**QUEENSLAND**

***COMMISSIONS OF INQUIRY ACT 1950***

**QUEENSLAND PUBLIC HOSPITALS COMMISSION OF INQUIRY**

**STATEMENT OF DR DARREN WILLIAM KEATING**

1. I, **DARREN WILLIAM KEATING**, Director of Medical Services, of Bundaberg Hospital, Bourbong Street, Bundaberg, in the State of Queensland, state as follows:-

## QUALIFICATIONS AND EXPERIENCE

2. I was awarded the degrees of Bachelor of Medicine and Bachelor of Surgery from the University of Melbourne in 1986. I attained a Masters degree in Health Service Management from Charles Sturt University in 2001. I am also a Fellow of the Royal Australasian College of Medical Administrators. I achieved that fellowship in 2004. A copy of my curriculum vitae is attached and marked **DWK1**.

3. I was appointed to the position of Director of Medical Services at the Bundaberg Health Service District on 21 January 2003 and commenced in that position on 14 April 2003. As I recall, the position was advertised in national newspapers.

4. The recruitment process in respect of my appointment to the position of Director of Medical Services was a lengthy one. I recall having applied sometime in September or October 2002 and not being interviewed until sometime in January 2003. The interview panel consisted of Peter Leck, District Manager, Dr Mark Mattiussi, the then Director of Medical Services at Redcliffe-Caboolture Health Service District, Ms Janet Tallon, then a member of the District Health Council and a person from the University of Queensland, Central Queensland Division, who I think was Associate Professor John Birks. I was subsequently offered the position, which I accepted sometime in January 2003. A copy of the position description, Director of Medical Services, is attached and marked **DWK2**.

.....D Keating.....

**DARREN WILLIAM KEATING**

5. On commencing employment I received no formal or informal orientation or training from Queensland Health. Following my arrival at the Hospital, I was provided with a brief handover from Dr Kees Nydam, who had been Acting Director of Medical Services prior to my appointment. I had a walking tour of the Hospital meeting a number of staff and met some of the senior medical staff at a lunch-time meeting. Subsequently I arranged meetings with the directors of the various clinical departments. Dr Nydam informed me that Dr Jayant Patel was the Director of Surgery and when I met Dr Patel he held that position.

**MEDICAL ADMINISTRATION**

6. As is apparent from my curriculum vitae, I have worked in clinical roles for in excess of 10 years. Areas of practice included internal medicine, emergency medicine, and general practice, predominantly in regional and rural areas. While in the Australian Army, I provided general practice services and support in Somalia and hospital services and support in East Timor. I continued clinical practice in Port Hedland at the regional hospital.

7. The position which I held immediately before my appointment at Bundaberg Base Hospital was as the Senior Medical Officer at the Port Hedland Regional Hospital in Western Australia, a hospital of about 90 beds. My duties and responsibilities included clinical and administrative duties. I reported to the General Manager and to the Director of Medical Services of the North-West region.

8. In 1997 I commenced study for a Master's degree in Health Service Management. Since that time I have worked predominantly in administration roles both in the Army and in public hospitals.

9. The increasing complexity of health care systems and institutions has necessitated specialised management for the co-ordination of services of highly trained personnel. Also costly technology must be used in the most effective and efficient way and the quality of health services must be continuously improved. Challenges include the aging of the population,

.....

**DARREN WILLIAM KEATING**

increasing demand for services, (including elective surgery, emergency care and mental health), reducing resources and work force shortages. These changes and challenges result in the need for trained health care managers who combine the skills and training derived from the discipline of medicine as well as those derived from the techniques of management. Consequently, medical administration is a specialist field in itself requiring post-graduate study and experience in the field and fellowship of the Royal Australasian College of Medical Administrators.

10. Bundaberg Hospital is of a sufficient size that it requires a Director of Medical Services who does not perform clinical duties.

11. In smaller hospitals in rural areas, the Medical Superintendents are responsible for administration and clinical roles. In those hospitals, because of the lack of specialist support, the Medical Superintendent's clinical duties may include general surgical procedures, obstetrics and gynaecology, anaesthesia and emergency medicine as well as normal general practice duties for inpatients and outpatients. The extent of the duties assumed will depend on the experience and training of the Medical Superintendent who will usually be a general practitioner and not a specialist.

12. In a regional hospital the size of Bundaberg with responsibility for the provision of specialist services comprising medical, surgical, paediatrics, emergency, intensive/coronary care, renal, orthopaedics, diabetes, obstetrics and gynaecology, oncology, rehabilitation and mental health services, the Director of Medical Services is not in a position to engage in clinical services. Each area of practice has its own senior practitioner who manages and controls the patient care in his or her department.

13. Each of those department heads reports to and is responsible to the Director of Medical Services.

14. The Director of Medical Services is responsible for not only medical staff of the Bundaberg Hospital but also those in Childers and Gin Gin Hospitals, and Mt Perry Health Centre.

.....

**DARREN WILLIAM KEATING**

15. The annual budget of Bundaberg Health Services District is in the order of $56million. The District has approximately 850 employees including medical practitioners. Approximately 85 of the employees including 65 medical practitioners reported to me.

16. As a medically qualified administrator I provided informed medically oriented advice, supervision and assistance in:-

    (a) advice to the District Manager and other Directors (such as the Director of Nursing) for planning and review purposes and policy implementation;

    (b) monitoring of health service outcomes;

    (c) dealing with complaints and medico-legal issues;

    (d) recruitment and selection of medical staff;

    (e) quality assurance;

    (f) co-ordination, review and disciplining of medical staff;

    (g) communication with external organisations such as universities, the ambulance service, general practitioners and other hospitals.

17. An example of the need for a medically qualified administrator is the management of medico-legal claims. In managing these claims I ensure that all necessary documentation and information is provided to the lawyers engaged for the Health Service. I also attend meetings with the lawyers, settlement conferences and mediations to provide instructions and advice. My medical training and experience enables me to ensure that appropriate advice and instructions are given to lawyers. In the absence of a medically qualified administrator, the head of the relevant clinical department would be required to perform these duties thus reducing the time he or she has available for clinical duties.

18. My duties at Bundaberg Hospital included:-

.....

**DARREN WILLIAM KEATING**

- frequent and regular meetings of committees consisting of medical, nursing, administrative and allied health staff. I estimate that I was a member of approximately 20 committees which met on a weekly to monthly basis;

- meetings in person or by telephone with individuals on issues of my or their choice;

- visiting the various departments such as pharmacy, radiology, the elective surgery office in the operating theatre block and the emergency department.

19. A typical working week would comprise of approximately 5 hours preparing for and attending committee meetings, 3 to 4 hours in staff interviews, about 7 to 8 hours investigating and responding to patient complaints and patient travel subsidy issues, 3 hours attending to staff recruitment and the balance dealing with rostering, correspondence and emails, reports, briefs and submissions to Queensland Health management.

20. Consequently, I was in constant contact with clinical staff where issues of concern might be raised. If necessary, arrangements could be made for issues to be discussed confidentially.

**CIRCUMSTANCES OF THE EMPLOYMENT OF DR PATEL BY QUEENSLAND HEALTH AND THE APPOINTMENT OF DR PATEL TO THE BUNDABERG HOSPITAL**

21. By the time I had commenced employment at the Bundaberg Hospital, Dr Patel had already been employed by Dr Nydam as a Senior Medical Officer – Surgery. He had also been appointed to the position of Director of Surgery. I had no involvement in this process. As far as I can recall there was no further documentation or processing of that appointment as suggested by Dr Nydam in paragraph 35 of his statement. (Exhibit 51)

22. Shortly after the commencement of my employment, I was involved in the appointment of an accountable officer of Operating Theatres. This

.....

**DARREN WILLIAM KEATING**

appointment was made in accordance with the Queensland Health guidelines, which arose out of a review of the Cairns Hospital operating theatres. The appointment did not involve any additional financial remuneration, but rather extra administrative responsibilities upon the appointee.

23. Three people were considered for the position, being Dr Martin Carter, Director of Anaesthetics and Intensive Care Unit; Jenny White, the then Nurse Unit Manager of the Operating Theatres; and Dr Patel in his capacity as Director of Surgery. I discussed the appointment with Dr Carter and Dr Patel. I also had a discussion with Peter Leck. I believe that Glennis Goodman, the then Director of Nursing, discussed the appointment with Jenny White. All of those persons were in agreement that Dr Patel be offered the position. He was seen as hardworking, enthusiastic and willing to work towards improving the elective surgery service by reducing cancellations and maximising theatre usage thus having a positive effect on the operating theatre staff.

24. When Dr Patel arrived at the Hospital it was struggling to achieve its elective surgery target. In the past, the Hospital had failed to achieve the elective surgery target resulting in a reduced funding allocation for the next financial year. There was also significant pressure to reduce the size of elective surgery waiting lists. This pressure arose in the form of increasing overall time spent by patients on the waiting lists, increasing numbers of people on the waiting lists and numerous complaints by patients' relatives and local Members of Parliament.

25. Elective surgery encompasses virtually all surgery other than emergency surgery for acute surgical conditions (such as injuries sustained in motor vehicle accidents) or severe immediately life threatening conditions. Elective surgery includes surgical treatment of patients with potentially fatal illnesses such as cancer where delay in treatment can result in death, treatment of patients in severe pain (such as those needing joint replacements), hernia repair and removal of a person's gall bladder.

.....D Keating.....

**DARREN WILLIAM KEATING**

26. Dr Patel appeared to have an understanding of these multiple pressures and worked hard to reduce elective surgery waiting lists. In conjunction with another overseas-trained doctor, Dr James Gaffield, he also assisted in the reduction of the outpatient waiting lists, being those patients waiting to be seen by a surgeon for an opinion as to future treatment. Many of these patients had been on the waiting list for 2 to 3 years. There was no financial benefit to the hospital in reducing these waiting lists. While it resulted in more patients being available for surgery it also made it more difficult to meet the performance indicators (as determined by Queensland Health) in relation to the length of wait before surgery.

**UNIVERSITY OF QUEENSLAND, SCHOOL OF MEDICINE APPOINTMENT**

27. In or around September 2003, I was informed by Associate Professor John Birks, the University of Queensland Regional Head, that the university was seeking to make an appointment to the position of Academic Coordinator – Surgery in the Central Queensland Region. I believe the position was advertised and that Associate Professor Birks wrote to a number of surgeons in the Central Queensland area. Correspondence dated 15 September 2003 enclosing the position description was also forwarded to me in my capacity as Director of Medical Services and also because Dr Birks requested that I be a member of the interview panel. A copy of that correspondence is Exhibit 253.

28. The appointee was to be located in Bundaberg and would have responsibility to lead and coordinate the delivery of clinical teaching in surgery across the Division's key teaching sites at Rockhampton, Bundaberg and Emerald. The position was a half-time appointment.

29. I discussed the appointment with Peter Leck, who suggested Dr Patel might be interested in applying. I then discussed the appointment with Dr Patel, who indicated he would be interested in applying for the position. I was one of three people appointed to the interview panel by the University of Queensland. The other two persons on the panel were from the University of Queensland, being a physician, Dr Llew Davies (the then Acting Head of the Region) and Dr Peter Bore, a senior lecturer in surgery

at the University of Queensland Medical School. There were two candidates for the appointment, one of whom was Dr Patel. The other candidate was Dr Geoffrey De Lacy, a general surgeon. Each of the candidates was required to provide a presentation addressing the selection criteria and answer any resulting questions. Following the interviews the panel unanimously agreed that Dr Patel was the most suitable interviewee and recommended him to the University for appointment.

30. The discussion amongst the panel occurred immediately after interviewing both candidates. Dr Patel as an employee at the hospital was in a ready position to take up teaching students at the hospital. Dr de Lacy did not at that stage hold a VMO appointment at the hospital so that some arrangements different to that ultimately entered into for Dr Patel would have to have been arrived at if Dr de Lacy had been appointed to that position. However, those matters were not discussed or considered by the panel which arrived at its decision to appoint Dr Patel solely on his apparent merit.

31. Because Dr Patel was sponsored by the Hospital for the purposes of his temporary work visa, he was unable to be employed by any other organisation. Accordingly, the Hospital entered into an agreement with the University of Queensland whereby the University paid to the Hospital a figure representing approximately one-half of Dr Patel's salary package.

32. These arrangements were negotiated between Peter Leck and Janelle Coe on behalf of the University some time after the panel made its recommendation. I assisted in those negotiations.

33. I can recall the panel discussing some of the selection criteria for the position (as set out in the final page of Exhibit 253) but I do not recall any discussion as to the essential qualifications required for the position. I have checked the presentation package provided by Dr Patel in which he claimed to be a Fellow of the American College of Surgeons.

.....

**DARREN WILLIAM KEATING**

**RENEWAL OF CONTRACT BETWEEN BUNDABERG HOSPITAL AND DR PATEL FROM APRIL 2004**

34. Whilst I was not involved in the initial appointment of Dr Patel by Bundaberg Hospital, I was aware Dr Patel had been appointed on 12 month contract from 1 April 2003. The contract was due to expire in March 2004. By letter dated 25 November 2003, I offered to extend Dr Patel's contract from 1 April 2004 to 31 March 2005. A copy of that correspondence is attached and marked **DWK3.**

35. The offer to renew Dr Patel's contract was made in late November 2003 even though the contract did not expire until 31 March 2004. To renew a contract for a practitioner who is not an Australian resident, it was necessary:-

    (a) for the Hospital to obtain written confirmation from Queensland Health that the person is proposed to be appointed to an "area of need" position;

    (b) to obtain renewal of the special purpose registration from the Medical Board under S135 of the *Medical Practitioners Registration Act* to the effect that the Board considers the practitioner suitable for practising the profession in the area of need; and

    (c) to obtain sponsorship approval from the Department of Immigration, so as to enable renewal of the practitioner's temporary working visa.

    After these steps were completed, the practitioner must renew his or her visa, which includes medical and police checks each time the visa is renewed. Consequently, it was necessary to commence these processes 3 to 4 months before the current contract expired, to ensure continuity of employment and care.

.....D Kea.....
**DARREN WILLIAM KEATING**

36. Queensland Health renewed Dr Patel's area of need certification on 21 November 2003 in which Dr Patel was described as "Director of Surgery – SMO" (see attachment 3 to the statement of Dr S Huxley (Exhibit 58)).

37. By a letter dated 1 December 2003, I advised the Medical Board of Queensland that the District had extended Dr Patel's contract to 31 March 2005. Dr Patel's application for registration was enclosed under the cover of that correspondence along with other documentation, including:-

- Form 1 – Area of need description;
- Form 2 – Summary of experience suitable to area of need;
- Assessment Form - Special Purpose Registration.

Attached and marked **DWK4**, **DWK5**, **DWK6** and **DWK7** are copies of that letter dated 1 December 2003 and the three forms referred to above.

38. As part of the registration process for all special purpose registrants in an area of need, the Medical Board of Queensland required that an annual assessment report be submitted. This assessment used a standardised form developed by the Medical Board. The assessment of Dr Patel dated 2 December 2003 was prepared and written by me. My normal procedure was to have these reports prepared by the clinical director responsible for the department. Consequently I wrote the report for Dr Patel as Director of Medical Services. This report was based on:

- ongoing meetings with Dr Patel,
- attendance at committee meetings which Dr Patel also attended,
- meetings with Dr James Gaffield, Staff Surgeon.
- feedback from Dr Martin Carter, Director of Anaesthetics & ICU,
- feedback from Ms Karen Smith, RN, Elective Surgery Coordinator,

.....

**DARREN WILLIAM KEATING**

- feedback from staff in various clinics that Dr Patel attended,
- review of medical records which included Dr Patel's notes in Outpatients and clinical management of inpatients,
- meetings with resident medical officers (principal and junior house officer level),
- review of junior house officers and intern term assessments plus feedback from Ms Judy O'Connor, Medical Education Officer,
- review of waiting lists, surgery throughput and progress towards the elective surgery target,
- review of Australian Council of Healthcare Standard's clinical indicators,
- investigation of complaints,
- reviews by Dr Patel of complaints against other medical practitioners (at my request).

39. Whilst there had been complaints concerning Dr Patel, the number of the complaints compared to the volume of patients he was seeing did not cause me any concern, nor was there any apparent trend to those complaints. My review of the patient records involving these complaints showed that Dr Patel was consistent in documenting in detail his patient care.

40. I did not physically observe Dr Patel's (or any surgeon's) technical competence in theatre as I am not qualified to do so. As Dr Patel was in the position of Director of Surgery when I started at Bundaberg Hospital, it did not occur to me that there was any need for supervision of Dr Patel.

41. The forms submitted to the Medical Board described Dr Patel as holding the position of Director of Surgery whereas his original registration was expressed to be contingent upon Dr Patel practising as a Senior Medical

.....

**DARREN WILLIAM KEATING**

Officer in Surgery at Bundaberg Hospital reporting to the Director of Surgery.

42. I do not recall checking his original registration at the time of applying for renewal of registration. It is unlikely that I did so, because the forms for renewal of registration are prepared by staff members for my approval and signature. Dr Patel's position at the time of renewal was Director of Surgery and he was described as such on the documents provided by me to the Medical Board.

43. I forwarded to the Department of Immigration an application (Form 55) by letter dated 1 December 2003 for an extension of Dr Patel's sponsorship. Attached and marked **DWK8** and **DWK9** respectively is a copy of that letter and the application.

44. By a facsimile transmission dated 27 January 2004, the Department of Immigration gave sponsorship approval in respect of Dr Patel. By letter dated 9 March 2004, the Medical Board of Queensland confirmed Dr Patel's registration as a Special Purpose Registrant. Copies of both pieces of correspondence are attached and marked **DWK10** and **DWK11** respectively.

***MEDICAL BOARD REGISTRATION***

45. Dr Patel was registered with the Medical Board of Queensland as a Special Purpose Registrant. He was not registered as a specialist although he had previously indicated to me that he intended to apply for specialist registration. Annexed and marked **DWK12** is a letter I wrote on 5th August 2003 at the request of Dr Patel supporting his application for registration as a Specialist General Surgeon. Annexed and marked **DWK13** dated 30 December 2003 is a Performance Appraisal and Development Agreement with Dr Patel outlining a performance plan, which included applying for specialist registration.

46. I did not regard Dr Patel's lack of registration as a specialist as an obstacle to his continued appointment as Director of Surgery. It was not

.....

**DARREN WILLIAM KEATING**

unusual at Bundaberg Hospital or elsewhere in Queensland Health to have an unsupervised director of a department who did not have specialist registration in Queensland.

47. Many foreign trained practitioners came to Australia without initial registration in Queensland as a specialist. While they worked in area of need positions providing specialist care, they often sought specialist registration. This required lodging relevant documentation with the Australian Medical Council, which reviewed the doctor's qualifications and then forwarded it to the relevant College for review. This process could take time and, as I have indicated, the lack of specialist registration did not prevent the practitioner from providing specialist level care. I encouraged foreign trained doctors to apply for specialist registration but it was not a condition of their employment that they do so.

**EVIDENCE OF TONI ELLEN HOFFMAN**

**Oesophagectomies – Patient P34 James Phillips – Statement (Exhibit 4) paragraphs 9-13 – Transcript pages 38-47**

48. On or about 30 May 2003, I had a meeting with Toni Hoffman and Glennis Goodman. At the meeting Toni brought to my attention that Dr Patel had described a post operative patient in the Intensive Care Unit (ICU) after an oesophagectomy as being stable, while requiring inotropic support and ventilation. I do not recall the issue of whether oesophagectomies should be performed at Bundaberg Hospital being raised on that occasion. I suggested that she speak to Dr Patel about his reasons for such a comment. Toni was more concerned about interpersonal relations between the ICU nurses and Dr Patel, after he was heard to make disparaging comments about the nurses, their skills and the capability of the ICU unit. I suggested that Toni make an appointment with Dr Patel to discuss those issues, explain unit capability and capacity and the need to work together as a team. She agreed to arrange this meeting with Dr Patel. Afterwards I asked Glennis Goodman how the meeting with Dr Patel went and she confirmed it went well. I also met with Dr Patel to

.....

**DARREN WILLIAM KEATING**

explain the limitations of the ICU in regards to patients requiring long-term ventilation. He appeared to accept my explanation.

***Patient P18 – James Graves – Statement paragraphs 10 to 26 – Transcript P47 to 53***

49. I do not recall any meeting with Toni Hoffman and Dr Jon Joiner in early June 2003 regarding oesophagectomies as suggested by Toni Hoffman in her statement and evidence. I also do not recall any meeting with Dr Jon Joiner in April or May 2003 concerning oesophagectomies as suggested in his statement. (***Exhibit 307 paragraphs 4 to 6***)

50. My diary (Annexure **DWK14**) indicates that I had a meeting or meetings with Drs Joiner, Patel and Younis on 17 June 2003. Dr Joiner who is a Visiting Medical Officer ("VMO") GP Anaesthetist had seen me earlier that morning by himself. He asked me whether Bundaberg Hospital should do oesophagectomies because there was a patient in the ICU, post operatively after this operation (Patient P18). Dr Joiner was concerned that the ICU didn't have the capacity for long-term ventilation and technical support required for these types of patients. He also said that the Hospital would need to be doing at least 30 such operations a year to maintain competency . He did not provide me with any journal article related to this matter. I acknowledged his concerns and said I would speak to Dr Patel and the Director of Anaethetics, Dr Carter, who was on leave. He also asked for the transfer of this patient. (Dr Joiner was the anaesthetist on duty). He believed the patient was stable but foresaw long-term problems. He said he wanted to transfer the patient while Dr Patel did not. I arranged for another anaesthetist, Dr Younis, to review the patient that day. Dr Younis told me that the patient didn't require immediate transfer. I met later that day with Drs Patel, Younis and Joiner and it was agreed that the patient would stay another 1 to 2 days, unless his condition deteriorated or the nursing workload in the unit increased.

51. I recall that after the meetings of 17 June 2003, I spoke to Dr Younis on several occasions concerning the condition of P18. He informed me that the patient's condition had changed and assured me that the patient would

.....

**DARREN WILLIAM KEATING**

be transferred to Brisbane as soon as an ICU bed could be found. I was not informed of the further operation by Dr Patel on this patient.

52. On 1 July 2003 I received a message that Dr Peter Cook from the Mater Hospital in Brisbane had telephoned Peter Leck to discuss P18. Annexed marked **DWK15** is a copy of the email message with my handwritten notes. I telephoned Dr Cook and subsequently spoke to him. Dr Cook said that P18's course had been very difficult but he was now reasonably well and likely to be discharged soon. Dr Cook expressed concern about this type of operation being performed at Bundaberg, in that this operation needed robust intensive care back up. I said that I would discuss his concerns with the Directors of Surgery and Anaesthetics and with the Credentials and Privileging Committee at the hospital.

53. Dr Cook did not express any concern to me about the competence of the surgeon who carried out the oesphagectomy.

54. I had not been able to speak to Dr Carter about this issue before Dr Cook called because Dr Carter had been on leave.

55. When Dr Carter returned from leave I spoke to both Dr Patel and Dr Carter individually about the issue of patients such as the oesophagectomy cases, which required extended periods of ventilation in the ICU. Dr Carter suggested that a period of 72 hours was acceptable before considering transfer of the patient. Both Dr Patel and Dr Carter accepted that transfer should occur if it was required. Each of them also were of the opinion that oesophagectomies could be performed at Bundaberg Hospital. Both Dr Joiner and Dr Patel inferred to me that oesophagectomies had in the past been conducted at Bundaberg Hospital.

56. At no stage did I say or suggest that any adverse event following the performance of an oesophagectomy, such as the death of patient P34 in May 2003, was acceptable as was suggested by Toni Hoffman (transcript page 85).

.....

**DARREN WILLIAM KEATING**

57. I had understood that the concern which had been expressed by Dr Joiner on 17 June 2003, Toni Hoffman in her email of 19 June 2003 (Annexure TH3 to her statement) and also by Dr Cook in his telephone call was directed towards the lack of ICU facilities to provide post operative care for these patients rather than the competence of the surgeon to perform complicated surgery.

58. At no time did Dr Patel say to me that he would resign if he was not permitted to perform oesophagectomies or any other surgical procedure nor was it ever communicated to me that he had made such a threat.

59. After speaking to Drs Patel and Carter I was left in the position where:-

- I was a newcomer to the hospital.
- Dr Patel, an apparently experienced American trained surgeon, claimed he was competent to perform complex procedures such as oesophagectomies.
- Dr Patel had informed me that he used a surgical technique, which did not require the chest cavity to be opened.
- The primary concerns which had been expressed by Toni Hoffman, Dr Joiner and Dr Cook had related to the ability of the hospital to manage the patients post operatively.
- Dr Carter, an experienced British trained and Australian qualified anaesthetist with extensive intensive care experience, was confident that oesophagectomies could be performed at Bundaberg Hospital and did not express any concerns as to the competence of Dr Patel to do so and that the ICU could manage the post operative care of the patients.

I accepted the advice of Drs Carter and Patel.

.....

**DARREN WILLIAM KEATING**

**Sexual Harassment – Statement paragraphs 27 to 29 - Transcript pages 59 to 60**

60. In her email of 19 June 2003 to me, Toni Hoffman raised the issue of the behaviour of Dr Patel. I assumed this behaviour was related to Toni's initial meeting with me of 30 May 2003. If there were concerns about sexual harassment I would have expected Toni to make an appointment with me to discuss the matter face to face.

61. At some time after that email, Cathy Fritz, the Human Resources Manager visited me. She told me that an informal complaint had been made about Dr Patel's behaviour towards an ICU nurse. She said the nurse did not wish to make a formal complaint which would be investigated. I was not informed of the complainant's name or the details of the complaint. Cathy Fritz suggested to me that Dr Patel should be counselled about his behaviour.

62. I subsequently met with Dr Patel and told him that an informal complaint had been received. I counselled him about appropriate behaviour and provided him with copies of the Qld Health Code of Conduct and its Policy on Sexual Harassment. He appeared taken aback and suggested it was a misunderstanding. Nevertheless he accepted the counselling and information. I subsequently informed Cathy Fritz of my discussion with Dr Patel.

**Wound dehiscence – Statement paragraphs 30 to 32 - Transcript P60 to 64**

63. I was not informed of any concerns among the nursing staff about increasing rates of wound dehiscence until the issue was raised by Gail Aylmer, the Infection Control Co-ordinator at the Leadership and Management meeting of 7 July 2003.

64. A copy of my notes of the meeting is annexed marked **DWK16**. Gail Aylmer said at the meeting that she would prepare a report. I asked that it be presented to the next ASPIC meeting and that she also discuss the issue with Dr Patel.

.....

**DARREN WILLIAM KEATING**

65. Exhibit 198 is a copy of an email dated 8 July 2003, which is the first email sent by Gail Aylmer to me on that day in which she indicated that she would be discussing her report with Dr Patel before the ASPIC meeting the next day. I did not see that email.

66. I subsequently received another email dated 8 July 2003, which is Exhibit 60. This email did not require any further action by me and the information contained within it was subsequently discussed at the ASPIC meeting of 9 July 2003. Annexed marked **DWK17** is a copy of the minutes of that meeting.

67. I believe that the issue raised by Gail Aylmer had been openly discussed, researched and resolved to the satisfaction of all concerned.

68. At no stage prior to Toni Hoffman's complaint of 22 October 2004 was I aware of any suggestion that junior doctors were instructed by Dr Patel not to use the word "dehiscence". I would have expected the junior medical staff, Gail Aylmer and Toni Hoffman to report to me any such irregularities in the recording of patient records. I expected Gail Aylmer to continue to monitor this concern in her role as Infection Control Co-Ordinator. I have no record or recollection of receiving any further reports from her on this matter. The matter was later raised in ASPIC meetings in mid 2004.

69. At the ASPIC meeting of 14 April 2004 (the minutes are Exhibit 81), the issue of wound dehiscence was raised by Di Jenkin, the Nurse Unit Manager of the Surgical Ward, who thought there had been an increase in the number of wound dehiscences. There was no suggestion from any person present that the extent of wound dehiscence was being concealed by junior doctors who had been told by Dr Patel not to use the word dehiscence in discharge summaries.

70. At that meeting, the issue of a definition of wound dehiscence was raised. There was confusion as to whether the term encompassed a breakdown at a superficial level of the surgical wound, or extended only to a breakdown at a deep level.

.....

**DARREN WILLIAM KEATING**

71. I encouraged Di Jenkin to research the issue and to approach the District Quality and Decision Support Unit (DQDSU) for support. Exhibit 90 is a copy of the definition located by Di Jenkin and tabled at the ASPIC meeting of 9 June 2004.

72. Subsequently DQDSU prepared a report for ASPIC from data up to 8th August 2004 on wound dehiscences for the years ended 30 June 2003 and 30 June 2004. The two reports prepared by DQDSU are Exhibit 64. It was apparent to me that there had been reduction in the incidence of dehiscences.

73. The issue of wound dehiscences continued to be reviewed by ASPIC's monthly meetings for several months until the relevant data was obtained. The committee decided that wound dehiscences would be reported as adverse events. (Exhibit 65) Subsequently only one wound dehiscence was reported as an adverse event (Patient 127). Consequently I did not believe the issue required my intervention.

74. I did not laugh when the issue was raised by Di Jenkin as suggested by Jennifer White in her statement at paragraph 19 (Exhibit 71). I strongly supported the investigation by the nurses of their concerns. I was only present at the ASPIC meetings of April and June 2004 when this issue was discussed.

75. On 2 November 2004 following receipt of Toni Hoffman's complaint dated 22 October 2004, Dr Risson informed me that he had never been told by Dr Patel not to write about wound dehiscences on discharge summaries.

***Intimidation by Dr Patel and confrontations – Transcript pages 64 to 67***

76. While I did become aware of differences between Dr Patel and other medical and nursing staff I was not aware of any suggestion that Dr Patel intimidated other practitioners or that there were "standup fights" in the intensive care unit.

.....

**DARREN WILLIAM KEATING**

77. Toni Hoffman was from time to time Acting Assistant Director or Acting Director of Nursing. She was never reluctant to inform me verbally or by email of matters of concern to her.

78. Dr Dieter Berens is a specialist anaesthetist and to my knowledge is a permanent resident of Australia and had been one for some time before returning to work at Bundaberg Hospital. There was not the slightest possibility that Dr Patel could cause Dr Berens to lose his position.

79. Dr Patel did speak to me on 8 March 2004 concerning a disagreement on 6 March 2004 with Dr Berens about the use of arterial blood gas haemoglobin readings to order blood transfusions. Dr Berens had said that he would no longer care for the surgical ICU patients that weekend because of the dispute. The matter had been first referred to me on Saturday, 6 March 2004 by the After Hours Nurse Manager. I asked her to speak to Dr Berens to ask him to reconsider his position and to ask him to speak to me on the following Monday. I also asked the After Hours Nurse Manager to contact me with the result of her phone call to Dr Berens. She rang back to say Dr Berens had reconsidered his position and would continue to provide care. After the weekend, I had discussions with both Dr Patel and Dr Berens in which I urged them to discuss the issue, act professionally and work together.

80. Attached and marked **DWK18** is a copy of a draft email which Dr Patel handed to me and which he proposed sending to Dr Carter prior to my resolution of the issue.

81. If there had been frequent altercations in any ward between any medical practitioners, I would have been informed by the nursing or medical staff, as I was in this case.

***Patient P39 – Statement paragraphs 33 to 37 – Transcript pages 67 to 69***

82. After receiving Toni Hoffman's email of 9 September 2003 (exhibit TH6 to her statement), I spoke to Dr Patel and Dr Carter.

.....

**DARREN WILLIAM KEATING**

83. Dr Patel told me that he was asked by Dr Carter whether he was prepared to operate on his patient who required drainage of a haemothorax.

84. Dr Carter had a special interest in anaesthesia of patients with thoracic conditions and Dr Patel told me Dr Carter had suggested that the patient's post-operative care could be managed in Bundaberg Hospital ICU.

85. Dr Carter told me he was happy for the patient to be operated on at Bundaberg. I asked both of them about the agreement suggested by Toni Hoffman and was told that there was no such agreement and that the patient would be transferred if it was necessary.

86. I cannot recall if I responded to Toni Hoffman concerning the email. The email was addressed to Glennis Goodman and it is likely that I passed on to her the outcome of my discussions with Drs Patel and Carter.

***Qureshi – Statement paragraphs 38 to 43 – Transcript pages 69 to 73***

87. Dr Qureshi was employed by Bundaberg Health Service District in February 2003 for a twelve-month period commencing 29th July 2003.

88. On 27th August 2003, a female patient made a complaint about Dr Qureshi's behaviour.

89. On 28th August 2003, I interviewed Dr Qureshi who denied any unprofessional conduct. I counselled Dr Qureshi about the need to provide a full explanation of a proposed examination, that he should not unnecessarily prolong examinations, and of the need for a chaperone to be present when examining female patients.

90. I then had a further discussion with the complainant in which I told her of Dr Qureshi's response and explained that there had been a lack of communication.

91. Annexed marked **DWK19** is a copy of the complaint registration form and notification of complaint form, which records my notes of the discussions which I had with Dr Qureshi and the patient. I also informed Dr Qureshi's

.....

**DARREN WILLIAM KEATING**

immediate supervisor, Dr Keil, the Director of the Department of Emergency Medicine of the circumstances of the complaint.

92. On Saturday, 18th October 2003, the hospital received a further complaint from another female patient concerning Dr Qureshi. Annexed marked **DWK20** is a copy of that complaint. I spoke to Dr Quereshi on the Saturday and told him that there had been a complaint, that he was to come to see me on Monday and that the nursing staff had been told that he required a chaperone with female patients at all times effective immediately.

93. I spoke to the female complainant on Monday, 20 October 2003. Annexed marked **DWK21** is a copy of my file note of my interview with the complainant.

94. I then spoke to Dr Qureshi on Monday, 20th October 2003. He denied any inappropriate behaviour.

95. I told Dr Qureshi that I was seeking further information and that I may have to refer the matter to the Medical Board because of the previous complaint and the seriousness of this complaint. I again told him that he must have a chaperone when consulting a female patient, that the nursing staff had been informed of this requirement and that if Dr Qureshi did not comply with that requirement, he would be immediately dismissed. Annexed marked **DWK22** is a copy of my file note of that interview with Dr Qureshi on 20th October 2003.

96. I subsequently spoke to the complainant on 21st October 2003 to advise her that the matter should be referred to the Medical Board and asked for her consent to do so.

97. On 22nd October 2003, I wrote to the Medical Board concerning Dr Qureshi. Annexed marked **DWK23** is a copy of my letter dated 22nd October 2003.

.....

**DARREN WILLIAM KEATING**

98. I subsequently received an email dated 6 November 2003 from Toni Hoffman (Exhibit TH8 to her statement) complaining of inappropriate behaviour by Dr Qureshi with nursing staff.

99. I next received a letter from the Medical Board of Queensland dated 17 November 2003 acknowledging receipt of my letter dated 22nd October 2003 and advising that the matter would be considered at the next meeting of the Board on 25th November 2003. Annexed marked **DWK24** is a copy of that letter.

100. On 8th December 2003, I received a further complaint concerning Dr Qureshi from nursing staff. Annexed marked **DWK25** is a copy of the complaint of the nursing staff.

101. I interviewed the patient concerned. Annexed marked **DWK26** is a copy of my file note of that interview.

102. I again interviewed Dr Qureshi on 9th December 2003. I asked Dr Qureshi to provide me with a written submission by 16 December 2003 outlining why he shouldn't be dismissed. Dr Qureshi denied any inappropriate behaviour. I suggested that he put his explanation in his submission. Annexed marked **DWK27** is a copy of my file note of my interview with Dr Qureshi. I advised Dr Qureshi that he would not be placed on call again until further notice.

103. On 11th December 2003, I again wrote to the Medical Board of Queensland concerning Dr Qureshi and the latest complaint. Annexed marked **DWK28** is a copy of that letter.

104. Annexed marked **DWK29** is a file note dated 11th December 2003, which I have made summarising Dr Qureshi's employment, his performance and my views of the complaints which were made against him.

105. On 11th December 2003, I wrote to Dr Quereshi enclosing copies of the complaints so that he could show cause why he shouldn't be dismissed. Annexed marked **DWK30** is a copy of my memorandum to Dr Quereshi of that date.

.....

**DARREN WILLIAM KEATING**

106. On 18th December 2003, I received a telephone call and facsimile from the Medical Board requesting further information about Dr Qureshi. Annexed and marked **DWK31** and **DWK32** is a copy of that facsimile transmission and my response dated 24th December 2003.

107. Following the third complaint received on 8th December 2003, I had discussions with Cathy Fritz, the Human Resources Manager at Bundaberg Hospital who subsequently spoke with the Corporate Office at Queensland Health concerning the appropriate procedure for dealing with Dr Qureshi's employment. Advice was received from the Corporate Office that the notice to show cause should be rescinded and the incidents reported to the Audit Branch for independent investigation. Annexed marked **DWK33** is a copy of a letter from Peter Leck to Dr Qureshi dated 23 December 2003 advising him that the complaints had been referred to the Audit and Operational Review Branch for investigation.

108. On 3rd February 2004, Peter Leck wrote to Dr Qureshi advising him that he was suspended from duty. Annexed marked **DWK34** is a copy of that letter

109. By letter dated 11th March 2004, the Medical Board of Queensland advised that it would accept the complaint about Dr Qureshi for investigation but that the investigation would be delayed and would commence within six months. Annexed marked **DWK35** is a copy of the letter of 11th March 2004 from the Medical Board.

110. In early February 2004, I was advised that the Crime and Misconduct Commission ("CMC") was investigating the allegations concerning Dr Qureshi and had requested that the Audit Branch take no further action until the CMC had completed their assessment of the allegations.

111. By letters dated 24th March 2004 and 29th March 2004, Dr Qureshi's employment with Queensland Health was terminated with effect from 14th March 2004. Annexed marked **DWK36** and **DWK37** are copies of letter from Peter Leck to Dr Qureshi dated 24th March 2004 and 29th March 2004 respectively.

.....

**DARREN WILLIAM KEATING**

112. On 31st May 2004, I received an email from Peter Leck attaching an email from a Michael Schafer asking that management in the Bundaberg Health District be made aware of the importance of their obligations in reporting suspected official misconduct in a timely manner. Annexed and marked **DWK38** is a copy of that email.

113. At the time of the second complaint concerning Dr Qureshi, I believed that the appropriate body to investigate the complaint was the Medical Board of Queensland. I was not aware that the Audit and Operational Review Branch would investigate such complaints.

114. I deny that I said to Toni Hoffman that I had failed to check Dr Qureshi's references. I was not at Bundaberg Hospital when he was offered employment. If I said that I had not handled the matter well, I was referring to the fact that I had referred the complaints to the Medical Board rather than Audit and Operational Review Branch.

115. During his employment at Bundaberg Hospital concerns had been raised about the clinical performance and competence of Dr Qureshi. I had discussed those issues with a number of the senior medical staff and his performance was under continual review.

***Fabricated records and reporting of adverse events – Statement paragraph 44 – Transcript pages 74 to 76***

116. The surgical procedure planned for a patient is recorded pre-operatively in the hospital records in the outpatient notes, in the booking forms, the admission forms, by the nursing staff in progress notes, on the consent form signed by the patient, on the preoperative anaesthetic record completed by the anaesthetist, on count sheets and other operative records prepared pre-operatively by the nursing and administrative staff, as well as on the surgery record completed by the surgeon post-operatively.

.....

**DARREN WILLIAM KEATING**

117. An abdominal operation for bowel surgery could not be renamed as a splenectomy without there being a glaringly obvious difference between the surgery proposed and that carried out.

118. No complaint of fabrication of records by Dr Patel was made to me during his employment at Bundaberg Base Hospital.

***Dr Miach's directive – Statement Paragraph 48 – Transcript Page 80***

119. At no stage before the commencement of the former Inquiry was I aware that Dr Miach had given instructions that his patients were not to be operated upon by Dr Patel. I was aware that concerns had been raised by nurses concerning infection control measures in the Renal Dialysis Unit as has been referred to by Gail Aylmer in paragraphs 19 to 21 of her statement (Exhibit 59) and in her evidence at page 986. I had raised the concerns with Dr Patel who denied the claims and took affront at the suggestions. I pointed out to him that he needed to set an example as Director of Surgery.

120. I subsequently received the email dated 3 December 2003 from Gail Aylmer, which is Annexure GA7 to her statement. My understanding was that subsequently Dr Patel only attended the Renal Unit if requested. Dr Patel continued to operate on patients who had been seen by Dr Miach and his medical team such as Marilyn Daisy (P52).

***ASPIC meeting 14 April 2004 – Statement paragraphs 22 to 60 – Transcript pages 103 to 105***

121. ASPIC meetings were monthly meetings of the anaesthetic surgical, pre-admission and intensive care staff.

122. At the ASPIC meeting held on 14 April 2004, Toni Hoffman (who kept the minutes of the meeting) raised the issue of patients requiring long-term ventilation in the intensive care unit. (The minutes are Exhibit 81)

123. At that meeting she did not raise the issue of the surgery being carried out by Dr Patel.

.....

**DARREN WILLIAM KEATING**

124. During 2004 we were experiencing difficulties in transferring patients to Brisbane because of the increased demand for ICU beds resulting from the closure of the neurosurgical service at Rockhampton and the vascular service at Redcliffe-Caboolture. There were also restrictions on night-time transfers due to the refusal of retrieval staff to fly helicopter services at night without adequate insurance.

125. As a result, the overtime hours in Bundaberg ICU increased.

126. The issue of ICU transfer and overtime continued to be discussed at ASPIC and other meetings including Finance Committee and Medical Staff Advisory Committee after April 2004.

127. I was asked by the District Manager in October 2004 to look into the issues

128. Exhibit 94 contains copies of an email dated 25 October 2004 from me to Martin Carter and Toni Hoffman and an email dated 1 November 2004 from Toni Hoffman to me together with the attachments to that email.

129. I examined statistics, which Toni Hoffman provided. They indicated during the period that 19 patients were ventilated for over 100 hours in the ICU. Of these 19 patients, 10 were medical patients who required over 1958 hours ventilation, and 9 were surgical patients, which required 1717 hours ventilation (see Exhibit 94).

130. My conclusion was the demand for ventilation in ICU from all specialities had increased and the demand was not confined to surgical patients but applied at least equally to medical patients.

131. After Dr Patel had left the hospital I obtained statistics as to the number of Dr Patel's patients kept in the ICU for more than 24 hours. Annexed and marked **DWK38A** is a copy of those statistics which show that over the period of his employment 24 of his patients were kept in the ICU for more than 24 hours. Approximately two-thirds of these patients were admissions from the emergency department or emergency transfers from other hospitals. The remaining patients were elective surgery patients.

.....

**DARREN WILLIAM KEATING**

There is nothing in those statistics to indicate that Dr Patel had a significant number of lengthy ICU admissions.

***Patient P11 – Desmond Bramich – Statement paragraphs 86 to 114 – Transcript Page 137***

132. Mr Bramich died at 00.10am on 28 July 2004.

133. My recollection is that I was informed of concerns relating to his management by Dr Martin Carter shortly after his death. Dr Carter suggested that the management of the patient be audited.

134. As a result, on 29 July 2004, I wrote to Dr Carter and Dr Patel in their capacities as Directors of Anaesthesia and Surgery requesting that they conduct an audit of the total management of Mr Bramich and report to Dr Nydam and myself within two weeks. Annexed and marked **DWK39** is a true copy of that memorandum.

135. I subsequently received a Sentinel Event Form dated 2 August 2004 signed by Toni Hoffman with the document which is annexure TH16 to Ms Hoffman's statement and an Adverse Event Report Form completed by Nurse Karen Fox dated 2 August 2004. Those documents are contained in annexure LTR9 to the statement of Leonie Raven (Exhibit 162).

136. On 26 August 2004 I was forwarded by Linda Mulligan the email dated the same day from Toni Hoffman, which is annexure TH21 to her statement.

137. On 26 August 2004 I received Dr Patel's audit report on Mr Bramich. A copy of the report is attached and marked **DWK40**.

138. I obtained from the Coroner a copy of the autopsy report on 31 August 2004.

139. I continued to press Dr Carter for his audit report. (see Exhibit 269)

140. On 13 September 2004 Dr Carter sent me his audit report on Mr Bramich. A copy of his report is Annexure TH19 to Ms Hoffman's statement. A copy of his email enclosing the report is annexed and marked **DWK41**

.....D. Keating.....

**DARREN WILLIAM KEATING**

141. During the course of my investigation of Mr Bramich's management, I also asked for a report from Dr James Gaffield who was the surgeon responsible for Mr Bramich. Annexed and marked **DWK42** is a copy of the report provided to me by Dr Gaffield dated 14 September 2004.

142. In his report Dr Gaffield stated that Mr Bramich was far too unstable to consider transfer and was "grossly unfit for helicopter transfer".

143. On 25 October 2004, Dr Carter forwarded a draft report for the Coroner, a copy of which is attached and marked **DWK43**. In that report Dr Carter indicated that he left the hospital after a CT scan had been performed.

144. In mid September an initial notice under the *Personal Injuries Proceedings Act 2002* was served on the State of Queensland by Mr Bramich's family. A response and available information were provided to Mr Bramich's family and on 15 September 2004 I received advice regarding the initial notice from the Hospital's solicitors.

145. On 27 September 2004, I discussed Mr Bramich's management with Dr Younis, a Senior Medical Officer – Anaesthetics. Dr Younis was critical of Dr Patel's management. Attached and marked **DWK44** is my file note of that conversation.

146. On 19 October 2004, I discussed the case with Dr Rodd Brockett an Intensive Care Specialist at Logan Hospital. Annexed and marked **DMK45** is my file note of that conversation. Dr Brockett also provided me with the names of three intensive care specialists who could review the case.

147. During my investigations and after receiving Dr Patel's initial report, I spoke to Dr Patel and gave him a copy of the Sentinel Event form and the statement prepared by Toni Hoffman, which is annexure TH16 to her statement. I asked him to respond to those documents.

148. Annexed and marked **DWK46** is a copy of Dr Patel's response in which he says that he did not refuse or delay the patient's transfer.

.....

**DARREN WILLIAM KEATING**

149. After receiving the reports mentioned above, it was apparent that there were a number of differences in the accounts of events relating to Mr Bramich. I considered that there were issues relating to the clinical management as well as personality problems.

150. I had reviewed the medical records and the various reports I had received. Annexed marked **DWK47** is a copy of the notes, which I made of my investigation. My plan had been to identify the clinical issues and meet with the medical personnel, Drs Patel, Gaffield, Carter and Younis and the nurses involved with the care of Mr Bramich (as well as Dr Nydam who was qualified and experienced in emergency medicine and critical care) to discuss the clinical issues and means by which we could prevent similar problems occurring. I also proposed to meet with Dr Patel, Toni Hoffman and Linda Mulligan to discuss the personality problems. The latter meeting was planned for 21 October 2004.

151. However on 20 October 2004, Toni Hoffman had had a meeting with Peter Leck and Linda Mulligan concerning Dr Patel.

152. Peter Leck was aware of my proposal for this planned meeting on 21 October 2004 and he asked me to delay any meeting with Dr Patel and Toni Hoffman until he told me it could proceed.

153. I subsequently received a copy of Toni Hoffman's letter of 22 October 2004 (Annexure TH37 to her statement) on that day. Following further discussions with Peter Leck, I believed that there would be an external review of Mr Bramich's management (as well as the other patients mentioned in that letter). I was directed by Peter Leck not take any further action in respect of my review of Mr Bramich's management.

154. Queensland Health's Incident Management Policy introduced on 30 June 2004 (Annexure **DWK48**) requires that sentinel events be investigated by a team and that the root cause analysis investigation tool and process be used. I have not been trained in root cause analysis, nor to my knowledge has any other staff member at Bundaberg Hospital.

.....

**DARREN WILLIAM KEATING**

155. To the best of my knowledge, at that time Queensland Health did not have any teams trained in root cause analysis available to travel to hospitals to investigate sentinel events.

156. I had become aware of the new policy on 5 August 2004 and subsequently arranged for Bundaberg Hospital's policy to be updated to conform with Queensland Health's requirement but at the time of Mr Bramich's death our procedures had not been updated. (***see paragraphs 380 to 387 below)***. Annexure **DWK49** is a copy of a memorandum from the Deputy Director-General Policy and Outcomes dated 30 June 2004 enclosing the new policy. I have noted that it was first sighted by me on 5 August 2004.

157. At no stage was Mr Bramich's death "down graded" by me or deemed not to be a sentinel event

158. I kept Linda Mulligan and Peter Leck informed of my investigation of the death. I expected Linda Mulligan to provide any necessary feedback to Toni Hoffman.

159. Until the introduction of this new policy, Queensland Health had no requirement that sentinel events be reported to the Director-General's office. The June 2004 policy on incident management introduced this requirement. I assumed that the policy did not apply to Sentinel Events which had been reported prior to the implementation of that policy at Bundaberg Hospital as set out in paragraph 156 above.

160. The investigation which I conducted into Mr Bramich's death was the best which I could do with the available resources. The issues which arose out of my investigation were complex and not easily resolved. They involved not just Dr Patel but other medical practitioners, nursing staff, physiotherapists and the retrieval system. As far as Dr Patel was concerned the issues which occurred to me were his multiple unsuccessful attempts at pericardiocentesis, his apparent failure to clearly establish himself as the clinician in charge after Dr Gaffield departed and his communication problems with relatives and nursing staff. None of

these concerns caused me to restrict Dr Patel's surgical activities. I did intend to pursue the various issues further as set out in paragraph 150 above but for the reasons set out in paragraphs 152 and 153 did not take the matter further.

***Thoracotomy – Statement paragraphs 101 to 106 – Transcript Pages 150 to 152***

161. On 26 August 2004, Toni Hoffman sent an email to Linda Mulligan, which is annexure TH21 to her statement. Linda Mulligan either forwarded the email to me or spoke to me about it. Dr Carter had previously spoken to me about this patient because he was concerned that about the ability of ICU to care for the patient post operatively after a thoracotomy. I suggested he speak to Dr Patel and review the patient's history.

162. I also spoke to Dr Patel and he informed me that the patient required a simple wedge resection of a nodule for pathology and that ICU care wasn't planned postoperatively.

163. I advised Dr Carter of this by email dated 20 August 2004 (Exhibit 270). He subsequently informed me that he was happy to proceed with the surgery.

164. Consequently I also informed Linda Mulligan that the thoracotomy involved a wedge resection biopsy only and would not require ICU involvement. (Annexure LMM16 to Linda Mulligan's statement - Exhibit 180).

165. Whether a thoracotomy (which is opening of the chest wall) is likely to require post-operative treatment in ICU depends on the extent of the surgery undertaken and the patient's overall medical condition. In this case both Dr Patel and Dr Carter were satisfied that treatment in ICU was unlikely to be required.

***Patient P26 – Statement paragraph 142 – Transcript Page 177***

166. I was first informed of this case by an email from Dr Steven Rashford, the Director Clinical Co-ordinator and Patient Retrieval Services, Queensland

.....

**DARREN WILLIAM KEATING**

Health. A copy of the email dated 4 January 2005 is part of annexure SJR2 to Dr Rashford's statement (Exhibit 210). In that he suggested that the role of earlier transfer needed to be considered.

167. The Zonal Manager, Dan Bergin subsequently asked Peter Leck for a brief on the case. Peter Leck asked me to prepare the brief. I reviewed the hospital records and spoke to Drs Gaffield, Carter and Risson. A copy of the notes I made of my discussion with Dr Risson is attached marked **DWK50**.

168. I then prepared a brief dated 5 January 2005 with an attached clinical summary and recommendation which I emailed to Peter Leck which he sent to Dan Bergin. A copy of the brief and clinical summary is part of Annexure SJR2 to Dr Rashford's statement (Exhibit 210).

169. Dan Bergin subsequently sent an email dated 7 January 2005 requesting discussion between relevant staff of Bundaberg and RBWH Health Service Districts to ensure the timely transfer of patients who require specialist vascular or other care not available in Bundaberg. A copy is annexed and marked **DWK51**.

170. My review of the hospital records showed that after the initial life saving operation by Dr Patel on 23 December 2004, the patient remained in the ICU until 27 December 2004.

171. Dr Patel went on leave on 26 December 2004 and Dr Gaffield assumed responsibility for the patient on that day.

172. The patient was transferred to Royal Brisbane Hospital on 1 January 2005.

173. My report recommended that patients with major vascular injury be transferred as soon as the patient's condition was stable (i.e. life and limb were safe). I concluded that the patient should have been transferred when stable on or about 25-26 December 2004.

.....

**DARREN WILLIAM KEATING**

174. I subsequently spoke to Drs Patel and Gaffield and explained there had been a review of this patient's case. I advised them that as a result of the review any patients undergoing emergency vascular surgery should be transferred as soon as they were stable. They appeared to accept this direction.

175. I was aware that this case raised issues as to Dr Patel's judgment with respect to the need for transfer of patients such as this. I did not perceive that it raised an issue as to his technical skills as a general surgeon performing a life saving operation on a complex vascular injury. No other more suitable surgeon was available in Bundaberg to do this surgery as Dr Thiele was on leave.

176. My report was provided to Peter Leck quickly because I was aware that that was the expectation of Dan Bergin. It dealt with the issue of earlier transfer because that was the concern expressed by Dr Rashford and I had not identified any other issues.

177. In my briefing to Dan Bergin I indicated that the hospital would institute a policy of transfer to tertiary facilities of patients with emergency vascular conditions when the condition was stable. I had verbally instituted this policy by speaking to the two senior surgeons responsible for management of these injuries. It was my intention to document the policy but I was working on other policies such as the Intensive Care Unit Admission policy and I did not document the emergency vascular policy before going on leave in April 2005.

***Patient P44 – Statement paragraphs 135 to 141 – Transcript pages 173 and 174***

178. On 20 December 2004, Peter Leck sent me a night report which showed that there had been a disagreement between Dr Patel and ICU staff concerning cessation of ventilation for this patient. A copy of his email and the night report is attached mark **DWK52**.

179. I assumed that the dispute had been resolved as I received no complaint from any staff member despite the fact that I had regular discussions with

.....

**DARREN WILLIAM KEATING**

Drs Carter and Patel. When Dr Joiner had a problem he had no hesitation in bringing it to my attention but he did not do so in relation to this incident. Vivienne Tapiolas' report dated 20 January 2005 was not sent to me (Annexure TH41 to Toni Hoffman's statement)

***EVIDENCE PETER JOHN MIACH***

***Patient P 51 – Statement paragraphs 37 to 45 – Transcript P272 to 276***

180. I recall that Dr David Smalberger came to see me in late 2003 or early 2004 about a dispute he had with Dr Patel regarding this patient.

181. His complaint was Dr Patel had treated him in a humiliating manner and did not appear to respect his knowledge, experience and position. He did complain about Dr Patel's interpretation of a CT scan, which I put down to a professional difference of opinion. He asked for advice on how to deal with Dr Patel in order to re-establish a working relationship.

182. I told him that he had 3 options. He could put in a formal written complaint, I could speak to both of them jointly, or I could speak to Dr Patel directly and outline his concerns. He said he would prefer the last option. I spoke to Dr Patel about the incident and explained that Dr Smalberger was very upset. I urged him to discuss the matter with Dr Smalberger and reminded him of the need to treat staff in a fair and reasonable manner. I had no further complaints from Dr Smalberger regarding Dr Patel's behaviour or competence.

***Patient P45 - Statement paragraphs 47 to 48 – Transcript pages 276 -277***

183. I have no recollection of any complaint being made by any staff member or Dr Anderson regarding this patient.

***Unidentified patient with breast cancer – Statement paragraphs 49 to 52 – Transcript pages 277 to 278***

184. I have no recollection of any complaint being made by any staff member concerning this patient. It is accepted practice to discharge cancer

.....D. Kea.....

**DARREN WILLIAM KEATING**

patients to their usual general practitioner after specialist follow-up for a number of years if there has been no recurrence of the cancer.

***Patient P33 – Statement paragraphs 53 to 59 - Statement of Toni Hoffman – paragraphs 149 to 152 – Transcript pages 181 and 182, 278 to 282***

185. I was first informed about this patient by Toni Hoffman's email of 4 March 2005, (Annexure TH44 to her statement).

186. Some time after both Dr Patel and Dr Miach asked to speak to me about this patient.

187. Dr Patel told me about the circumstances of his involvement with the patient. He told me that the medical Principal House Officer ("PHO") had requested review by a surgeon following the PHO's perforation of the carotid artery. Dr Patel was in theatre when the referral was received. He asked his surgical PHO to see the patient. Following this Dr Patel decided to see the patient himself. He said he suggested to Dr Miach that surgery was required but Dr Miach had said that he could manage the patient without surgery.

188. Dr Miach next came to see me about this patient. He wanted to know why the surgeons had been involved.

189. I told him my understanding was that his PHO had asked for the surgical review. He said he wasn't aware of it. We then had a discussion about the particular PHO who had had previous complications and I suggested Dr Miach speak to Dr Carter about the PHO to ensure he was adequately supervised when performing invasive procedures.

190. I was concerned that a relatively junior PHO should have performed this procedure unsupervised on the patient in question.

***Concerns Regarding Dr Patel's Surgery – Statement paragraphs 66 to 83***

191. At no stage prior to this inquiry did Dr Miach raise with me concerns which he may have had:-

.....

**DARREN WILLIAM KEATING**

- regarding surgery on patient P34 – James Phillips;
- regarding surgery on patient P53 –
- that Dr Jason Jenkins had warned him in June or July 2003 that Dr Patel should not do any more vascular surgery;
- that Dr Miach would not permit Dr Patel to operate on Dr Miach's renal patients.

192. In relation to patient P34 - James Phillips, the hospital records extracts of which appear as Exhibit 98 show as follows:-

- The patient underwent an endoscopy on 23rd April 2003, which revealed a suspicious nodule. The biopsy showed a poorly differentiated invasive carcinoma.
- Dr Miach ordered a further CT scan to investigate the extent of the patient's cancer.
- The CT scan was performed on 6th May 2003;
- The patient was seen by Dr Patel on 10th May 2003.
- At the consultation on 10th May 2003, Dr Patel noted that there was no clinical evidence of metastases and recommended that the patient undergo an oesophagectomy.
- The oesophagectomy was carried out by Dr Patel on 19th May 2003 commencing at 10.05am and ending at 3.10pm. Dr Martin Carter was the anaesthetist.
- The patient was reviewed by Dr Miach at 5.00pm on 19th May 2003, post-operatively and subsequently at 2.30am on 20 May 2003.
- The patient was reviewed by Drs Miach, Carter and Patel on a "conjoint round" on 20th May 2003 at about 8.00am.

.....

**DARREN WILLIAM KEATING**

- The patient died on 21st May 2003.

193. I was aware of the issues raised by the Renal Unit (paragraphs 119 to 120 above) and the Baxter program and catheter audit issues (paragraphs 201 to 221 below) and that Dr Miach preferred to have Dr Gaffield insert Permacaths. Apart from these discrete areas Dr Miach did not express any concerns to me regarding Dr Patel's competency.

***Patient 52 – Marilyn Daisy – Statement paragraphs 75 to 79 – Transcript pages 286 to 288***

194. When I returned from leave in October 2004, I was informed by staff members (my secretary and Dr Nydam) that Dr Miach had been involved in a number of disputes with other staff members. I met with Dr Miach on 21 October 2004 and we had a lengthy conversation.

195. Dr Miach told me that he and Dr Patel had had a heated conversation about a patient but he did not give me any details.

196. On 8 November 2004 Dr Miach gave me a copy of a letter from Dr Jason Jenkins dated 2 November 2004 (Exhibit 17) without any further comment.

197. I then spoke to Dr Patel and asked him what had happened. He acknowledged that there had been a heated debate about who was caring for the patient and that the care had been taken over by Dr Miach. He said he was unsure what follow-up had been arranged or had occurred.

198. I told him that he should make sure that the patient was followed up and report back to me why it had occurred and what arrangements had been put in place.

199. Dr Patel saw me a few days later and said that one of the surgical PHOs had reviewed the patient in the Renal Dialysis Unit and an appointment had been made for further review in out patients. He could not explain why the patient had not been followed up and reviewed earlier and acknowledged that it should not have happened but also said that the medical team had not sought a surgical follow up.

.....

**DARREN WILLIAM KEATING**

200. The hospital records in relation to patient 52 Marilyn Daisy (some of which are contained in Exhibit 100) show as follows:-

| | |
|---|---|
| 23/08/2004 | The patient was seen in the Outpatients at the Nephrologist Private Clinic by Dr Miach. He referred her to Royal Brisbane Hospital and asked the patient to return in six weeks time. |
| 24/08/2004 | The patient was seen in Outpatients in a medical ward review. A below knee amputation was planned and also to optimise renal function and to exclude significant coronary artery disease. |
| 07/09/2004 | The patient was seen again in Outpatients in a medical ward review. She was assessed as suitable for a below knee amputation. |
| 07/09/2004 | The patient was seen in Outpatients in a surgical ward review by Dr Patel. He notes that she is for a below knee amputation. |
| 20/09/2004 | The amputation was carried out by Dr Patel. |
| 21/09/2004 | The patient was seen by Dr Patel in the ward postoperatively. |
| 21/09/2004 | The patient was seen by a surgical medical officer. |
| 22/09/2004 | The patient was seen by Dr Sanjeeva, Surgical PHO. |
| 22/09/2004 | The patient was seen by Dr Smalberger and others on a ward round. |
| 23/09/2004 | The patient was seen by Dr Patel. He ordered removal of a drain and steri-strips and indicated he will review the stump. |
| 23/09/2004 | The patient was seen by Dr Smalberger and others. |
| 23/09/2004<br>24/09/2004<br>25/09/2004 | The patient was seen by Dr Miach |
| 27/09/2004 | The patient was seen by Dr Patel. He indicated to continue physiotherapy. |
| 27/09/2004 | The patient was seen by Dr Smalberger. |

.....DKeating.....

**DARREN WILLIAM KEATING**

| | |
|---|---|
| 27/09/2004 | The patient was seen by Dr Miach. |
| 28/09/2004 | The patient was seen by Dr Patel. He recommended the patient be transferred to the medical ward and noted that the stump was healing well, that there were no concerns surgically that the patient should be followed up in the outpatients department and that she should be seen at the outpatients department in two weeks time. |
| 02/10/2004 | The patient was transferred from the surgical ward to the medical ward for dialysis. The patient was wanting to be discharged and was advised that it would be against medical advice. |
| 04/10/2004 | The patient was seen by Dr Gardner. He noted some problems with stump, that the patient is to have a permacath inserted by Dr Gaffield the next day and that the patient is to have a surgical review of her stump by Dr Patel's team. She was to have the temporary catheter out as soon as the permacath was put in and can potentially go home after dialysis if the surgical team is happy. |
| 04/10/2004 | The patient was seen by a Surgical PHO, who noted that the stump looked okay with a small area of wound breakdown on the lateral edge of the wound. He ordered daily dressings and review. |
| 05/10/04 | The patient was seen by a surgical house officer. He reviewed chest x-rays with Dr Gaffield and ordered the patients return to ward. |
| 06/10/04 | The patient elected to be discharged from hospital despite advice from a medical officer that she may become unwell and even die. |
| 09/10/04 | The patient presented to the emergency department indicating that she was advised to present by the medical ward for dressing change. |
| 11/10/04 | The patient cancelled an outpatients appointment with Dr Miach. |
| 12/10/04 | The patient has her dressing changed in the emergency department. |
| 12/10/04 | A surgical ward's outpatients note indicates an appointment with no entry. |
| 19/10/04 | The patient has a dressing change in the emergency |

.....

**DARREN WILLIAM KEATING**

| | |
|---|---|
| | department. |
| 28/10/04 | The patient has a dressing change in the emergency department. |
| 01/11/04 | The patient was seen by Dr Jenkins at the RBH. |

***Catheter Audit and Baxter Program – Statement paragraphs 88 to 103 – Transcript pages 289 to 292***

201. I recall the Acting Director of Nursing Paddy Martin spoke to me in February 2004 of concerns by the nursing staff in relation to complications following the insertion of peritoneal dialysis catheters performed by Dr Patel.

202. I was concerned that the issue was being raised by the nursing staff rather than by Dr Miach before he had gone on leave in January 2004. While I said words to Paddy Martin to the effect "If they want to play with the big boys – bring it on" I did not expect those words to be repeated and they were said in the context that if the nursing staff wish to raise these issues it required data to back up the concerns. I asked Paddy Martin to provide me with that data and expected that it would be provided. I was not told that there was a 100% complication rate in Dr Patel's performance of this procedure.

203. Paddy Martin subsequently copied to me an email dated 10th February 2004 to Robyn Pollock in which he requested those statistics (annexure RP5 to Robyn Pollock's statement (Exhibit 70)).

204. Dr Miach subsequently spoke to me in late April or early May 2004 about his concerns with the placement of peritoneal dialysis catheters by Dr Patel. These concerns were raised to support the introduction of a catheter access program by Baxter Health Care Pty Ltd. Dr Miach informed me that he had had problems with other surgeons previously employed at Bundaberg Base Hospital in inserting the catheters, that he was unable to have the catheters put in place at the Hervey Bay Hospital and that there were difficulties in getting the procedures done in Brisbane.

.....

**DARREN WILLIAM KEATING**

Dr Miach was proposing the Baxter program for placement of the catheters.

205. Dr Miach provided me with an email dated 29th April 2004 from Brian Graham at Baxter concerning the proposal (a copy is annexed marked **DWK53**) with a note requesting that I discuss the proposal with him.

206. In the course of discussing the proposal with Dr Miach I asked him for more details of the program and I also asked if he had any data concerning Dr Patel's problems with the catheters. Dr Miach said he would supply me with the further details and data.

207. I was willing to support the Baxter program because:-

(a) Queensland Health had been provided with increased funding prior to the recent election to expend on elective surgery with a significant proportion being spent in the private sector.

(b) There was a drive from Queensland Health to develop private sector relationships in order to provide an integrated public and private system for overall health care.

(c) The Baxter program would provide timely local access to this procedure rather than requiring patients to travel to Brisbane.

(d) There was no cost to the public sector and performance of the procedure in a private hospital reduced the demand on public hospital resources.

208. Dr Miach had advised me at our initial meeting that Dr Brian Thiele was the likely surgeon to perform the procedures. At that time Dr Thiele no longer had regular operating sessions at the Bundaberg Base Hospital and if he was to provide this service it was likely that he would wish to fit the patients into the operating lists at the private hospital at which he regularly operated namely the Friendly Society Private Hospital. It would not have been convenient for Dr Thiele to come to the Bundaberg Base Hospital on the infrequent occasions that the procedure was required. I

.....

**DARREN WILLIAM KEATING**

was also aware from my previous discussions with Dr Thiele that he was unwilling to resume operating at Bundaberg Base Hospital.

209. Further considerations in relation to the Baxter Program were:-

(a) The Central Zone Management Unit was requiring an increase in the number of patients using alternatives to dialysis in the hospital premises (peritoneal dialysis is managed by patients at home).

(b) There was reduced access to Brisbane surgical services for the implanting of these catheters.

(c) Implantation of the catheters requires extra training and experience by a general or vascular surgeon and apart from Dr Patel, none of the surgeons at Bundaberg Base Hospital or the Hervey Bay and Maryborough Hospitals were sufficiently trained or experienced in the procedure to provide the service.

(d) Dr Miach was unhappy with Dr Patel inserting the catheters and had told me that he had problems with other surgeons in the past in implanting the catheters. My understanding was that Dr Miach was not concerned with the general competence of these surgeons but rather their ability to perform this particular procedure. I recall Dr Jayasekera as a surgeon mentioned by Dr Miach in this context. By reputation I believed (and still do believe) Dr Jayasekera to be a competent surgeon.

210. On 15th June 2004 I attended a meeting with Dr Miach, Robyn Pollock, Lindsay Druce, the Baxter representatives, Dr Thiele, the Friendly Society Private Hospital representatives and Dr Hanelt from the Fraser Coast Health Service District.

211. At some time on that day I received from Dr Miach the document headed peritoneal dialysis stats which is exhibit 69. I do not recall receiving the document but it was received by me in the context of the Baxter proposal. I did not regard that document as suggesting that Dr Patel had a 100%

.....

**DARREN WILLIAM KEATING**

complication rate or that he had performed all of the procedures listed in the document.

212. At the meeting on 15th June 2004 the Baxter representatives outlined their proposals and answered questions put to them. I said that it would be necessary to inform Central Zone Management of the proposal but that I could not see any problems with the proposal.

213. After the meeting I sought further information as to the number of Tenckhoff catheters that had been inserted at Bundaberg Base Hospital. Annexed marked **DWK54** and **DWK55** are two emails dated 17th June 2004 from Kaye Ferrar at DQDSU together with a report showing the number of Bundaberg Hospital patients who had Tenckhoff catheters inserted. The reports showed eight patients had had the cathethers inserted between 1 July 2003 and April 2004 and that those 8 patients had had eleven procedures. The purpose of obtaining these reports was to estimate how many patients the Baxter program would be dealing with. I did not obtain the reports to check the information provided to me by Dr Miach. However, the data in the reports does show that there were more Tenckhoff catheters inserted during the relevant period than is set out in Exhibit 69.

214. After considering the proposal it was decided to proceed with the Baxter program. On 9th September 2004 I wrote to Mr Trevor Barnett, the Regional Manager of Baxter Health Care, confirming acceptance of their offer to provide the program. A copy of that letter is at annexure RP11 of the statement of Robyn Pollock (Exhibit 70).

215. Subsequently on 20th September 2004 I prepared a briefing note for Dan Bergin, Zonal Manager of the Central Zone setting out details of the program. Annexed marked **DWK56** is a copy of that briefing note together with Mr Bergin's subsequent hand written comments and a response from Peter Leck to Mr Bergin dated 14th October 2004 replying to the questions raised by Mr Bergin.

.....

**DARREN WILLIAM KEATING**

216. In the meeting, which I had with Dr Miach prior to 15th June 2004, Dr Miach raised with me who would inform Dr Patel of the Baxter program and that Dr Thiele would be the surgeon involved. I said that I would do so.

217. At that stage Dr Patel was on leave and when he returned from leave in July 2004, I informed him of the Baxter program. Dr Patel asked me why the Baxter program was being adopted. I said that it was in part due to concerns about complications with his insertion of the catheters. Dr Patel acknowledged that he had had problems with the catheters moving after insertion but said that the Tenckhoff catheter was a different type of catheter than the one he had used in the past. I told him that we were not going to change the type of catheter and that he had more than enough surgery to keep him busy. Dr Patel accepted this proposal.

218. At the meeting in my office with Dr Miach on 21 October 2004, we had a heated exchange about many issues during which he claimed to have previously given me data about his audit of catheter placements. I denied having previously received the audit document. After the meeting I emailed Dr Miach requesting a copy of the document. Annexed marked **DWK57** is a copy of the documents received by me from Dr Miach on 22 October 2004. A copy of the sheet headed "Peritoneal Dialysis Catheter Placements – 2003" is Exhibit 18. The peritoneal dialysis statistics differ from the earlier report.

219. On 22nd October 2004 I reviewed the two sheets of statistics provided by Dr Miach. It was not clear to me whether the peritoneal catheter placement audit was an analysis of all such placements by Dr Patel or only the ones with problems. Neither survey did any analysis of the results. There was no comparison with previous years or other hospitals, nor did the audit show placements which had been referred from Bundaberg to Royal Brisbane Hospital. The second sheet of statistics regarding permacath insertions in 2003 showed that the procedure was carried by a number of practitioners at Bundaberg and Brisbane with variable success.

.....

**DARREN WILLIAM KEATING**

220. By this stage the Baxter program had been implemented and I had told Dr Patel that he would not be continuing to place the catheters. Dr Miach did not suggest to me that the catheter statistics demonstrated general incompetence on the part of Dr Patel. I was aware that it was an area where other surgeons had had problems or were not prepared to undertake the procedures without further training. Furthermore, at about this time I was informed of Toni Hoffman's complaint to Peter Leck and was aware that an external review was to be conducted in relation to Dr Patel, which would include the peritoneal catheter issue.

221. I have a recollection of discussing the catheter audit document with Peter Leck who told me he had received a copy also. I believe this discussion took place after Toni Hoffman's complaint had been received by Peter Leck. I told Peter Leck that I had seen the audit and that I did not regard the audit as a good quality audit, but that Dr Patel was no longer doing the procedures and the Baxter program was in place.

***Meeting of 21 October 2004 – Statement paragraphs 96 -97 – Transcript Pages 296 - 299***

222. I have already set out in paragraphs 194 to 195 some of the details of that meeting. At that meeting I do not recall discussing the proposed Dialysis Day which had been scheduled for 22nd September 2004 (I had previously informed Dr Miach if he wished to participate in such initiatives he should bring them to the attention of the State Health Department in the planning phase to ensure prior approval.) To my recollection the meeting dealt with the several disputes which Dr Miach had had with Dr Patel and other staff members as well as the catheter audit which Dr Miach said he had provided to me previously.

***On call rostering – Statement paragraphs 104 to 113 – Transcript pages 314 to 317***

223. At the meeting with Dr Miach on 21st October 2004 we also discussed on-call rostering.

.....

**DARREN WILLIAM KEATING**

224. Dr Miach remained unhappy with changes that I had made in July 2003 to on-call rostering of resident medical staff in order to reduce fatigue and increase availability of staff during the day-time and to increase the number of staff in the emergency department at night.

225. The changes were made as a result of a review conducted by Dr Mark Mattiussi in 2001, which had not been previously implemented. I was asked by Peter Leck to implement the recommendations of the review, which I thought were reasonable. One of the results of the changed rostering arrangements was to cease the 24-hour (or potentially longer) periods for which the RMOs were on duty from 8.00am to 5.00pm and then on call from 5.00pm to 8.00am. Often the RMO went without rest for over 24 hours. The majority of the hospital's senior medical staff were supportive of the changes.

226. Attached and marked **DWK58** is a copy of Dr Mattiussi's review.

227. As can be seen from that review, the changes were not designed to make PHOs more available for elective surgery as suggested by Dr Miach. One of the results of the change was that it imposed a slightly higher burden on the senior staff such as Dr Miach to take night-time calls from less experienced personnel.

228. I had a number of conversations with Dr Miach concerning the changed roster. I asked him to provide me with details of instances where the changed rostering had impacted on patient care. He did not do so. Dr Miach is not correct when he says that after 5.00pm it is "open slather" and the onus on the admissions was put on the accident and emergency staff with some help from some of the medical staff if needed. The on call RMO on a particular day remains on call until 10.00pm. After 10.00pm the on call RMO is only called out for serious problems in the hospital. Routine admissions and ward calls are performed by accident and emergency staff. This reduces the need for the on call RMOs to come to the wards after 10.00pm for routine matters. Annexed and marked **DWK59** are memoranda dated 3 July 2003, 17 July 2003, 18 July 2003 and 30 October 2003 which I circulated explaining these changes.

.....

**DARREN WILLIAM KEATING**

229. The introduction of the changed roster resulted in a 63% reduction of fatigue leave hours for RMOs as set out in the attached report marked **DWK60**. Fatigue leave entitlement arises after a medical officer has had an insufficient break from duty for rest between working periods and as a result is regarded as unsafe to continue working.

***Meetings with Dr Miach – Statement paragraph 104 – Transcript P300***

230. When I first met with Dr Miach he wanted to arrange regular meetings with me. I said to him that I did not think that regular meetings were the best use of his or my time particularly if there were no issues to discuss. I told him I would be happy to meet with him about any issue that he had at a time suitable to him.

231. I also explained to him that my door was open to the clinical directors in relation to urgent issues. I always met with him when requested.

232. I visited the hospital wards frequently for a variety of purposes. It was not my position to treat patients. However if inpatients made complaints I went to see them and discussed their complaints.

***Peritonitis Protocol – Statement paragraph 115 – Transcript P325***

233. The change, which I requested be made to the protocol for treatment of peritonitis arose as a result of a legal claim involving a patient who received an excessive dose of gentamicin, an antibotic. Dr Michael Whitby, an infectious diseases expert who commented on the case made the recommendation that the protocol be changed. Dr Whitby's specialist expertise includes the administration of antibiotics. Queensland Health's lawyers recommended the change and I wrote to Dr Miach to request that it be implemented.

234. I was not told by Dr Miach that he had refused to implement the change. He did not discuss the matter with me at all.

235. Exhibit 97 is a copy of that memorandum and an extract from the solicitors' letter.

.....

**DARREN WILLIAM KEATING**

236. The solicitors who act for Queensland Health in these matters are required by Queensland Health to advise on risk management issues raised in claims against the hospital. Queensland Health staff are similarly required to adopt any such reasonable risk management recommendations.

***Vascular access – Statement paragraphs 120-125***

237. I recall receiving Dr Miach's letter of 8 November 2004 (Exhibit 20). After receiving it I made a number of attempts to arrange to speak to Dr Thiele. I did not speak to Dr Brian Thiele until 2 February 2005 concerning Dr Miach's proposal, because Dr Thiele was on leave for much of this period.

238. Dr Thiele asked for an indication as to how many cases he would be asked to do. I said I would get some details and send them to him. We also discussed the options as to whether the procedures would be done privately or in the public system. He said he would consider doing them in the public system as long as the procedures were elective (ie he would not be asked to do emergency procedures out of hours) and in prearranged sessions where he would do a number of the procedures in the one session.

239. On 3 February 2005 a teleconference was held with the Zonal Manager Dan Bergin, Dr Miach and others to discuss the proposal. Dan Bergin asked me to follow up Dr Thiele to get him to agree to do the public sessions. I subsequently wrote to Dr Thiele providing him with details of the number of likely procedures. A copy of that letter dated 22 February 2005 is Exhibit 119. I recollect that it was agreed that a submission would be forwarded to Dan Bergin for extra funding if Dr Thiele would not operate at Bundaberg Hospital.

240. At the time I went on leave in April 2005 I had not received Dr Thiele's reply.

241. Dr Thiele is a VMO to Bundaberg Hospital. He conducts an amputee clinic and from time to time does emergency vascular surgery. Dr Thiele

.....

**DARREN WILLIAM KEATING**

had previously conducted 2 public sessions a week, but in January 2004 he had requested that he terminate his VMO contract.

242. I asked him to reconsider because he was a very good surgeon and Bundaberg Base Hospital required his services.

243. I asked why he wished to terminate his VMO contract. He told me that he was unhappy with the quality of service provided by the anaesthetic department. At my request he agreed to continue the amputee clinic and do some limited emergency operations if available.

***Meeting of 1 June 2004 – Statement paragraph 127 – Transcript pages 332 - 335***

244. I had a meeting with Dr Miach, Linda Mulligan and Robyn Pollock on 1 June 2004 concerning renal services and in particular the integration of the renal units at Bundaberg and Hervey Bay.

245. Dr Miach wanted additional medical staff. Linda Mulligan and I agreed that additional staff were required in the longer term but the first step was arriving at a plan as to how the integration would occur, for instance:

- where the acute patients would be treated
- where the nursing education was to be located
- how to standardise treatment protocols and procedures so that nurses could maintain patients on dialysis in order that the best use was made of Dr Miach's knowledge and experience.

246. It was in this context that I told Dr Miach that there is a business side to managing hospitals. I did not say "This is a business. It's not a hospital."

247. I was merely attempting to tell Dr Miach that expenditure had to be planned and justified having regard to competing priorities across the whole health service.

248. Dr Miach frequently put forward uncosted proposals for expenditure in his department without apparent consideration of the demand for funding of

.....

**DARREN WILLIAM KEATING**

other areas of the service. While this is understandable in a clinician, as an administrator I was required to take a wider view.

***Threats – Statement paragraphs 128 – 130 – Transcript page 335***

249. After Toni Hoffman's letter of 22 October 2004 was tabled in Parliament, I was informed by hospital staff that Dr Miach was unhappy at being publicly named in the letter. I went to his office to discuss the issue. He thought that the letter had been leaked by someone in administration and was upset and seeking an apology. I said that a number of the other nursing staff were upset about the leaking of the letter. When I said "you know what goes around comes around" I was merely suggesting that whoever had leaked the letter would suffer the displeasure of those who were upset. It was not a threat. I had no reason to threaten Dr Miach.

250. I have been supportive of all the overseas trained doctors employed by Bundaberg Hospital. I have assisted them to extend their visas, undertake Australian Medical Council exams and apply for specialist recognition. This support has included reimbursement of fees, leave and roster adjustments. There was not the slightest suggestion that the position of any of these doctors would be vulnerable because of any involvement with the Dr Patel issue or because they were overseas trained doctors.

***Lack of feedback – Transcript Page 343***

251. The Executive Council meeting to which Dr Miach refers at page 343 of the transcript was held on 4 March 2005.

252. At that meeting the Council received minutes of a number of other meetings including the minutes of the Medical Clinical Services Forum held on 1 February 2005. Annexed and marked **DWK61** is a copy of those minutes.

253. When Dr Miach raised the issue of feedback, I told him I would speak to him privately because I did not wish to embarrass him at the meeting concerning the lack of content in his minutes.

.....

**DARREN WILLIAM KEATING**

## EVENTS SUBSEQUENT TO TONI HOFFMAN'S COMPLAINT OF 22ND OCTOBER 2004

254. After Peter Leck had provided me with a copy of Toni Hoffman's letter of complaint dated 22nd October 2004, I arranged meetings with a number of the Bundaberg Hospital doctors who Toni Hoffman had suggested shared her concerns. Annexed **DWK62, DWK63, DWK64** are file notes which I made of meetings with Dr Dieter Berens on 29th October 2004, Dr David Risson on 2nd November 2004 and Dr Martin Strahan on 5th November 2004.

255. Peter Leck had decided to arrange an external review of the allegations made by Toni Hoffman. He assumed responsibility for the management of the complaint and organising the external review. I assisted him as requested. I obtained the names of several surgeons who might conduct the review. My preference was to have the review conducted by a surgeon who understood the demands and limitations of practicing in a regional hospital. A suitable person was located at Redcliffe Hospital, but Peter Leck had spoken to the Audit & Operational Review Branch following which it had suggested that Dr Gerry Fitzgerald conduct the audit. I believe this occurred before Christmas 2004 but Dr Fitzgerald was unable to conduct his investigation until February 2005. While there was considerable delay in organising the review, during this period the Tilt Train crash occurred which required a greatly increased workload for most hospital staff, including Peter Leck.

256. During the Tilt Train episode, Dr Patel's performance was seen to be of a very high standard. This was not only my observation but also that of the Director of the Emergency Department at Royal Brisbane and Women's Hospital who was seconded to Bundaberg Hospital at the time.

257. On 20 October 2004 before I became aware of Toni Hoffman's complaint, Dr Patel had approached me asking for a renewal of his contract. He had also asked that his visa sponsorship be renewed for a four-year period. Recent changes had extended the permissible visa period from one year to four years to give foreign trained doctors a greater period in which to sit for the AMC examination and/or gain specialist qualification. Prior to this

Dr Patel had given me some excuses as to why he had not completed his application for specialist qualification; but at this stage I still had an expectation that he would do so.

258. After Toni Hoffman's complaint I delayed taking any action in relation to Dr Patel's request as I was awaiting the outcome of the review. However, in December 2004, Dr Patel approached me concerning the unresolved sentinel event report regarding Mr Bramich. Dr Patel indicated that he was very uncertain whether he wished to renew his contract for the following year and demanded that an offer be made to extend his contract prior to his taking planned leave over the Christmas period. Dr Patel said he would give consideration to an extension of his contract during his leave.

259. Consequently, I wrote to Dr Patel by a letter dated 24th December 2004 offering to extend his contract from 1st April 2005 to 31st March 2009. Annexed marked **DWK65** is a copy of that letter together with the enclosures with that letter. I was not aware of any Queensland Health guidelines, which required temporary appointments greater than one year to involve a formal merit based assessment.

260. As I have indicated in paragraph 35 above, it was necessary for arrangements for renewal of medical practitioners' temporary visas to be made well in advance of the expiration of their current visa. While concerns had been raised by Toni Hoffman, those concerns were yet to be investigated and verified. Renewal of Dr Patel's contract would not prevent any necessary disciplinary or remedial action being pursued including termination of his contract. However, if arrangements were not put in place to renew his contract or to find a replacement in the near future, then the hospital would find itself without a senior surgeon.

261. Dr Patel returned from his leave in early January 2005. In the meantime I had conducted a review of incidents, which had occurred during his tenure and had discussions with Peter Leck concerning Dr Patel's future. In those discussions I suggested that the best option for the hospital would be to recruit a new Director of Surgery as soon as possible and that in the

interim further boundaries in relation to Dr Patel's surgical practice would be developed. Annexed marked **DWK66**, is a copy of my summary of incidents during Dr Patel's tenure and my discussions with Peter Leck.

262. I also prepared a summary of my impressions of Dr Patel. Annexed and marked **DWK67** is a true copy of that document.

263. On 13th January 2005, I arranged a meeting between myself Dr Patel, and Peter Leck to discuss the clinical issues that had arisen and the complaints that had been made by nursing staff.

264. Prior to that meeting Dr Patel was unaware of the intended investigation by Dr Fitzgerald. At the meeting Dr Patel was told of the intended investigation. He said that he felt that his position was untenable and that he did not intend to renew his contract. At that meeting, Dr Patel agreed, at our request, not to undertake elective surgical cases requiring admission to ICU.

265. Annexed marked **DWK68** is a copy of a letter dated 14th January 2005 from Dr Patel to myself in which he indicated that he would not renew his contract as Director of Surgery but would fulfil his obligations until 31st March 2005. I replied to Dr Patel's letter the same day (Exhibit 16). That letter was not intended to be a reference. It was no more than an expression of appreciation for Dr Patel's efforts during the previous two years.

266. Following Dr Patel's resignation, I received a letter of support from a number of the junior medical practitioners on the hospital's staff. This letter and a reply from me are annexures ARA4 and ARA5 of Dr Athanasiov's statement Exhibit 142.

267. At about the same time that Dr Patel indicated he would not be renewing his contract, I had received notice from the other staff surgeon, Dr James Gaffield, that he intended to go into private practice and would be ceasing his employment at approximately the same time as Dr Patel. I had discussions with Dr Gaffield and he agreed to extend his contract for a

.....

**DARREN WILLIAM KEATING**

further six weeks. We also discussed the possibility of Dr Gaffield being a VMO at Bundaberg Base Hospital.

268. One to two weeks after Dr Patel indicated he would not be renewing his contract, Dr Patel spoke to me and indicated that he would be prepared to extend his contract to the end of July 2005 or such earlier date as the hospital was able to recruit another surgeon. In view of Dr Gaffield's resignation, Dr Patel indicated that he felt an obligation to the hospital, particularly in relation to the waiting lists and his teaching commitments with the University of Queensland.

269. Consequently, I wrote to Dr Patel by letter dated 2nd February 2005 confirming the offer of a temporary full time position of Locum General Surgeon for the period from 1st April 2005 to 31st July 2005. Annexed marked **DWK69** is a copy of that letter. I also wrote to the Medical Board by letter dated 31st January 2005 seeking renewal of his registration. In that letter I have indicated that the contract was to be extended to 31st March 2009. I also wrote to the Department of Immigration seeking an extension of Dr Patel's visa for four years. Annexed marked **DWK70** and **DWK71** are copies of the letter to the Medical Board dated 31st January 2005 and to the Department of Immigration dated 1st February 2005 together with the enclosures to those letters.

270. In those letters I described the period of Dr Patel's proposed employment as four years. As I have indicated in paragraph 257, the immigration rules had altered such that four year visas were available for medical practitioners on temporary visas such as Dr Patel. Medical Board registration was still required on a year-to-year basis as was the area of need certification. However renewal of the immigration visas yearly required a great deal of paper work. It was not certain when the hospital would be able to engage a replacement surgeon. Dr Patel had indicated that he would be available to return as a locum in the future after his daughter's wedding. Consequently I sought a four year visa so as to avoid the need for future paper work in the event that Dr Patel did return as a locum in the future. Dr Patel's visa would be conditional upon his

.....

**DARREN WILLIAM KEATING**

continued employment with Bundaberg Hospital as a sponsor and he was not entitled to be employed by any other employer.

271. The letter to the Medical Board dated 31 January 2005 was incorrect when it referred to the extension of Dr Patel's contract to 31 March 2009. The error is likely to have arisen because the documents were originally prepared in connection with the earlier documents referred to in paragraph 259.

272. I did not correct the error because I did not notice it.

273. The documents provided to the Immigration Department, which described the proposed period of employment as four years were, as I have indicated above, designed to obtain a four year visa confined to employment at Bundaberg Hospital.

274. At the time I completed the documents for renewal of Dr Patel's registration with the Medical Board my expectation was that he would continue as Director of Surgery until a replacement was found and might also subsequently return from time to time as a locum. When I completed the assessment of Dr Patel's performance it was done in haste and in the knowledge that it would be seen by Dr Patel, which on reflection affected my assessment of his performance. I accept that I overrated his performance in most categories; however it remained at that time my view that he appeared to be a very good teacher and to be professionally responsible. He did also appear to be knowledgeable. Whilst my view was that he had acted inappropriately in his communications with the Bramich family, I had received many good reports about his communication with patients generally. I acknowledge that there had been other complaints about his communications with patients but that is not unusual for a practitioner in his position. His documentation and time management skills appeared to me to be good. I did not at that time have so much concern about his clinical skills, but I did in the assessment overstate his clinical judgement and teamwork skills.

.....

**DARREN WILLIAM KEATING**

275. While I was on leave in late March and early April 2005, Toni Hoffman's letter of 22nd October 2004 was tabled in the State Parliament and Dr Patel resigned with effect from 31st March 2005.

276. I returned from leave on 4th April 2005. On 5th April 2005, I wrote to the Department of Immigration withdrawing the hospital's sponsorship of Dr Patel's visa.

277. Because of the controversy which had arisen I became curious as to Dr Patel's history. As a result at home on the evening of 6th April 2005, I conducted an internet search and discovered the restrictions on Dr Patel's registration in Oregon and the cancellation of his registration in New York.

278. On 7th April 2005, at the first available opportunity, I informed Dr Buckland, the Director-General, Queensland Health who was visiting Bundaberg Hospital that day of the results of my internet search. Dr Buckland informed me that he would ensure the information was passed on to the Medical Board of Queensland. I did not tell him that I wished to remain anonymous.

279. Attached marked **DWK72** and **DWK73** are memoranda dated 6 April 2005 and 14 April 2005 which I sent to hospital staff regarding Dr Patel's resignation. When I wrote the first memorandum I was unaware of Dr Patel's history and was concerned that the investigation into Dr Patel was not to be completed. A number of the hospital staff had mentioned their concerns that, while they might not have liked Dr Patel as a person, they thought he deserved an opportunity to defend himself. Many were concerned such a process could happen to them and that there was a loss of trust in the working relationship between medical and nursing staff. The second memorandum was written before I agreed to go on leave.

**STUDY AND OTHER TRAVEL REIMBURSEMENT FOR DR PATEL**

280. Because of the difficulty in recruiting and retaining senior medical practitioners at Bundaberg, I encouraged them to maximise their use of

.....

**DARREN WILLIAM KEATING**

their entitlements and tried to avoid placing obstacles to their access of these benefits.

281. In relation to the approval and reimbursement of airfares and expenses for study leave taken in October 2003 I was unaware that overseas trained doctors with no permanent residency were not entitled under the relevant award to study and conference leave. I was also unaware of the requirement that leave taken prior to the initial one year's continuous service required ministerial approval. I believed that Dr Patel was entitled to the leave and that the approval could be given at District level. To some extent I relied on the Human Resources Department to advise me of restrictions of these types when the approved leave application was sent to that Department, if the leave approved by me was not authorised by the guidelines. In the past if I approved leave, which was not authorised or available the Human Resources Department would advise me. It did not do this on this occasion. The airfares and expenses were reimbursed as part of what I believed was Dr Patel's study leave entitlement.

282. In September 2003 Dr Patel approached me regarding his entitlement to return airfares at the end of each contract period, i.e. yearly. He claimed he was entitled to this under the terms of his original contract negotiated between Bundaberg Base Hospital and Wavelength. I could not find any documentary evidence of this. Dr Nydam was on leave so contact was made with Wavelength by telephone and it was confirmed that this had been agreed in the negotiations. I cannot recall whether I made the contact or had a staff member do it. Annexed marked **DWK74** is a copy of a memorandum which I made recording the telephone advice.

283. Consequently I accepted this arrangement and approved travel from 30 April 2004 to 4 July 2004. I was not aware at that time that Dr Patel had previously been reimbursed for the cost of his original travel to Australia which would be regarded as part of that annual entitlement.

284. In the application for leave, which I approved on 17 February 2004, the leave is described as 21 days study leave and the balance as recreation leave.

.....

**DARREN WILLIAM KEATING**

285. I have mistakenly approved the study leave without any proposed study program being provided or any check as to his entitlement to study leave having been carried out.

286. The leave should have been approved only as recreation leave with the balance being leave without pay.

287. I subsequently approved reimbursement of Dr Patel's return airfare to the United States from 27 December 2004 to 10 January 2004 in the belief that it represented his entitlement for his second contract year as set out in paragraphs 282 and 283 above.

***PATIENT P21 – G KEMPS***

288. I first became aware of this patient on 21 December 2004 when Peter Leck sent me by email a night report, which indicated that Mr Kemps was not expected to survive. Annexed marked **DWK75** is a copy of the email dated 21 December 2004 and the attached night report.

289. I subsequently spoke to Dr Patel about the patient. Dr Patel told me that the patient previously had had an abdominal aortic aneurysm repaired and that Dr Patel believed that he had had a thoracic aortic aneurysm, which had haemorrhaged following the oesophagectomy.

290. I checked to see how many oesophagectomies had been performed by Dr Patel. I found he had carried out 4 (including Mr Kemps), 2 of whom had survived.

291. On 21 December 2004 I also carried out some research about oesophagectomies, including the means by which they were performed and likely outcomes. Dr Patel had in the past told me that there were two methods of performing the procedure and he used the method, which did not require the thorax to be opened. My research confirmed that this was one of the accepted methods.

.....

**DARREN WILLIAM KEATING**

292. I also spoke to Gail Doherty, the Nurse Unit Manager of the Operating Theatre. She told me that a number of the nursing staff were also concerned as to this patient's outcome.

293. The issue of oesophagectomies had been raised in Toni Hoffman's complaint to Peter Leck. I resolved to instruct Dr Patel to cease these procedures.

294. Dr Martin Carter also rang me shortly after the death of Mr Kemps to ask whether a death following an operation was required to be reported to the Coroner. I explained that there was a new Coroner's Act in force which did not require all peri-operative deaths to be reported. I arranged to send Dr Carter some information about deaths that were required to be reported.

295. Dr Carter and Dr Berens subsequently visited me to discuss whether the death should be reported to the coroner. I informed them of the information, which Dr Patel had given me about the cause of Mr Kemps' bleeding.

296. At that meeting I told Dr Carter and Dr Berens that if they considered that the death should be reported, they should do so. I said that it was their decision as they were present at the operation and knew what had happened.

297. Dr Carter checked the local newspaper and found that the funeral was scheduled that morning. Both he and Dr Berens decided that they would cause the family distress by asking that the funeral be postponed and decided not to report the matter to the Coroner.

298. At that meeting Dr Carter and Dr Berens also discussed with me their concerns about the outcomes for Dr Patel's oesophagectomies. I told them that Dr Patel would not be permitted to perform any more oesophagectomies. I asked them to inform their staff of that decision.

299. On 15 April 2005 I reported Mr Kemps' death verbally to the Coroner in the company of Dr Nydam.

.....

**DARREN WILLIAM KEATING**

300. I was not aware of the statements made by nurses Zolak, Law and Gaddes concerning Mr Kemps and Dr Patel, which were provided to Linda Mulligan and then Peter Leck as they were treated as "whistleblowers".

***EVIDENCE OF DR T M STRAHAN***

301. In his statement (Exhibit 232) and evidence at pages 3275 to 3277 Dr Strahan describes a patient with a tumour in the duodenum, whom he suggests was kept away from Dr Patel by a nurse. Toni Hoffman in her statement (paragraph 153) and evidence (pages 182 to 184) refers also to a patient, who was admitted as a medical patient so that she could be transferred to Brisbane without Dr Patel's knowledge to save her from having an oesophagectomy.

302. Dr Strahan spoke to me about this patient in March 2005. He did not tell me anything to the effect that he, Toni Hoffman and Dr Miach were collaborating to hide this patient from Dr Patel. He told me that he had concerns that the patient had an underlying medical condition and that the operation was beyond the capabilities of Dr Patel and the hospital. He said that he planned to tell Dr Patel of the patient's transfer after it had occurred because he was reluctant to tell Dr Patel beforehand. He asked me to inform Dr Patel that the patient had an underlying medical condition and would need to be transferred to Brisbane. I informed Dr Patel of the decision, which he accepted. I informed Dr Strahan of this.

***EVIDENCE OF DR G DE LACY***

303. In July 2003 Dr de Lacy asked me if he could do weekly sessions at Bundaberg Base Hospital. He had already had discussions with the other public and private general surgeons and had agreed to contribute to the surgical weekend on call roster.

304. I told him that the hospital did not have any VMO positions available for general surgery. I wished to use any available additional funding to employ a recently arrived ear, nose and throat surgeon who had expressed a desire to be employed at the hospital. The hospital had no

ear, nose and throat service at all. As my next priority I was also keen to employ an ophthalmologist as a VMO.

305. Dr de Lacy commenced contributing to the on call roster shortly after his arrival but only as Dr Anderson's nominee to share Dr Anderson's weekend duty. Because of the industrial award arrangements Dr de Lacy could not be appointed as a VMO to the hospital because we could not afford to allocate any operating sessions to him. There was also some administrative difficulty with Queensland Health in Brisbane resulting from his previous employment at Fraser Coast Health Service, which delayed his appointment as a VMO. His formal appointment as a VMO was not finalised until October 2004.

306. Consequently in August 2003 Dr de Lacy did not have a formal appointment as a VMO to the hospital.

307. I do not recall Dr de Lacy speaking to me about P265 prior to his admission on 12 August 2003. However, I accept that I did have a conversation with him at some time. Given the time at which the admission and initial treatment took place Dr de Lacy would have to have telephoned me at home unless the conversation took place the next day at work or on a subsequent day. If he had phoned me at home in the middle of the night I would recall the call.

308. The hospital records show that P265 was admitted directly to the ICU at Bundaberg Base Hospital at 10.00pm on 12 August 2003 where he was seen by Dr Joiner who arranged for Dr Smalberger to review the patient. The patient was next seen by Dr Risson and then by Dr Patel.

309. I have no recollection of my discussion with Dr de Lacy concerning P 265. However, it is clear from the hospital records that the patient was admitted as an emergency patient directly to the ICU. While the hospital's records show him to be a private patient the person responsible for private admissions did not work after hours. It is likely that the patient was treated as a public patient initially and the paperwork for his private admission was not completed until the next day. Consequently the patient was

.....

**DARREN WILLIAM KEATING**

admitted under the care of the surgeon on call for that day. It is unlikely that at the time of my conversation with Dr de Lacy that I knew that the patient had been admitted at any stage as a private patient.

310. If Dr de Lacy had had a formal appointment as a VMO at that time it would have been possible for him to have been responsible for the patient's care as a private patient.

311. After Dr Patel left Bundaberg Base Hospital in March 2005, Dr de Lacy arranged to meet with me. It was intended that Dr Gaffield also attend the meeting but he was unable to keep the appointment.

312. Dr de Lacy said he was keen to assist the hospital as a VMO surgeon but was concerned that he might be subjected to complaints in the same way that Dr Patel had.

313. Dr de Lacy told me he was seeking to take over Dr Patel's university appointment. I told him that he would have to work out those arrangements with the university but that the hospital would not wish to pay him for his public patient sessions if he was being paid for that time by the university. I said he could be paid directly by the university or the university could pay the hospital for his teaching services (a large portion of the teaching time is spent performing public patient clinical work). I took no action in relation to Dr de Lacy's suggestion as I took leave shortly afterwards.

314. It has been suggested that Dr de Lacy would have been a suitable appointment as Director of Surgery instead of Dr Patel because Dr de Lacy had Australian specialist qualifications. I did not consider this possibility because Peter Leck made it clear to me that he preferred to have a full time employed surgeon as director and I did not disagree with this preference.

.....

DARREN WILLIAM KEATING

## COMPLAINTS REGARDING DR PATEL

## EXTERNAL COMPLAINTS

315. In April or May 2005, I asked the DQDSU for copies of all complaints and registration forms involving Dr Patel.

***Patient P136 -***

316. Dr Patel was involved in an incident concerning this patient on 14 May 2003. He underwent a gastroscopy by Dr Patel, for which he was not scheduled or consented. He was admitted for a right epididyectomy, which he received. My report of this incident with recommendations is attached as **DWK76**. The patient didn't attend his follow-up appointment on 15 August 2003 with me and he could not be contacted thereafter.

***Patient P53 -***

317. This patient made a complaint on 26 May 2003. Her injury was caused by another surgeon and not Dr Patel. Dr Patel was asked for an opinion on the incident, which he provided as found at annexure GF19 of Dr Fitzgerald's statement Exhibit 225.

***Patient P151 -***

318. The next external complaint about Dr Patel was received from this patient on 1 June 2003. The patient complained that a procedure on his ear to remove a skin lesion was performed on the wrong area of his ear.

319. On receipt of the complaint, I investigated it. The lateral margin of a skin cancer had only been removed at the operation. I discussed the patient with Dr Patel who agreed to review him the following week. I rang the patient on 3 June 2003 to inform him of these arrangements. Another letter of complaint dated 11June 2003 was received. Peter Leck requested me to review the chart and complaint. Thereafter Peter Leck spoke to the patient who agreed to a further operation on 22 July 2003. No further complaint about this procedure was received. All the notes

.....

**DARREN WILLIAM KEATING**

relating to this complaint (including my notes) are contained in Annexure GF19 of the statement of Dr FitzGerald Exhibit 225.

***Patient P126 – Mr Ian Fleming***

320. Mr Fleming telephoned Bundaberg Base Hospital on 28th October 2003 to make a complaint. The Notification of Complaint form was completed by Joan Dooley, a secretary in the Executive Services Section. The procedure requires that the person who takes the complaint completes the Notification of Complaint form with the details of the complaint. That document is annexure "IGF3" to Mr Fleming's statement, which is exhibit 114.

321. The complaint was referred to me and I spoke to Dr Patel on 29th October 2003. My notes of that conversation are contained on the Notification of Complaint form referred to above.

322. After informing Dr Patel of the circumstances of Mr Fleming's complaint, Dr Patel advised me that he had authorised an early outpatient's appointment for Mr Fleming and that he would review Mr Fleming in the Outpatients Department with a view to carrying out a colonoscopy if required.

323. My secretary subsequently obtained details of the date for outpatients review which was 2.15pm on 11th November.

324. I telephoned Mr Fleming in the afternoon of 30th October 2003. My notes of that conversation are contained on the Notification of Complaint form.

325. I informed Mr Fleming that the colonoscopy list was not an open list that he could be placed on but required a referral and review by a specialist. I explained that he would need to come to the Outpatients Department on 11th November 2003 at 2.15pm to be seen by a specialist. I explained that colonoscopy is one investigation of rectal bleeding but not the only investigation. I explained also that his haemoglobin level had remained constant. I informed Mr Fleming that he needed medical attention but that

.....

**DARREN WILLIAM KEATING**

his condition was only semi-urgent and that he must wait for the appointment.

326. In relation to the allegations in paragraphs 23 to 29 of Mr Fleming's statement, Mr Fleming may have discussed with me his post-operative wound infection since that was recorded in the original notification of complaint. If however Mr Fleming had made further complaints concerning Dr Patel's actions then I would have recorded those complaints.

327. I deny that I described Dr Patel as set out in paragraphs 23 and 29 of Mr Fleming's statement. My usual practice was to describe Dr Patel as a senior experienced surgeon.

328. I also deny that I suggested that morphine was expensive. I would not make a statement to that effect.

329. I believe that the substance of my discussions with Mr Fleming are as set out in my contemporaneous notes of that discussion.

***Patient P 198 -***

330. This patient complained on 21 November 2003 about swelling and bruising of his scrotum following repair of his inguinal hernia. I provided an explanation, reassurance and offered him three options. These were to attend his local GP or the emergency department for immediate review or early review at Dr Patel's Outpatient Clinic. I believe he accepted the last option and an early review appointment was made.

***Geoffrey Smith***

331. The next complaint was from Mr Geoffrey Smith on 27 February 2004. He was unhappy about Dr Patel using local anaesthetic only to remove a lesion on his shoulder. He had requested general anaesthetic for the procedure as he was fearful that local anaesthetic didn't work. Dr Patel discussed the situation with the patient who agreed to have local

.....

**DARREN WILLIAM KEATING**

anaesthetic. However during the procedure the patient believed the local anaesthetic wasn't working and more was administered with little effect.

332. In some patients local anaesthetic is not effective and Mr Smith may have been such a patient.

333. The patient was unhappy with Dr Patel's attitude towards him throughout this time. In recovery, he felt unwell possibly related to the amount of local anaesthetic and associated anxiety. He was discharged and returned the next day seeking a medical certificate as he had not been provided with one. I met with Mr Smith and followed up with a written apology. (Annexure GS1 to Mr Smith's statement Exhibit 174) Dr Patel was counselled about his manner in such situations and an alert was placed on the patient's file relating to the use of local anaesthetic. (Exhibit 190).

***Patient P108 - Vicki Lester***

334. In March 2004 Mrs Lester applied for patient travel subsidy in order that she could be treated at the Rockhampton Hospital. I refused that application because the surgery was available locally and Mrs Lester had previously visited the Bundaberg Base Hospital regarding this problem.

335. Mrs Lester subsequently spoke to my secretary. A note of my secretary's conversations with Mrs Lester is contained with the patient travel subsidy scheme documentation and is annexed marked **DWK77**.

336. I subsequently received a telephone call from a person with the Health Rights Commission indicating that Mrs Lester had made a complaint to the Health Rights Commission. I explained that I had not previously received a complaint but would be happy to review it when it was received.

337. On 2 March 2005 I received a letter of complaint from Mrs Lester dated 25 February 2005, which I acknowledged on 4 March 2005 (See annexures VEL5 and VEL6 to Mrs Lester's statement Exhibit 176). I briefly reviewed the records relating to Mrs Lester and proposed to discuss the matter with Dr Patel on his return. From my brief review I could see that Mrs Lester's relevant history was long and complex and involved many other

.....

**DARREN WILLIAM KEATING**

practitioners over a long period of time and would take some considerable time to investigate before I could speak to Dr Patel. I received a follow-up phone call from a person at the Health Rights Commission. I explained my limited review and plan. However I did not get an opportunity to discuss her case with Dr Patel before he left the country and I went on leave.

***Patient 131 -***

338. This patient made a complaint on 2 July 2004 involving Dr Patel. After a normal screening mammogram, she had presented to Dr Patel in July 2003 with an itchy area around her right nipple. He diagnosed eczema and prescribed a steroid cream. The patient didn't attend the follow-up appointment in September; but did present to Dr Gaffield in October 2003 for review of another unrelated surgical condition. He reviewed the nipple area and recommended review in three months. At this next review by a Surgical PHO, the patient's complaint hadn't resolved. Further investigation revealed Pagets Disease of the breast. Treatment options were discussed with the patient who demanded to have a double mastectomy which was performed. This complaint was discussed with Dr Patel, who provided an explanation of his diagnosis and management plan based upon the normal mammogram. The notes related to this complaint are at annexure GR19 of Dr FitzGerald's statement - Exhibit 225. The patient is also discussed at paragraphs 51 to 61 of Dr Gaffield's statement - Exhibit 294.

***Adverse Event Reports – Dr Patel***

***Patient P127 -***

339. An Adverse Event Form relating to this patient was received by DQDSU on 20 August 2004. This form reported a wound dehiscience, which was to be discussed at the next Surgical Erromed meeting. I reviewed the form on 27 August 2004 noting that a recent audit had showed a reduced yearly incidence of wound dehiscience. I was pleased to see that the clinical staff were to discuss this report in order to identify any actions that

.....

**DARREN WILLIAM KEATING**

could have prevented this outcome. I expected the system to monitor the number of these reports and I don't recollect any other reports of dehiscience being forwarded to me.

***Patient P15 -***

340. An Adverse Event Form relating to this patient was received by DQDSU on 29 October 2004. This form reported a post-operative complication following an elective laparoscopic cholecystectomy. I recommended that the Surgical Errormed meeting should review the case.

**EVIDENCE OF JENNIFER WHITE**

341. In paragraphs 28 and 29 of her statement – Exhibit 71, and in her evidence (at pages 1237 to 1239). Jennifer White refers to Dr Patel's actions regarding a motor accident at Mon Repos in about June 2003 which she described as entirely inappropriate.

342. The facts surrounding that incident as I recall were as follows:-

- The Bundaberg Hospitals' Department of Emergency Medicine was initially informed of the accident and one of its staff was sent to the accident site with a supply of the medications which might be required for such an event, including those required for emergency anaesthesia.

- That staff member when he arrived at the accident scene telephoned and requested that a surgeon be sent because a person was trapped inside the vehicle, was possibly in a critical condition, and might require an amputation to be performed so that the injured person could be removed from the vehicle urgently.

- I was contacted by the Department of Emergency Medicine to seek permission for medical staff to be sent as usually medical staff would not be sent to an accident site.

.....

**DARREN WILLIAM KEATING**

- With my approval Dr Patel, an intern from the surgical staff, an intern from the medical staff, and a nurse went to the accident scene. However it was not necessary for an amputation to be performed.

**EVIDENCE OF DR JAMES BOYD**

343. In paragraph 70 of the statement of Dr James Boyd (Exhibit 260), Dr Boyd refers to a conversation with me regarding wound infections. The conversation was an interview at the time of Dr Boyd finishing his term at Bundaberg Hospital. Because Dr Boyd had worked recently at other similar hospitals, Toowoomba and Rockhampton, I was interested to compare his experiences at Bundaberg with the other hospitals and to get some comparison of Bundaberg's performance with other hospitals.

**EVIDENCE OF DR GERARD FITZGERALD**

344. I met with Dr Fitzgerald on 14 February 2005 regarding the investigation of Dr Patel. Dr Fitzgerald asked me during that meeting of my assessment of Dr Patel. I informed Dr Fitzgerald that some weeks earlier Dr Patel had been directed and had agreed not to perform any further oesophagectomies or any elective surgery requiring intensive care support.

345. Later that day I had a further meeting with Dr Fitzgerald and other members of the hospital executive. Dr Fitzgerald expressed concern that operations had been performed which were outside the scope of practice of the hospital. He also expressed concern about the lack of a credentialing and privileges process with respect to Dr Patel. I informed Dr Fitzgerald that the surgeons at the hospital had not been through that process because the Royal Australasian College of Surgeons had not provided a representative for the credentialing and privileges process.

346. Dr Fitzgerald said that if the Hospital could not get a representative from the College of Surgeons then it should ask a local surgeon to do the task even if he was not nominated by the College.

.....

**DARREN WILLIAM KEATING**

347. Dr Fitzgerald said he was unsure whether he would refer the issues concerning Dr Patel to the Medical Board and would have to carry out further investigations. He said he had identified significant personality issues among the staff including Dr Patel and particularly the intensive care staff and that the case involving Mr Bramich had been the trigger for the complaint by Toni Hoffman and that Dr Carter had tended to pour oil on both fires, that is, the nurses' side and Dr Patel's side.

348. Dr Fitzgerald said that he would prepare a draft report and forward it to the executive to review. He also said there was a need at the hospital to improve data collection and review.

349. During one of the meetings on 14 February 2005, Dr Fitzgerald requested that he be supplied with any claims made against the hospital by patients arising out of Dr Patel's practice. I informed Dr Fitzgerald that the only claims apart from the Bramich claim made against the hospital concerned another surgeon Dr Gaffield but that there had been some minor patient complaints regarding Dr Patel which had been resolved.

350. Dr Fitzgerald did not ask me for details of patient complaints or adverse event reports relating to Dr Patel.

351. I next met with Dr Fitzgerald on 13 April 2005 when he outlined the findings of his investigation. In his draft report (Exhibit 230) Dr Fitzgerald refers to data from which he has arrived at conclusions suggesting that Bundaberg Hospital had higher rates of unplanned readmissions and certain complications than other hospitals. The data from the Client Service Unit of the Health Information Centre upon which Dr Fitzgerald relied was not routinely supplied to hospital administrators such as myself nor was the information easily accessed for the purpose of observing trends at the hospital. This data is primarily intended to be used for epidemiology purposes and is not routinely validated by clinicians. I understood that the relevant data for observing trends at individual hospitals was that contained in the Transition II database.

.....D.Keating.....

**DARREN WILLIAM KEATING**

## ORGANISATION STRUCTURE OF BUNDABERG HEALTH SERVICE DISTRICT

352. The organisational structure of the Bundaberg Health Service District is explained in the annexed organisational charts marked **DWK78**. The basis of this structure is function i.e. all medical services being the responsibility of the Director of Medical Services and all nursing services being the responsibility of the Director of Nursing Service. These charts outline the reporting lines for staff, including medical staff. The Director of Medical Services position description sets out those positions directly reporting to the position (DWK2).

353. During the recruitment and selection process for the position of Director of Medical Services, the position description showed there was management responsibility for allied health staff. Prior to my arrival at Bundaberg Base Hospital in April 2003, this responsibility had been temporarily transferred to the Director of Community Health Services. In early December 2003, management responsibility for pharmacy and medical imaging was transferred back to the Director of Medical Services position.

## QUALITY AND SAFETY ISSUES

### *Scope of Practice*

354. When I arrived at Bundaberg Hospital the process for establishing a Senior Medical Officer's credentials and granting clinical privileges had lapsed. In August 2002 Queensland Health had introduced a policy in this respect – the Credentials and Clinical Privileges for Medical Practitioners Policy and the Credentials and Clinical Privileges Guidelines for Medical Practitioners -Exhibit 279.

355. In conjunction with Dr Terry Hanelt, Director of Medical Services Fraser Coast Health Service Department (HSD), a joint policy for the two districts on this subject was completed to comply with the Queensland Health Guidelines – Exhibit 276. A joint policy was developed to ensure a critical mass of practitioners was available to undertake the process and to use scarce resources efficiently. The District Manager approved interim clinical

.....

DARREN WILLIAM KEATING

privileges for senior medical practitioners based upon advice from the Director of Medical Services.

356. A Credentials and Privileges Committee is required by the Queensland Health Guidelines to have a representative of the relevant specialist college attend meetings where a practitioner of that specialisation is seeking privileges. Dr Hanelt agreed to contact the relevant colleges to seek representatives. Attached as annexure marked **DWK79** are a bundle of emails between Dr Hanelt, Dr Gopalan and myself outlining efforts to progress the establishment of this committee. Due to staff shortages, Dr Hanelt was unable to complete this task in 2003. When his Deputy Director, Dr Gopalan was appointed, he began seeking college representative nominations. The Royal Australasian College of Surgeons was not willing to provide a nomination due to the high number of requests and uncertainty about indemnity for decisions made by their members. (See the emails of 15 July 2004 and 1 January 2005). The Royal Australian and New Zealand College of Obstetricians and Gynaecologists and Royal Australasian College of Physicians (Adult and Paediatric Divisions) did provide nominations with practitioners in these specialities submitting their credentials to the committee. Meetings were held on 26 and 29 November 2004. Annexed marked **DWK80** and **DWK81** are copies of the minutes of the meeting. The practitioners received privileges approved by the relevant District Manager.

357. At that time no-one had suggested to me nor did I understand the policy to allow the appointment of a specialist to a Credentials and Privileges Committee who was not nominated by the relevant college to fill the role of the intended college appointee.

358. I was aware that the problem with the College of Surgeons not providing nominees was being experienced in other districts from conversations with other Directors of Medical Services. I assumed that Queensland Health senior management was also aware of the problem. I kept Peter Leck informed of the progress of the credentialing process and the problem with

.....

**DARREN WILLIAM KEATING**

the College of Surgeons from time to time in our regular weekly and then fortnightly meetings.

359. Pending implementation of the formal committee process, all senior medical staff were awarded interim privileges upon my recommendation. Annexure **DWK82** is a bundle of copies of letters dated 13 June 2003 from Peter Leck to Dr Patel and dated 26 June 2003, 6 November 2003 and 29 July 2004 from me to Dr Patel. Similar letters were sent to all other senior medical staff at Bundaberg Hospital. Annexure **DWK83** is a copy of a spread sheet of the status of privileges for Senior Medical Officers at Bundaberg Base Hospital.

360. As Dr Patel had been employed through a specialist recruitment company I assumed that his experience and references had been checked and that he was considered qualified for the position of Director of Surgery. Consequently I did not carry out any further investigation when granting him temporary privileges. Furthermore as there was no framework in place for determining the extent of clinical privileges, I relied on the two senior surgeons, Drs Patel and Gaffield, to delineate the areas of practice in general surgery.

361. In relation to paragraph 85 of Professor Stable's statement - Exhibit 366, in late 2003 the Australian Council of Healthcare Standards carried out a visit to survey Bundaberg Hospital. I informed the Australian Council of Healthcare Standards' representatives of the progress I was making in re-establishing a credentialing process and that in the interim temporary privileges were in place. As a result the hospital was shown as having a credentialing and privileges process in place. No further visit was done in my time of Director of Medical Services.

***Service Capability Framework***

362. Peter Leck performed the initial assessment of the service capability of Bundaberg Hospital in about June 2004. He asked me to review the assessment, which I did using the draft Service Capability Framework released in July 2003.

.....

**DARREN WILLIAM KEATING**

363. In July 2004, the final framework was introduced to replace a number of out of date publications about service capability of hospitals. I was not aware of any prior assessment of Bundaberg Hospital's service capability. Hospitals were given a 12 month period to establish the new framework.

364. On 21st September 2004, I received an email from Ms Rachel Sewell (Corporate Office) requesting that I review the service capability of Bundaberg Health Service hospitals. I made a number of amendments, which were emailed to her and Peter Leck on 22nd September 2004.

365. On 7th December 2004 Peter Leck and Linda Mulligan attended a meeting of representatives from Health Service Districts in Central Zone. The purpose of this meeting was to clarify solutions to the deficiencies in service capability of all hospitals in Central Zone.

366. I believe the framework requires further development in its definitions because they are imprecise and open to variable interpretation.

367. The indicative range of procedures described within the complex surgery section (at pages 100 to 101 of the Service Capability Framework - Exhibit 231) is very broad and includes caesarean section, abdominal hysterectomy, joint replacements, limb amputations, bowel resections, mastectomy, aortic surgery and oesophagectomies The framework must be used in conjunction with the credentialing and privileging process.

368. In his evidence (at page 1836) Dr Brian Thiele said that if there had been a viable recognisable ethics committee functioning within the hospital this may have avoided some of the difficulties which subsequently occurred. After my arrival at Bundaberg Hospital I caused the ethics committee to be reinstated. Dr Miach and Toni Hoffman were members of the committee. My experience of hospital ethics committees is that they are established primarily to approve and monitor research projects in addition to expressing views on ethical issues which are referred to the committee.

.....

**DARREN WILLIAM KEATING**

***Complaints Procedure***

369. At the time of my arrival in April 2003, complaints management was directed by the Queensland Health policy titled 'Queensland Health Complaints Management Policy' dated 23 July 2002 and the Bundaberg Health Service District (BHSD) policy titled 'Complaints Management System' dated May 2001. A copy of the former is Exhibit 292. The latter is Annexure LTR2 to the statement of Ms Leonie Raven - Exhibit 162. Both policies were available on the hospital's computer network and most staff had access to the network so they could read and print the policies.

370. The BHSD complaints system was managed by the Quality Co-Ordinator and there was a clear expectation that complaints should be resolved at the point of origin, whenever possible. In practice this didn't happen with most complaints being referred to Executive Services. The BHSD policy did not outline any specific or different process or procedure for the making, receipt or dealing with complaints or concerns relating to clinical practices and procedures of hospital medical staff.

371. In approximately June 2003, DQDSU staff updated the Complaints Register so that regular, reliable and valid reports could be produced.(Annexed marked **DWK84** is a sample of such a report). These reports were distributed to the Executive, Clinical Directors and Heads of Department, including presentations at the monthly Heads of Department meeting. As information became available, review and analysis of any trends were to occur and strategies put in place to rectify concerns. Clinical Managers were expected to be fully involved in this process. Feedback from recipients on the report composition was requested and all line managers could request DQDSU to produce more detailed reports on areas of concern or interest after receipt of the summary report.

***External Complaints***

372. BHSD receives many complaints from patients, relatives, the Health Rights Commission, local Members of Parliament and Ministers. These

complaints are registered by DQDSU and allocated to a member of the executive.

373. Any complaints relating to medical care, waiting lists, elective surgery or the Patient Travel Subsidy Scheme were forwarded to me for investigation and preparation of a draft response.

374. Many of these complaints were related to waiting periods for specialist appointment or elective surgery and non-approvals of applications for Patient Travel Subsidy Scheme. Other complaints related to the behaviour or attitude of staff while a minority related to clinical practice. My normal procedure was to read the complaint, request the medical records, speak to or request a written response from the staff involved and seek specialist medical advice if required. A reply would be drafted which was forwarded to the District Manager for review, signing (if in his delegation) or forwarding to the Zonal Manager. The Complaint Registration Form would be completed and forwarded (with any accompanying letter or notes) to DQDSU for the completion of the registration process.

375. When interviewing medical staff (more often junior staff), I sought to gather all relevant information. If I believed that they had made an error, I would counsel the doctor, suggest an alternative method of practice and inform the relevant Clinical Director. Dr Nydam, the Director of Clinical Training, would also be informed so he could follow-up with the doctor to identify any training or support necessary. He would regularly provide feedback to me about such meetings. If the complaint was of a serious nature, the process outlined in paragraph 378 below would be used.

***Internal Complaints***

376. The usual process for making, receipt and dealing with complaints or concerns relating to clinical practices and procedures of hospital medical staff was that the complaint would be sent to me directly. At times, I forwarded some complaints to the appropriate Clinical Director for initial

investigation. Ideally, the complaint should be written containing relevant information and data to backup the complaint.

377. I would seek relevant information from the practitioner concerned, medical records, patient and clinical information systems and appropriate hospital policies. Specialist medical advice from a Clinical Director would requested also. I received a limited number of complaints in this area and often the issue was related to a lack of awareness or misinterpretation of a hospital policy or procedure. This type of situation could be resolved quickly with a suitable solution implemented and feedback given to the complainant.

***Clinical Practice***

378. If the complaint related to a medical practitioner's clinical practice and was rated as high risk, as much information would be gathered for discussion with the District Manager. Queensland Health policy - Exhibit 292 is that consumer complaints about medical practitioner's health, competence or conduct are referred to the Medical Board of Queensland for investigation. I was aware that those referrals should be made via the Senior Executive Director Health Services. I am unaware of any documented Queensland Health process or procedure to investigate clinical practice complaints from other Queensland Health clinicians. I was unaware that the Chief Health Officer could investigate such complaints. Other possible avenues to provide advice on this form of complaint could include seeking review by the Medical Staff Advisory Committee, external peer review, or a review by the appropriate speciality college.

379. In my two years at Bundaberg Base Hospital, the Medical Staff Advisory Committee meetings were not well attended or supported by the senior medical staff including the VMOs.

***New Incident Monitoring System***

380. Queensland Health did not release any policy related to Adverse Events until June 2004 (see paragraphs 154 to 156 above). It only conducted

.....

**DARREN WILLIAM KEATING**

limited training in Root Cause Analysis and is presently rolling out an interim software package that registers, collates and reports adverse events. Patient Safety Officers in many hospitals (including Bundaberg) are yet to be appointed. The Queensland Health Patient Safety Centre has overall responsibility for this area and was only established in late 2004.

381. I concur with paragraph 9 of Ms Raven's statement (Exhibit 162) relating to the history of incident reporting. The common staff complaint was the disappearance of their complaints into a 'black hole' and clinical managers did not have a clear oversight of the major issues.

382. There was a growing awareness that clinical incidents often went unreported yet could have a major effect on patient care. A requirement existed to develop an incident monitoring or adverse event system.

383. In late 2003, the Quality Co-Ordinator conducted a session with available Heads of Department to develop an Adverse Event Incident Monitoring system. This new system aimed to incorporate the incident reporting systems in place, gather information about unreported clinical events, reduce duplication, utilise one central registration area and produce meaningful reports for all levels of management.

384. Following this meeting, DQDSU staff and I developed an Adverse Event Policy, a Sentinel Event Policy, an Adverse Event form, a register spreadsheet and reports. Jenny Kirby (Manager DQDSU) and I provided 13 education sessions to BHSD staff about the Adverse Event System from 1 April 2004 until 26 August 2004. These sessions included medical staff from the medicine, surgery and anaesthetics departments. (Copies of the initial Adverse Event and Sentinel Event policies and my presentation are attached marked **DWK85**, **DWK86**, **DWK87** respectively).

385. I concur with paragraphs 23, 24 and 28 of Ms Raven's statement (Exhibit 162) about the operation of the Incident Monitoring System. On several occasions I explained to the District Manager that no one in BHSD had

received Root Cause Analysis training, which affected the hospital's ability to investigate any events rated high, very high or sentinel in risk.

386. It was intended that a regular report of adverse events would be distributed to each clinical area. Each clinical area will have a varying frequency of issues that will require local solutions in conjunction with facility wide policy or procedure. This report would enable middle managers to make decisions, ensure clinicians were informed of issues and could take control to reduce the incidence of high frequency but lower risk incidents.

387. The staffing of DQDSU was reduced in mid 2004. The loss of staff was due to secondment, sickness and transfer to another position. The implementation of the Adverse Event System was affected with delay in registration of events and compilation of regular reports for the various clinical areas and Executive. The staff developed the view that this system was another 'black hole'. I recollect expressing this concern at various executive meetings in 2004. The Quality Co-ordinator made a significant effort in late 2004 to produce regular reports in order to re-establish confidence in the system.

***Patient Safety and Quality Improvement***

***Reports***

388. BHSD participates in the Australian Council of Healthcare Standards (ACHS) accreditation process. This process includes ongoing measurement of 63 clinical indicators (CIs) across a number of areas in Bundaberg Hospital and the other facilities in the Health Service District. These indicators are prepared every six months by nominated staff. The Quality Co-ordinator collates the measurements and forwards them to ACHS. Approximately 2 months later a report is received from ACHS providing comparison with like facilities and all facilities which submit CIs. This report is distributed to Executive Council, all staff who submit indicators as well as being presented at Heads of Department meetings and more recently was placed on a network drive for all staff to view. The

.....

**DARREN WILLIAM KEATING**

report to Executive Council was a summary of several six-month periods of data in order to help determine any significant trend. Annexure **DWK88** is a copy of the summary sheet and the comparison sheets for five surgical CIs. This summary sheet includes notations by me in order to identify significant trends.

389. There were also a number of reports produced from different areas of the hospital, which provided information about the clinical performance of all practitioners. These reports were distributed to various committees and middle managers for review and distribution to staff.

390. Monthly performance reports were produced for the Clinical Directors for the Executive Council. In these reports were sections for each ward listing post operative/procedure infections and readmissions to the wards for the month and year to-date with comparisons with the previous year. This information was reviewed at the monthly meetings and often the District Manager directed follow-up of patterns of change.

391. Post-operative infection reports produced by Gail Aylmer the Infection Control Coordinator (ICC) were submitted to the ASPIC Committee on a regular basis. These reports tracked post-operative infection rates for selected surgical procedures in orthopaedics, general surgery and obstetrics and gynaecology. There was no significant trend noted during this time. This information was also submitted to the Leadership & Management Committee by the ICC during her regular reports and to ACHS as one of the many clinical indicators measured at Bundaberg Hospital. I don't recollect the ICC raising any concerns about Dr Patel's infection rate.

392. Ms Jo-ann Elmes, Health Information Manager, produced a report listing and comparing readmission rates for all specialities every six months. This report was reviewed at the Information Management Committee and forwarded to the Executive Council and Clinical Service Forums for further review and analysis as required. These rates were monitored and explanation sought from the relevant Director or specialist about reasons for major increases. Annexure **DWK89** is a copy of these reports from

1999-2004. When I reviewed this data in mid-2004 and early 2005 I had found that Dr Patel had a higher number of readmissions than other surgeons but it did not seem out of proportion to the volume and nature of the surgery performed by him as compared with the other surgeons. Wound infection appeared to be a common cause of readmission for all surgeons.

393. The capability to request ad-hoc reports on complication rates was available through DQDSU. DQDSU uses a corporate database called Transition II, which collects clinical data for all patients admitted to the hospital. Clinical staff used this capability on a regular basis, particularly to provide information for review at the Clinical Service Forums and department morbidity and mortality meetings.

***Audit and Mortality and Morbidity Meetings***

394. The Clinical Service Forums (CSF) were the ideal forum to review clinical performance of a unit (including clinical audit results) and its practitioners in order to improve the quality of health care provided. The Paediatrics and Obstetric and Gynaecology CSFs functioned well leading to development of a Paediatric 'Erromed' forum and a Perinatal Mortality and Morbidity Committee. These latter forums also performed well with the Perinatal Committee reviewing all mortality and serious morbidity related to neonatal care at Bundaberg Hospital. A Surgical 'Erromed' forum was developed in 2004, which had three meetings. Dr Patel attended these meetings.

395. The hospital was a member of the Queensland Health sponsored Cardiac Collaborative, Renal Collaborative and Stroke Collaborative. Each patient admitted with a cardiac, renal or stroke problem would have data entered into the collaborative database. The results allowed benchmarking of care against all Queensland Health hospitals in the collaborative group. These results were submitted to the Executive.

396. The Medical Department conducted 3 monthly mortality audits, comparing medical units with the surgical units.

.....

**DARREN WILLIAM KEATING**

397. Specific audits of patients with stroke and patients suffering from bleeding from the bowel were conducted by Dr Smalberger with changes made to the care of these patients on his recommendations. I actively supported Dr Smalberger as he performed these audits.

398. The Director of the Emergency Department reviewed all category 1, 2 and 3 patients who were not seen within the correct waiting time to ensure no adverse outcome occurred. Cases with adverse outcomes were presented at Departmental meetings.

399. The various departments were responsible for organising meetings at which adverse outcomes and interesting cases were presented and discussed primarily for the purpose of education and improvement of services and systems.

400. These meetings were not intended to provide data on adverse outcomes to the hospital administration rather the meetings often requested data from District Quality Decision Support Unit (DQDSU) for the purpose of these discussions.

401. My recollection is that these meetings were regularly conducted in the surgical, obstetric and paediatric departments.

402. The "Otago" system is a computer based surgical audit system introduced to Bundaberg Hospital by Dr P. Anderson, when he was the Director of Surgery.

403. Soon after my appointment in 2003, concerns about the operation of this system were bought to my attention. My review of the system found that:

(a) multiple pieces of paper were required to be completed for each patient;

(b) for at least 12 months, surgical staff had failed to complete the forms, despite repeated requests;

.....

**DARREN WILLIAM KEATING**

(c) for at least 12 months, the untrained Administration Officer responsible for data input had completed the forms to the best of her ability;

(d) invalid results were being produced and accepted by medical staff;

(e) similar reports (unaffected by the above deficiencies) were available from the Transition II database in DQDSU.

404. Dr Patel informed me there was limited support for the system in the Surgical Department and proposed a paper based audit system whereby the surgical department would identify for themselves the cases which needed to be reviewed and discussed. Whatever data was required regarding trends could be obtained from the Transition II database.

405. I agreed to the proposal and strongly recommended reports be requested from DQDSU from the Transition II database. I understand ad-hoc reports were requested from DQDSU over the next two years. I was not made aware of any concerns about the quality or conduct of those audit meetings. I would expect the senior surgical staff to have informed me of any concerns.

***Executive – System of Review***

406. Mrs Mulligan has outlined the function and composition of the many committees at Bundaberg Hospital in her statement which is Exhibit 180. I concur with her outlines in annexure LMM5 paragraphs (a), (d), (e), (f), (g), (p), (x) and (ee). The Executive received copies of all of the reports and minutes of meetings referred to above. These reports and minutes were reviewed and discussed at the Leadership and Management Committee meetings and Executive Council meetings. Individual incidents such as the Bramich case were not discussed at these meetings. There was nothing in the reports or minutes provided to these meetings which suggested that Dr Patel had any greater incidence of adverse events or complaints than other surgeons.

.....

**DARREN WILLIAM KEATING**

***Summary***

407. While a number of complaints and adverse events involving Dr Patel were brought to my knowledge, all medical practitioners and particularly surgeons have complications, adverse outcomes and complaints. At no time did I consider that Dr Patel's problems were sufficiently serious for me to take any different action than I did.

408. Like any person my preference if I require surgery is to have the best available surgeon and I would use my private health insurance to that end. However, at no time while Dr Patel was operating at Bundaberg Hospital would I have refused to allow him to perform on me the procedures which he was carrying out on patients of the Bundaberg Hospital, if I had required that surgery. My view changed upon becoming aware of Dr Patel's history.

Dated 24 October 2005

.....

DARREN WILLIAM KEATING