6/8/03
115831-2	22/1/01	LUDCKE, SKYE	Swallowed coin
142212	21/12/69	MacPHAIL, VAUGHAN	MVA Appropriate treatment
139925-3	13/9/38	MAISEY, SHIRLEY	Transferred to Childers Hospital for palliative care following right hemicolectomy for metastatic carcinoma
033696-3	18/8/33	MANDERSON, JOYCE	Admission from SFPH with sub acute bowel obstruction. Carcinoma of the colon resected with establishment of colostomy on 29/4/04. End stage COAD resulted in a tracheostomy on 7/5/04. Transferred to the Redcliffe Hospital for long term ventilation Patient expired 30/5/04
064794	10/11/42	MANTHEY, SUZANNE	Excision of breast lesion

UR	DOB	Name	CLINICAL DIAGNOSIS
130172-9	29/11/43	MARR, RAYMOND	Tenckhoff catheter insertion and repositioning
010299-1	20/5/35	MARSDEN, HEATHER	Appropriate transfer
084445	3/3/45	MACNAMARA, SYLVIA	Recurrent abdominal hernia problems following initial repair in May 01 with mesh. Abscess April 02. Treated December 02 by Dr De Lacey for an periumbilical empyema. Wound probed. CT 29/10/03 reported a sub cutaneous abscess and enterocutaneous fistula. At operation by Dr Patel on 5/11/03 a fistula was apparent between the appendix and the anterior abdominal wall. The appendix stump was stapled.
144201-1	18/10/43	MCPHERSON, RUSSELL	Appropriate transfer
098782-6	5/12/33	MEIERS, LAURENCE	Appropriate transfer
111085-1	14/8/09	MELLOR, HECTOR	Admitted from Gayndah 21/3/04 with bowel obstruction and an irreducible right inguinal hernia. Previously considered unfit for surgical repair of his inguinal hernia in both Maryborough and Bundaberg Hospitals by other surgeons. Removed from Dr Baker's category one waiting list 3/12/01. Dr Patel elected conservative treatment Patient died 23/3/04.
129324-1	26/1/03	MINNS, PHILLIP	Admission 12/1/04 for end stage palliative care of thyroid carcinoma Patient died 17/1/04. This record gives insight into the compassion and concern of Dr Patel
029817-2	12/3/1905	MOFFAT, JOHN	Ischaemic right leg, amputation. Appropriate transfer
139830	1/11/41	MONAGHAN, BRIAN	Anterior resection of rectal carcinoma locally invading bladder wall
880266	21/3/56	MOORE, TREVOR	Multi trauma Appropriate transfer after relief of a tension pneumothorax
106639-16	14/6/25	MORONEY, ALICE	Admitted 11/9/03 under Dr Miach with shortness of breath, vomiting and diarrhoea History of many admissions for COAD, iron deficiency anaemia with a haemoglobin of 64 and RCC 2.64. A colonoscopy in 2001 had revealed diverticular disease. It was considered that the patient was not for resuscitation and the patient expired 16/9/03
122960-2	20/12/66	MORSE, SIMONE	Appropriate transfer for management of obstructive jaundice
053832-11	5/5/38	MURRAY, LIAM	Appropriate transfer
084654-4	23/9/62	NOPPE, PHILLIP	Complex dialysis patient Appropriate removal of pericardial tube
013431-5	15/7/53	O'DEA, JOHN	Excision biopsy left groin
124218-3	15/2/32	PARK, GRAHAM	Laparotomy 4/11/04 Inoperable tumour Pleural effusion drained Patient died 7/11/04
059257-2	10/10/37	PARSONS, JOHN	Recurrent laryngeal carcinoma Appropriate transfer
023142-5	2/1/22	PATTERSON, JAMES	Transferred from Eidsvold Hospital 17/7/04 with PR bleeding Past history of 3 total hip replacements, CVA, diabetes & bronchiectasis. Dr Patel's preoperative assessment and management considered appropriate. Patient continued to bleed PR. Sigmoid colectomy performed on 23/7/04. Troponin leak Patient died 25/7/04
083866-2	7/10/37	PEARSON, JOHN	Admitted with bowel obstruction of 7 days standing Appropriate transfer
139301-1	13/11/51	PEDERSON, RENE	Appropriate transfer
091206	23/4/68	PERRY, MARK	Multilocular clear cell carcinoma of the kidney
026824-3	4/7/50	PETERS, MARINUS	Appropriate transfer
057570-4	1/2/42	PETTITT, JUDITH	Referred from Childers Hospital with non functioning colostomy Narrowed stoma refashioned Patient suffering widespread metastatic disease
025333	8/8/43	PIROVANO, FELICA	Subtotal gastrectomy for carcinoma
134655-4	28/8/38	PORTER, ISOBELL	Transferred from RBH 4/2/04 Ischaemic heart disease, extensive vascular disease, COAD, CRF. Died 11/2/04
110212-3	21/9/44	POUND, GWLADYS	Recurrent breast cancer Appropriate surgery and transfer Recurrent ovarian carcinoma with metastases Levine shunt 23/2/04 Patient died 4/3/04
131374-1	19/1/51	PULLIN, CHERYL	Laparotomy and adhesiolysis for small bowel obstruction
775009	8/5/02	PUNCH, TORI	Challenging cystic hygroma Managed with appropriate consultation with Staff at the RCH
041253-1	27/10/51	REIN, BARRY	Appropriate referral

UR	DOB	Name	CLINICAL DIAGNOSIS
061490-2	11/5/69	REYNOLDS, PETER	Appropriate transfer
028486	9/12/37	ROACH, GWYNNETH	Management of breast disease in consultation with Dr Gaffield
143888-1	19/2/24	ROBINSON, JAMES	Appropriate transfer
775999-2	24/10/03	ROHDMANN, DOMINIC	Appropriate transfer for surgery to correct pyloric stenosis. Vomiting post operatively required re-operation
041571-2	3/2/26	ROLL, JEAN	Admission 10/9/03 with 8 weeks of abdominal discomfort and nausea 12/9/03 ilio-colic anastomosis for a non resectable caecal carcinoma Discharged home 17/9/03 Follow up at surgical outpatients 30/9/03 patient satisfactory
104490	13/12/41	RYAN, THOMAS	Amputation of toe
075841	22/6/82	SAROGLIA, CASSANDRA	Excision of swanuoma right thigh
135261-1	29/11/21	SCOPE, KATHLEEN	Laparotomy 25/11/03 at Mater Private Bundaberg - Dr Andersen. Inoperable situation with tumour in the antrum invading the pancreas. Cholegastrojejeunostomy performed. Sustained respiratory arrest in recovery and was transferred to Bundaberg Base Hospital to the care of Dr Patel. Patient died 26/1/04
126538-5	25/2/93	SIMPKINS, LAUREN	Admitted 8/2/04 Discharged 13/2/04 to the RCH with subacute bowel obstruction. Died 7/1/05
002736-7	7/4/38	SINGHO, KEVIN	Metastatic neck carcinoma. Fine needle aspiration, panendoscopy revealed normal tissue. Dr Patel biopsied a cervical node. The wound healed satisfactorily. The patient died 31/5/04.
032407	6/8/30	SMITH, MERVYN	Motor Vehicle accident, 5 fractured ribs, loculated haemothorax left chest with poorly expanded lungs 10/9/03 left thoracotomy DR Patel
120676-1	8/12/50	SMYTH, PATRICK	Appropriate transfer
019627-3	27/7/34	SONDERGELD, ERNEST	Medical demise
023485	10/2/44	SONTER, RAYMOND	Pancreatitis, cholecystectomy Appropriate transfer
000144	28/7/35	SPANN, MERVYN	Complex djalysis patient of Dr Miach suffering polycystic disease Admitted 29/3/03 with chills, fever, pain in the right upper quadrant and jaundice. It was considered that he may have ruptured a liver cyst. His condition deteriorated and on 3/4/03 Dr Miach on his ward round noted that he was unwell, jaundiced, confused with a blood pressure of 63/50 oximeter recorded 85 despite supplemental oxygen. The CT of his abdomen suggested a likely enlarged gall bladder. The patient was seen by Dr Patel on the request of Dr Miach. Dr Patel's comments are informative- Cholecystostomy 1500hrs Patient expired 4/4/03 2220hrs
055819-7	27/7/36	STANTON, JOSEPH	Appropriate palliative treatment
075156-4	17/3/26	STEPHENSON, ALLEN	Appropriate transfer
029727	8/10/87	SULLIVAN, AMANDA	Insertion of PICC line
117790-1	19/9/26	SULLOCK, VAL	Appropriate transfer
013712	29/3/45	SVENSSON, MARGARET	Appropriate management of breast pathology
772896	9/6/99	TARATOA, CHRISTIAN	Not seen by Patel despite email to the contrary
075042-2	14/9/52	TEBBIT, GORDON	Appropriate transfer
138813-1	30/6/41	THIELE, COLIN	Abdominoperineal resection for adenocarcinoma with unresectable liver metastasises Died 26/8/04
039868-2	28/10/35	THOMPSON, LESLIE	Conservative management of PR bleeding transferred
135321	28/1/55	THOMPSON, NEIL	
122651-2	23/4/34	THORNE, LESLIE	Admission 8/7/04 exploratory laparotomy revealed severely necrosed pancreas and colon. Considered non salvageable Patient died 13/7/04
136902-1	16/11/35	TREMBLE, LOTTIE	Appropriate transfer
132412-2	26/7/32	TUCKER, LAWRENCE	Admission 27/8/04 with ischaemic leg. Management discussed with RBH in relation to transfer. Toe amputated under local anaesthesia 7/9/04 Subsequent followed by below knee amputation Died 12/10/04
037658-5	25/548	TURCAROLO, ANITA	Admitted 19/2/04 with pancreatitis. Appropriate transfer 22/2/04
013422-4	29/12/52	TURNER, CHRISTINE	Appropriate management of axillary mass

UR	DOB	Name	CLINICAL DIAGNOSIS
043441-5	13/8/41	TURTON, ROBYN	Appropriate management
001697-15	18/8/31	WALES, IRENE	Admitted 25/11/03 with cholecystitis. Histological examination of the gall bladder removed the following day revealed severe acute cholecystitis with focal gangrenous change in the wall. The patient's ejection fracture on echo cardiography was thirty per cent (30%). Appropriate discussion pre operatively of the prognosis and consent. Died 28/11/03
143944-1	17/4/39	WALKER, NEVILLE	Ruptured abdominal aortic aneurysm with preoperative arrest
112736-13	25/1/48	WARREN, KEVIN	Appropriate management of chronic pancreatitis
063751	10/2/45	WEBB, ANNETTE	Admitted 10/12/03 Difficulty obtaining dialysis access Transfer 12/12/03 Died 26/1/04
005020-2	14/9/24	WEBB, VALMA	Admitted 1/2/05 following haemorrhage from presacral veins occurring during a rectopexy. Haemorrhage was controlled with packs. Following transfer to Bundaberg Base Hospital the packs were removed and the patient transferred back to FSPH on 10/2/05
017316-2	3/11/38	WEINHOLZ, KEITH	Appropriate transfer
N083830	19/9/26	WEIR, ALWYN	Insertion of Tenckhoff catheter
095018-5	27/12/25	WELLER, RONALD	Right hemicolectomy
142406-1	3/3/78	WELLS, FAYE	Lap Cholecystectomy Appropriate transfer
080692-13	30/11/32	WHALLEY, JAMES	Appropriate transfer
055189-6	23/4/26	WHEELER, NOEL	Following a right nephrectomy by Dr Anderson on 16/9/04, the patient was admitted on 11/10/04 with lung metastases, cough and dsypnoea Patient died 21/10/04
124584-3	12/1/27	WHITCOMBE, DAVID	Admitted 22/9/03 underwent a repair of a ruptured left common iliac aneurysm by Dr Theile. The wound dehiscence was resutured by Dr Patel on 23/9/03 Post operative fluid management was complex. There was a suggestion of a pulmonary embolism. The patient had a myocardial infarct. Patient died 22/10/03
120588-3	24/9/20	WHITNEY, BERYL	Appropriate transfer
097482-2	3/6/20	WILLETTS, HENRY	Admitted under the care of Dr Gaffield from Gin Gin Hospital on 9/10/04 with a diagnosis of oesophageal carcinoma OGD by Dr Patel complete oesophageal obstruction, malignant pleural effusion, palliative care
027515-1	15/3/27	WILLIAMS, GRACE	Admitted 8/12/03 defunctioning colostomy performed for an anal carcinoma Discharged home 12/12/03 Died 4/8/04
108809-2	19/4/61	WILLIAMS, MAUREEN	Appropriate transfer
N096063	11/4/68	WILLIAMS, SCOTT	Attempt at vasectomy under local anaesthesia abandoned and completed under a subsequent general anaesthesia
045187-9	9/10/31	WOMERSLEY, JOAN	Insertion of portacath

1.1.1 Clinical Case Chart Review

3.2.1.1

HBCIS records show that at the Bundaberg Hospital Dr Patel was involved in the care of approximately fourteen hundred and fifty seven (1457) in-patients undergoing 1824 admissions between March 2003 and April 2005.

Of those there were two hundred and twenty-two (222) patients who:

a) Died

b) Were transferred to another institution or

c) Had an outcome considered 'adverse' by anyone concerned with his/her care, family, acquaintances or other interested people

3.2.1.2

In respect of each of those two hundred and twenty-two (222) patients, Dr Woodruff

a) Examined their case notes'

b) Examined any other related significant documents (eg. coroner's reports or infectious diseases reports) and

c) Examined statements of complainants or informants.

3.2.1.3

Dr Woodruff considered three questions in relation to each of those two hundred and twenty-two (222) patients

a) Did Dr Patel contribute to an adverse outcome?

b) Was Dr Patel acting outside the scope of expertise of either himself or the hospital?

c) Was the patient's management reasonable?

3.2.1.4

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

3.2.1.5

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

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

Selection Value	Count
Total	222
Maybe	25
No	175
Yes	22

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

Selection Value	Count
Total	222
Maybe	5
No	214
Yes	3

3.2.1.8 Table: Patients in respect of whom management was not or may not have been reasonable

Selection Value	Count
Total	222
Maybe	20
No	15
Yes	187

3.2.1.9

The following are attached as Appendix E:

1. List of the 222 patients referred to in paragraph 3.2.1
2. Notes concerning patients with adverse outcomes considered to have been contributed to by Dr Patel
3. Notes concerning patients with adverse outcomes which **may** have been contributed to by Dr Patel
4. Notes concerning patients operated on by Dr Patel outside his expertise or scope of practice or that of the hospital
5. Notes concerning patients operated on by Dr Patel where to do so may have been out side his expertise or scope of practice or that of the hospital
6. Notes concerning patients where Dr Patel's management was considered satisfactory

3.2.1.10

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

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

a) The case notes provide no basis for a finding that Dr Patel intentionally inflicted harm upon any patient

b) In the cases identified, he caused or may have contributed to adverse outcomes; or operated beyond his scope of practice or the hospitals' scope of practice.

c) Dr Patel, exhibited an unacceptable level of care in some cases

d) It is difficult without an empirical denominator to quantify (in relative terms) Dr Patel's adverse outcomes, however
   1. The occurrence of wound dehiscence was higher than normal,
   2. The occurrence of anastomotic leakages was higher than normal
   3. And the failure of dialysis access raised concern.

e) Dr Patel's unacceptable level of care contributed to three (3) deaths: Kemps Ur 007900, Nagel Ur 130567, Phillips Ur 034546.

There may have been an unacceptable level of care which contributed to a further six (6) deaths:
Johnson Ur134333, Jones Ur 080457, Gautray Ur 057809, McDonald Ur 002443, Slater Ur009677, Walk Ur 135796.

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

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

h) Dr Patel's cases notes were legible and full and his clinical decisions generally well reasoned.

3.2.1.11

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

In particular

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

b) There was no system of contemporary review of patient's care particularly those involving adverse outcomes. Constructive and contemporary review among those involved in a patient's care if necessary with input from other experienced senior clinicians would go a long way towards improving outcomes.
Ideally from the perspective of healthcare outcomes alone, such a review would be confidential and conducted within a culture which

encouraged the open disclosure, discussion and analysis of adverse outcomes, clinical events and near misses.

3.2.1.12

There is no doubt too that the hospital would benefit from regular review by peer bodies of the surgeon's level of skills. Inadequate skills are more likely to fester in regional hospitals were the level of informal peer influence is likely to be less. It would be worthwhile, for example, for there to be regular validation of surgical skills in surgical skills laboratories and the concept of mobile review by senior experienced surgical colleagues would permit a prompt, rapid and focussed response to complaints about particular problems or surgical outcomes.

1.1.2 Interview Feedback Relating to Dr Patel Clinical Performance

During the interviews with staff who had observed Dr Patel operating, the Review Team sought information regarding their observations of Dr Patel's surgical technique and performance. Many provided comments including the following:

- Wound closure techniques,
- Infection control practices
- Didn't close wounds in layers and opted for 'mass closures'
- Sutured too 'tight'
- Performed bowel anastomosis with suture material and sutures were spaced 'too far apart'
- 'Coughed and wiped his nose with a gloved hand'
- Operating with 'active dermatitis of his arms'.

Dr Patel is said by some to have been a fast surgeon and have reasonable technique with some of the 'basic stuff' though from the information gathered during interviews by the Review Team it was reported that he didn't 'protect

the bowel' nor was he considered as meticulous in his dissection of vital structures as other surgeons were considered to have been though 'he was better than others'.

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

It was not possible to form an objective opinion on the reported concerns regarding Dr Patel's surgical technique from a clinical case chart review.

From: "Peter Dwyer" <Peter.Dwyer@CrownLaw.qld.gov.au>
To: "Peter Crofts" <Peter_Crofts@health.qld.gov.au>
Date: 06/06/2005 17:53:54
Subject: RE: Inquiry - Review team interim report

Peter

Thanks for following this up.

When the interim report is ready, in accordance with the process we have established with the Commission could you please forward it on to me and I will send it on to the Commission under the cover of a letter (and provide a copy to our Counsel at the same time). The interim report falls within item 6 of the Commission's request of 11 May 2005 as well as the summonses dated 18 May 2005 served on each member of the review team and this will be the formal basis upon which the report will be provided to the Commission.

As an interim report, there will no doubt be certain qualifiers to any findings. Could you please give me instructions in that regard, so that can be addressed in my letter in my letter.

Regards

Peter

Peter Dwyer
Principal Lawyer
Queensland Health - Bundaberg Hospital Inquiry Team
Crown Law
Phone: 323 96169
Fax: 322 47431
Email: peter.dwyer@crownlaw.qld.gov.au

-----Original Message-----
From: Peter Crofts [mailto:Peter_Crofts@health.qld.gov.au]
Sent: Monday, 6 June 2005 4:38 PM
To: Peter Dwyer
Cc: Geraldine Weld; Leanne Patton; Peter Brockett; boddice@qldbar.asn.au
Subject: Re: Inquiry - Review team interim report

Peter - I have spoken with Leeanne Patton who is assisting the review team to edit the interim report. I have also spoken with Dr Mattiussi. The most likely ETA is tomorrow morning. David Andrews rang me this afternoon to ask about the progress of the report and I have left a message at his chambers as above. Leanne - we will have to provide a copy of the report as a PDF as well as in hard copy - the 'draft' watermark is important. We can expect that the report will be published by the BCI. Regards Peter Crofts GC

>>> "Peter Dwyer" <Peter.Dwyer@crownlaw.qld.gov.au> 06/06/05 02:11pm >>>
Peter

You said in the meeting that the interim report may be completed this
afternoon. Could you follow this up and let me know the current status
by close of business today. In our communications with the

Commission,
we indicated that the review team expected to have finalised the interim
report by 3.6.05.

Thanks

Peter

Peter Dwyer
Principal Lawyer
Queensland Health - Bundaberg Hospital Inquiry Team
Crown Law
Phone: 323 96169
Fax: 322 47431
Email: peter.dwyer@crownlaw.qld.gov.au

If you are not the intended recipient(s), or if you have received this email in error, you are asked to immediately notify the sender by telephone or by return email. You should also delete this email and destroy any hard copies produced.

****
****

****

****

CC: "Geraldine Weld" <Geraldine_Weld@health.qld.gov.au>, "Leanne Patton" <Leanne_Patton@health.qld.gov.au>, "Peter Brockett" <Peter_Brockett@health.qld.gov.au>, <boddice@qldbar.asn.au>

From: Leanne Patton
To: Peter Crofts; peter.dwyer@crownlaw.qld.gov.au
Date: 07/06/2005 9:52:42
Subject: Interim Report from Review Team

Dear Peters
Please find attached pdf version of Interim Report.

There are still a significant number of chart reviews to be completed. As a consequence 3.2 is only in the fledgling stages. The chart review will also alter risk management and other sections once completed. Obviously the conclusion and exec summary can not be completed until the rest of the document is finalised.

I have a hard copy available- where should I deliver it to?
Kind Regards
Leanne
Principal Project Offier
Bundaberg Review Team
323 40323

From: Peter Crofts
To: Leisa Elder
Date: 07/06/2005 13:09:07
Subject: Fwd: Interim Report from Review Team

Leisa -
Attached is a copy of the Bundy review team interim report. This is an draft report and is not finished. A copy has been provided to CLO for Morris. We have no idea if this is going to be published but it is a safe bet that it will. Steve is across its content.
Regards
Peter Crofts GC

CC: Catherine Flynn; Geraldine Weld; Jill Pfingst; Katherine Curnow; Leanne Chandler; Penelope Eden; Peter Brockett

Crown Law
Queensland Government

Your ref:
Our ref: CS5/HEA027/5744/DZP
Contact: Peter Dwyer
Direct ph: (07) 323 96169
Direct fax: (07) 3224 7431

Department of
Justice and Attorney-General

7 June 2005

Mr A S Stella
Solicitor to Commission of Inquiry
Bundaberg Hospital Commission of Inquiry
Level 9
Brisbane Magistrates Court
363 George Street
BRISBANE Q 4000

Dear Mr Stella

Interim report – Bundaberg Hospital Review Team

Further to your letter of request dated 11 May 2005 (item 6), I enclose a copy of the draft interim report of the "Review of Clinical Services Bundaberg Base Hospital" undertaken by Drs Mattiussi and Wakefield and Associate Professors Woodruff and Hobbs. I note that the interim report is also the subject of summonses dated 18 May 2005 served on each member of the review team.

As is clear on the face of the document, the review team emphasise that the report is not yet finalised and so some of its content, including findings, may change in the course of finalising the report.

Yours faithfully

Peter Dwyer
Principal Lawyer
for **Crown Solicitor**

encl

State Law Building
50 Ann Street Brisbane
GPO Box 149 Brisbane
Queensland 4001 Australia
Dx 40121 Brisbane Uptown
CDE D38
Telephone 07 3239 6703
Facsimile 07 3239 0407
ABN 13 846 673 994

From: Peter Crofts
To: Leisa Elder
Date: 07/06/2005 13:09:07
Subject: Fwd: Interim Report from Review Team

Leisa -
Attached is a copy of the Bundy review team interim report. This is an draft report and is not finished. A copy has been provided to CLO for Morris. We have no idea if this is going to be published but it is a safe bet that it will. Steve is across its content.
Regards
Peter Crofts GC

CC: Catherine Flynn; Geraldine Weld; Jill Pfingst; Katherine Curnow; Leanne Chandler; Penelope Eden; Peter Brockett

From: Leanne Patton
To: peter.dwyer@crownlaw.qld.gov.au
Date: 10/06/2005 8:26:00
Subject: Tables as requested

Dear Peter
Please find attached tables from Peter - very much in draft form
Kind Regards
Leanne
323 40323

CC: Peter Crofts

From: Peter Crofts
To: Geraldine Weld; Katherine Curnow; Leanne Chandler; Penelope Eden; Peter Brockett
Date: 10/06/2005 8:54:30
Subject: Fwd: Tables as requested

Hi team - preliminary report from Woodruff re clinical review of Patel charts Pete

Bundaberg Hospital *Commission of Inquiry*

10 June 2005

Mr D K Boddice SC
Level 8
Inns of Court
107 North Quay
BRISBANE QLD

BY E-MAIL: BODDICE@QLDBAR.ASN.AU

Dear David

Bundaberg Hospital *Commission of Inquiry*

I understand that a team of four investigators engaged by Queensland Health has obtained some information from one of its members, Dr Woodruff about Dr Woodruff's findings in relation to a number of clinical notes which he has reviewed.

I would appreciate it if I could be supplied with those findings in respect of the patients reviewed to date by Dr Woodruff.

I understand that in its thoroughness the review team would prefer for Dr Woodruff to continue reviewing many more files relating to the Bundaberg Base Hospital, and to complete his report after reviewing all those files.

Because the Inquiry Team must assemble evidence for the Commission before it gets to Bundaberg, I ask for the preliminary findings.

I understand that the review team desires also that Dr Woodruff provide some commentary in respect of a number of files he has completed reviewing. I would be very pleased to have that commentary as soon as it is available.

I understand that Dr Woodruff has attempted to find the file of one Chris Sniff for the purpose of review. I would be pleased if Dr Woodruff would review that file too as soon as it is located.

Yours faithfully

David Andrews
Counsel Assisting the Commission of Inquiry

Commissioner
Anthony Morris QC
Deputy Commissioners
Sir Llewellyn Edwards AC
Margaret Vider RN
Counsel Assisting
David Andrews SC
Errol Morzone
Damien Atkinson
Secretary
David Groth

Level 9
Brisbane Magistrates Court
363 George Street
Brisbane Qld 4000
PO Box 13147
George Street Qld 4003
Telephone: 07 3109 9150
Facsimile: 07 3109 9151.
Toll Free No: 1800 610 558
Email:
bhci@bhci.qld.gov.au
Website:
www.bhci.qld.gov.au

From: "Peter Dwyer" <Peter.Dwyer@CrownLaw.qld.gov.au>
To: "Geraldine Weld" <Geraldine_Weld@health.qld.gov.au>
Date: 15/06/2005 7:31:59
Subject: FW: BHCI-#434-v1-David_Boddice_re_Dr_Woodruff.DOC

This was the letter Andrews sent to Boddice requesting Dr Woodruff's preliminary findings.

My letter sent to Andrews at around 6:45pm yesterday was in response to the attached letter.

Peter

Peter Dwyer
Principal Lawyer
Queensland Health - Bundaberg Hospital Inquiry Team
Crown Law
Phone: 323 96169
Fax: 322 47431
Email: peter.dwyer@crownlaw.qld.gov.au

-----Original Message-----
From: Peter Dwyer
Sent: Friday, 10 June 2005 2:46 PM
To: 'Peter Crofts'
Cc: 'Mark_Mattiussi@health.qld.gov.au'
Subject: FW: BHCI-#434-v1-David_Boddice_re_Dr_Woodruff.DOC

Peter

See attached request that David Boddice received from David Andrews. This seems to be in confirmation of his verbal request for Dr Woodruff's interim "findings" from charts he had reviewed to date.

Boddice said to Andrews that we would get back to him first thing on Tuesday in response to his request (which Andrews was happy with). As result, I have not provided the table as yet. Before I do (which will be Tuesday am) I would like to get Mark's instructions regarding the "commentary" which Dr Woodruff has been asked to provide in relation to these cases. I believe these are the "case summaries" Mark mentioned to me when we spoke this morning. I understood from Mark that these are a little way off but obviously the Commission are hoping it will be sooner rather than later.

Perhaps Mark could make contact with Dr Woodruff over the weekend and come back to you or me first thing Tuesday.

Just to confirm that I am away for the weekend but I'm likely to come back in to the office Monday pm.

Regards

Peter

Peter Dwyer
Principal Lawyer
Queensland Health - Bundaberg Hospital Inquiry Team
Crown Law
Phone: 323 96169

Fax: 322 47431
Email: peter.dwyer@crownlaw.qld.gov.au

-----Original Message-----
From: David Boddice [mailto:boddice@qldbar.asn.au]
Sent: Friday, 10 June 2005 2:12 PM
To: Peter Dwyer
Subject: FW: BHCI-#434-v1-David_Boddice_re_Dr_Woodruff.DOC

-----Original Message-----
From: Merilyn Carter [mailto:Merilyn.Carter@BHCI.qld.gov.au]
Sent: Friday, 10 June 2005 1:59 PM
To: David Boddice
Subject: BHCI-#434-v1-David_Boddice_re_Dr_Woodruff.DOC

Dear Mr Boddice,

Please find attached letter from David Andrews at the Bundaberg Hospital Commission of Inquiry.

Yours faithfully

For David Andrews. <<BHCI-#434-v1-David_Boddice_re_Dr_Woodruff.DOC>>

From: Geraldine Weld
To: Uschi.Schreiber@premiers.qld.gov.au
Date: 16/06/2005 9:15:00
Subject: Review Committee Report

Dear Uschi

1. The interim Review Committee report was sent to the COI on 7 June 2005. See attached letter dated 7 June 2005.

2. The 2 page Woodruff report was sent to the COI by fax 6.43 pm on 14 June 2005 and then sent by email to Tony Stella at the COI. See attached fax sheet and letter from Crown Law to COI.

David Andrews SC advised Crown Law last week that Dr Woodruff had produced this report and asked for a copy. This was obtained from Ms Leanne Patton, who is assisting the Review Committee and sent to the COI on 14 June 2005.

The letter sending the report states that the document is a preliminary report in relation to 124 charts.

3. Dr Woodruff is preparing the chart reviews and his review will form part of the Review Committee report. In the draft report it appears on page 36. It states that the total number of charts to be reviewed is 249.

4. As at 10 June 2005 Dr Woodruff had reviewed 124 of a total 221 charts he is reviewing. It is expected that he will finish his review this week. Other members of the Review Committee (Dr Mattuissi and Dr Wakefield) are reviewing 30 charts. This will result in a total of 251 charts being reviewed.

Regards
Geraldine Weld
Special Project Officer
Commission of Inquiry Team
Queensland Health
Ph: 3234 1166
Fax: 3234 1482

email: Geraldine_Weld@health.qld.gov.au

CC: Jill Pfingst

BR022521

Queensland Government
Queensland Health

A BRIEFING TO THE DIRECTOR-GENERAL

BRIEFING NOTE NO:

REQUESTED BY: Dr Steve Buckland

DATE: 16 June 2005

PREPARED BY: Geraldine Weld, Registrar, Commission of Inquiry Team, Queensland Health GW.

CONSULTATION WITH:

CLEARED BY:

DEADLINE: 17 June 2005

SUBMITTED THROUGH: Jill Pfingst, Executive Manager, Executive Services

SUBJECT: **Provision of** the Bundaberg Review Team Draft **Report -** *"Review of Clinical Services Bundaberg Base Hospital"* **- to the Commission of Inquiry**

DIRECTOR-GENERAL'S COMMENTS:

Noted - actions ① Copy to Minister
② Copy to ADG DPC
Thanks

Note interim report was at request of COI as was Dr Woodruff's report

Keep copy in office for reference

Buckland

DR STEVE BUCKLAND
Director-General

18/6/05

PURPOSE:

To outline events surrounding the provision of the Bundaberg Review Team draft report "*Review of Clinical Services Bundaberg Base Hospital*" to the Commission of Inquiry (COI).

BACKGROUND:

Queensland Health received a letter on 13 May 2005 from the COI dated 11 May 2005 ("11 May letter") to provide items including but not limited to:

6. *All documents, including electronic communications, relating to the investigation by Drs Mattiussi, Woodruff, Wakefield and Associate Professor Hobbs including:*
    a) *All briefing notes to the Honourable the Premier and the Honourable the Minister for Health;*
    b) *Any documents relating to their appointment;*
    c) *Any documents prepared in the course of that investigation;*
    d) ***Any interim reports prepared by that investigation;***
    e) *Any witness statements or records of interview taken by that investigation;*
    f) *Any diary notes, memoranda, or electronic communications prepared in the course of that investigation.*

As at 13 May 2005 the Bundaberg Review Team had commenced but not finalised their review. Therefore, the Department collected copies of all documents held by the Bundaberg Review Team and provided these to the COI as at 26 May 2005, when it provided copies of all documents which fell within the categories identified in the 11 May letter. In order to allow the Bundaberg Review Team to continue its review, no further documents will be taken from the Bundaberg Review Team until they have finished their review and provided their report. At that time, the Department will provide copies of all documents held by the Bundaberg Review Team to the COI, in order to satisfy the COI request contained in the 11 May letter.

The Bundaberg Review Team report was also the subject of a summons dated 18 May 2005 served on each member of the Bundaberg Review Team.

On or about 6 June 2005 the COI asked the Department's lawyers when the Bundaberg Review Team Report would be available. The Department advised on that day that an interim draft report would be available on 7 June 2005.

Events thereafter are as follows:

- Leanne Patton, Principal Project Officer, Bundaberg Review Team provided the Bundaberg Review Team interim report to lawyers acting for the Department (Peter Crofts, Director LALU and Peter Dwyer, Crown Law) on 7 June 2005. See attached email dated 7 June 2005 (Attachment 1).

- The Bundaberg Review Team interim report was sent by Crown Law to the COI on 7 June 2005, in accordance with the protocol established by the Department for providing documents to the COI. See attached letter dated 7 June 2005 (Attachment 2).

- Following a request from the COI on 8 June 2005, Crown Law asked Leanne Patton for an estimated date for completion of the final version of the Bundaberg Review Team report (Attachment 1).

- Leanne Patton advised Crown law that the anticipated completion date is 30 June 2005. She noted that one of the Bundaberg Review Team members, Dr Peter Woodruff, had a number of chart reviews to complete (Attachment 1).

- On 9 June 2005, the Department understands that Mr Andrews SC, Counsel assisting the COI contacted the Department's legal counsel, Mr Boddice SC and advised him of the existence of a summary prepared by Dr Woodruff and sought a copy of this summary which the COI understood Dr Woodruff had provided to the Department. Mr Boddice asked for the request to be made in writing. See attached letter dated 10 June 2005 (Attachment 3).

- Crown Law sought this information from the Bundaberg Review Team and Leanne Patton provided the information, a two page summary by Dr Woodruff, to Crown Law on 10 June 2005. See email dated 10 June 2005 (Attachment 4).

- Crown Law provided the information to the COI by fax and email on 14 June 2005 at approximately 6.43 pm. See attached letter (Attachment 5)

- On the morning of 16 June 2005 I was contacted by Ms Schreiber, Acting Director General of the Department of Premier and Cabinet (DPC) with a request to advise her on the history of provision of the Bundaberg Review Team draft report to the COI and I advised her by email. See email dated 16 June 2005 (Attachment 6).

KEY ISSUES:

- The Department is under an obligation, as set out in the 11 May letter from the COI, to provide copies of any documents relating to the Bundaberg Review Team processes. In accordance with this duty, the subject documents were provided to the COI as soon as the Bundaberg Review Team interim report was available and as soon as the COI advised the Department's legal advisers of the existence of the 2 page summary by Dr Woodruff.

- The Department, at the request of DPC, set up a steering committee to steer the Department responses to the COI, the Forster Review and the CMC investigations relating to Bundaberg Health Services. DPC requested that it be advised of any documents provided to the COI. In accordance with this request:

    - A copy of the Bundaberg Review Team interim draft report was provided to Ms Schreiber by email on 7 June 2005. See email dated 7 June 2005 (Attachment 7).

    - A copy of the 2 page summary by Dr Woodruff was provided to Ms Schreiber and Dr Leo Keliher, Director General of DPC at the Steering Committee meeting on Friday, 10 June 2005.

RELATED ISSUES:

N/A

BENEFITS AND COSTS:

N/A

ACTIONS TAKEN/ REQUIRED:

No action required.

ATTACHMENTS:

Attachment 1	E-mail 7 June 2005 - Leanne Patton to lawyers acting for the Department. E-mail 8 June 2005 - Crown Law to Leanne Patton E-mail 9 June 2005 - Leanne Patton to Crown law
Attachment 2	Letter from COI to Mr David Boddice re summary prepared by Dr Woodruff
Attachment 3	Letter from Crown Law to COI dated 7 June 2005 re Bundaberg Review Team interim report
Attachment 4	E-mail from Leanne Patton to Crown Law dated 10 June 2005 re the two page summary by Dr Woodruff.
Attachment 5	letter Crown Law to the COI 14 June 2005
Attachment 6	email dated 16 June 2005 Geraldine Weld to Ms Schreiber, re the history of provision of the draft report to the COI
Attachment 7	Email Jill Pfingst to Ms Schreiber dated 7 June 2005 re provision of the Bundaberg Review Team interim draft report

From: Leanne Patton
To: Peter Dwyer
Date: 6/9/05 8:42am
Subject: RE: Interim Report from Review Team

Dear Peter

At this time we don't anticipate having our final report available until our due date 30th June 2005.

Peter Woodruff still has a significant number of charts to review (approx 100) which he is in the process of doing now. Peter is currently reviewing charts whilst he is on long service leave. Until Peter has finished his chart review and the data has been analysed, there are several sections of the report which can not be written.

I have validated the above with Mark Mattiussi this morning.

Kind Regards
Leanne
323 40323

>>> "Peter Dwyer" <Peter.Dwyer@CrownLaw.qld.gov.au> 06/08/05 06:49pm >>>

Leanne

Does the review team have an estimated time for completion of the final report?

Is there any possibility that it would be finalised by the start of the Bundaberg sittings of the inquiry (20/6/05)?

Peter

Peter Dwyer
Principal Lawyer
Queensland Health - Bundaberg Hospital Inquiry Team
Crown Law
Phone: 323 96169
Fax: 322 47431
Email: peter.dwyer@crownlaw.qld.gov.au
-----Original Message-----
From: Leanne Patton [mailto:leanne_patton@health.qld.gov.au]
Sent: Tuesday, 7 June 2005 9:52 AM
To: Peter Dwyer; Peter Crofts
Subject: Interim Report from Review Team

Dear Peters
Please find attached pdf version of Interim Report.

There are still a significant number of chart reviews to be completed. As a consequence 3.2 is only in the fledgling stages. The chart review will also alter risk management and other sections once completed. Obviously the conclusion and exec summary can not be completed until the rest of the document is finalised.

I have a hard copy available- where should I deliver it to?
Kind Regards
Leanne
Principal Project Offier
Bundaberg Review Team
323 40323

Crown Law
Queensland Government

Your ref:
Our ref: CS5/HEA027/5744/DZP
Contact: Peter Dwyer
Direct ph: (07) 323 96169
Direct fax: (07) 3224 7431

Department of
Justice and Attorney-General

7 June 2005

Mr A S Stella
Solicitor to Commission of Inquiry
Bundaberg Hospital Commission of Inquiry
Level 9
Brisbane Magistrates Court
363 George Street
BRISBANE Q 4000

Dear Mr Stella

Interim report – Bundaberg Hospital Review Team

Further to your letter of request dated 11 May 2005 (item 6), I enclose a copy of the draft interim report of the "Review of Clinical Services Bundaberg Base Hospital" undertaken by Drs Mattiussi and Wakefield and Associate Professors Woodruff and Hobbs. I note that the interim report is also the subject of summonses dated 18 May 2005 served on each member of the review team.

As is clear on the face of the document, the review team emphasise that the report is not yet finalised and so some of its content, including findings, may change in the course of finalising the report.

Yours faithfully

Peter Dwyer
Principal Lawyer
for **Crown Solicitor**

encl

State Law Building
50 Ann Street Brisbane
GPO Box 149 Brisbane
Queensland 4001 Australia
Dx 40121 Brisbane Uptown
CDE D38
Telephone 07 3239 6703
Facsimile 07 3239 0407
ABN 13 846 673 994

Document No.: 1161968

Bundaberg Hospital *Commission of Inquiry*

10 June 2005

Mr D K Boddice SC
Level 8
Inns of Court
107 North Quay
BRISBANE QLD

BY E-MAIL: BODDICE@QLDBAR.ASN.AU

Dear David

Bundaberg Hospital *Commission of Inquiry*

I understand that a team of four investigators engaged by Queensland Health has obtained some information from one of its members, Dr Woodruff about Dr Woodruff's findings in relation to a number of clinical notes which he has reviewed.

I would appreciate it if I could be supplied with those findings in respect of the patients reviewed to date by Dr Woodruff.

I understand that in its thoroughness the review team would prefer for Dr Woodruff to continue reviewing many more files relating to the Bundaberg Base Hospital, and to complete his report after reviewing all those files.

Because the Inquiry Team must assemble evidence for the Commission before it gets to Bundaberg, I ask for the preliminary findings.

I understand that the review team desires also that Dr Woodruff provide some commentary in respect of a number of files he has completed reviewing. I would be very pleased to have that commentary as soon as it is available.

I understand that Dr Woodruff has attempted to find the file of one Chris Sniff for the purpose of review. I would be pleased if Dr Woodruff would review that file too as soon as it is located.

Yours faithfully

David Andrews
Counsel Assisting the Commission of Inquiry

Commissioner
Anthony Morris QC

Deputy Commissioners
Sir Llewellyn Edwards AC
Margaret Vider RN

Counsel Assisting
David Andrews SC
Errol Morzone
Damien Atkinson

Secretary
David Groth

Level 9
Brisbane Magistrates Court
363 George Street
Brisbane Qld 4000

PO Box 13147
George Street Qld 4003

Telephone: 07 3109 9150
Facsimile: 07 3109 9151

Toll Free No: 1800 610 558

Email:
bhci@bhci.qld.gov.au

Website:
www.bhci.qld.gov.au

From: Leanne Patton
To: peter.dwyer@crownlaw.qld.gov.au
Date: 10/06/2005 8:26:00
Subject: Tables as requested

Dear Peter
Please find attached tables from Peter - very much in draft form
Kind Regards
Leanne
323 40323

CC: Peter Crofts

Tables: Summary of Charts Reviewed to Date

Patients Referred to the Coroner: Kemps (Bundaberg), Walk (Brisbane)

Patients where Chart Review requested by the Coroner: Dorron, Gautray

Did Patel Contribute to Adverse Outcome

Selection Value	Count
Total	124
Maybe	13
No	98
Yes	13

Yes: Bellamy, Blight, Bramich, Connors, Cox, Fleming, Grave, Johnson, Paul Jones, Kemps, Mobbs, Nagle, Phillips

Maybe: Daisey, Delaney, Dorron, Gautray, Grealish, Leonard Green, Anita Jones, McDonald, Pancheri, Parsons, Harold Roach, Slater, Walk

Was Patel Outside of Expertise Scope

Selection Value	Count
Total	124
Maybe	4
No	116
Yes	4

Yes: Grave, Kemps, Phillips, Tebbit

Maybe: Deakin, Gautray, Leonard Green, Slater

Was Patient Management Reasonable

Selection Value	Count
Total	124
Maybe	14
No	11
Yes	99

No: Bellamy, Bramich, Cox, Dewitt, Grave, Anita Jones, Paul Jones, Kemps, Mobbs, Nagle, Phillips

Maybe: Blight, Connors, Daisey, Deakin, Dorron, Fleming, Gautray, Leonard Green, Barry Johnson, Mc Donald, Pancheri, Harold Roach, Slater, Walk

14/06/2005 18:43
4OLP00044
TC:107658

REMOTE STATION	START	TIME	Pages	RESULT	REMARKS
031099151	14-06 18:43	00:00 30	004/004	OK	

REMARKS TMR:Timer, POL:Poll, TRN:Turn around, 2IN:2in1 Tx, ORG:Original size set, DPG:Book Tx
FME:Frame erase Tx, MIX:Mixed original, CALL:Manual-Com, KRDS:KRDS,FWD:FORWARD
FLP:Flip Side 2, SP:Special Original
FCODE:Fcode, MBX:Confidential, BUL:Bulletin, RLY:Relay, RTX:Re-Tx, PC:PC-FAX
S-OK:Stop communication, Busy:Busy, Cont.:Continue, No ans:No answer
M-full:Memory full, PW-OFF:Power switch OFF, TEL:Rx from TEL

Crown Law
Queensland Government

Your ref:
Our ref: CPS/HEA027/5744/DZP
Contact: Peter Dwyer
Direct ph: 3239 6169
Direct fax: 323 96386

Department of Justice and Attorney-General

14 June 2005

Mr David Andrews SC
Counsel Assisting the Commission of Inquiry
Bundaberg Hospital Commission of Inquiry
Level 9
Brisbane Magistrates Court
363 George Street
BRISBANE Q 4000

Dear Mr Andrews

Request for preliminary findings of Dr Peter Woodruff

I refer to your letter dated 10 June 2005 to Mr David Boddice SC requesting the preliminary findings of Dr Peter Woodruff, a member of Queensland Health's Bundaberg Hospital review team, in relation to the clinical charts he has reviewed to date.

I now enclose a summary, in table form, of Dr Woodruff's preliminary findings in relation to 124 charts.

As regards your request for Dr Woodruff's commentary in respect of a number of the charts he has reviewed, I am still awaiting instructions on when this may be available. I expect to receive these instructions tomorrow.

I am instructed that your reference to "Chris Sniff" in the final paragraph of your letter was in fact meant to be to Chris "Smith". Another member of the review team spoke with Dr Woodruff earlier today in relation to his review of this patient's chart and I am instructed that Dr Woodruff provided the following summary:

- The patient had his surgery on 22 March 2004– bilateral inguinal hernia repair with insertion of mesh.

State Law Building
50 Ann Street Brisbane
GPO Box 149 Brisbane
Queensland 4001 Australia
Dx 40121 Brisbane Uptown
CDE D38
Telephone 07 3239 6703
Facsimile 07 3239 0407
ABN 13 846 673 994

Document No.: 1163947

Crown Law
Queensland Government

Your ref:
Our ref: CP5/HEA027/5744/DZP
Contact: Peter Dwyer
Direct ph: 3239 6169
Direct fax: 323 96386

Department of
Justice and Attorney-General

14 June 2005

Mr David Andrews SC
Counsel Assisting the Commission of Inquiry
Bundaberg Hospital Commission of Inquiry
Level 9
Brisbane Magistrates Court
363 George Street
BRISBANE Q 4000

Dear Mr Andrews

Request for preliminary findings of Dr Peter Woodruff

I refer to your letter dated 10 June 2005 to Mr David Boddice SC requesting the preliminary findings of Dr Peter Woodruff, a member of Queensland Health's Bundaberg Hospital review team, in relation to the clinical charts he has reviewed to date.

I now **enclose** a summary, in table form, of Dr Woodruff's preliminary findings in relation to 124 charts.

As regards your request for Dr Woodruff's commentary in respect of a number of the charts he has reviewed, I am still awaiting instructions on when this may be available. I expect to receive these instructions tomorrow.

I am instructed that your reference to "Chris Sniff" in the final paragraph of your letter was in fact meant to be to Chris "Smith". Another member of the review team spoke with Dr Woodruff earlier today in relation to his review of this patient's chart and I am instructed that Dr Woodruff provided the following summary:

- The patient had his surgery on 22 March 2004– bilateral inguinal hernia repair with insertion of mesh.

State Law Building
50 Ann Street Brisbane
GPO Box 149 Brisbane
Queensland 4001 Australia
Dx 40121 Brisbane Uptown
CDE D38
Telephone 07 3239 6703
Facsimile 07 3239 0407
ABN 13 846 673 994

- The patient was examined by Dr Barry O'Loughlin after referral from the Patient Liason Service in this year. The patient complained of ongoing pain which prevented him from caring for his acreage.

- On examination the patient was found to be tender over the left inguinal ring. The wound had healed as expected without breakdown on infection.

- Dr O'Loughlin ordered an ultrasound which showed some thickening of the spermatic cord vessel. There was no atrophy of the testicle on the left side. Dr O'Loughlin treated the patient for neuralgia by injecting hydrocortisone locally and suggested that if the neuralgia did not continue to subside the patient may need the mesh removed from the repair.

- Dr Woodruff indicated that the neuralgia may have occurred if the patient had been operated on by another general surgeon. As the patient was continuing to improve according to Dr O'Loughlin's notes, Dr Woodruff's overall summary of the surgical management of Mr Chris Smith is: "Maybe" Dr Patel contributed to the patient's "adverse outcome".

I will contact you tomorrow regarding Dr Woodruff's progress on his commentary in respect of certain charts.

Yours faithfully

Peter Dwyer
Principal Lawyer
for **Crown Solicitor**

encl

Tables: Summary of Charts Reviewed to Date

Patients Referred to the Coroner: Kemps (Bundaberg), Walk (Brisbane)

Patients where Chart Review requested by the Coroner: Dorron, Gautray

Did Patel Contribute to Adverse Outcome

Selection Value	Count
Total	124
Maybe	13
No	98
Yes	13

Yes: Bellamy, Blight, Bramich, Connors, Cox, Fleming, Grave, Johnson, Paul Jones, Kemps, Mobbs, Nagle, Phillips

Maybe: Daisey, Delaney, Dorron, Gautray, Grealish, Leonard Green, Anita Jones, McDonald, Pancheri, Parsons, Harold Roach, Slater, Walk

Was Patel Outside of Expertise Scope

Selection Value	Count
Total	124
Maybe	4
No	116
Yes	4

Yes: Grave, Kemps, Phillips, Tebbit

Maybe: Deakin, Gautray, Leonard Green, Slater

Was Patient Management Reasonable

Selection Value	Count
Total	124
Maybe	14
No	11
Yes	99

No: Bellamy, Bramich, Cox, Dewitt, Grave, Anita Jones, Paul Jones, Kemps, Mobbs, Nagle, Phillips

Maybe: Blight, Connors, Daisey, Deakin, Dorron, Fleming, Gautray, Leonard Green, Barry Johnson, Mc Donald, Pancheri, Harold Roach, Slater, Walk

From: Geraldine Weld
To: Uschi.Schreiber@premiers.qld.gov.au
Date: 16/06/2005 9:15:00
Subject: Review Committee Report

Dear Uschi

1. The interim Review Committee report was sent to the COI on 7 June 2005. See attached letter dated 7 June 2005.

2. The 2 page Woodruff report was sent to the COI by fax 6.43 pm on 14 June 2005 and then sent by email to Tony Stella at the COI. See attached fax sheet and letter from Crown Law to COI.

David Andrews SC advised Crown Law last week that Dr Woodruff had produced this report and asked for a copy. This was obtained from Ms Leanne Patton, who is assisting the Review Committee and sent to the COI on 14 June 2005.

The letter sending the report states that the document is a preliminary report in relation to 124 charts.

3. Dr Woodruff is preparing the chart reviews and his review will form part of the Review Committee report. In the draft report it appears on page 36. It states that the total number of charts to be reviewed is 249.

4. As at 10 June 2005 Dr Woodruff had reviewed 124 of a total 221 charts he is reviewing. It is expected that he will finish his review this week. Other members of the Review Committee (Dr Mattuissi and Dr Wakefield) are reviewing 30 charts. This will result in a total of 251 charts being reviewed.

Regards
Geraldine Weld
Special Project Officer
Commission of Inquiry Team
Queensland Health
Ph: 3234 1166
Fax: 3234 1482

email: Geraldine_Weld@health.qld.gov.au

CC: Jill Pfingst

From: Jill Pfingst
To: uschi.schreiber@premiers.qld.gov.au
Date: 7/06/2005 3:07:53 pm
Subject: Fwd: Interim Report from Review Team

Uschi
Here is a copy of the interim report from the Bundaberg Review Team. It has already gone to Mr Morris.
Regards
JILL

Jill Pfingst
Executive Manager
Director-General's Office
Queensland Health
email jill_pfingst@health.qld.gov.au
Telephone 32341177

From: Leanne Patton
To: Peter Dwyer; peter.dwyer@crownlaw.qld.gov.au
Date: 23/06/2005 8:08:18
Subject: As requested

Dear Peter
Information as requested. Please note the content may change. Pter Woodruff is giving me more amendments today after overnight editing.
Kind Regards
Leanne

CC: Mark Mattiussi; Peter Crofts