SUPREME COURT OF QUEENSLAND

CITATION:	*R v Patel* [2010] QSC 233
PARTIES:	**R** v **JAYANT MUKUNDRAY PATEL**
FILE NO/S:	Indictment No. 387 of 2009
DIVISION:	Trial Division
PROCEEDING:	Sentence
ORIGINATING COURT:	Brisbane
DELIVERED ON:	1 July 2010
DELIVERED AT:	Brisbane
HEARING DATE:	1 July 2010
JUDGE:	Byrne SJA
CATCHWORDS:	CRIMINAL LAW – JUDGMENT AND PUNISHMENT – SENTENCE – Manslaughter and grievous bodily harm – where surgeon found guilty of three counts of manslaughter and one count of grievous bodily harm arising out of criminal negligence under the *Criminal Code Act 1899*, s 288 – where surgeon had reason to believe he may have had deficiencies in his knowledge and aptitude – where surgeon had restrictions placed on his practise in Oregon, United States by an order of a local Board of Medical Examiners – where surgeon did not advise patients or hospital of restrictions – where no criminal history – where serial, serious offending – sentenced to three years' imprisonment in respect of the grievous bodily harm offence – sentenced to seven years' imprisonment in respect of each of the manslaughter offences – sentences to be served concurrently. *Penalties and Sentences Act 1992*
COUNSEL:	R G Martin SC and D Meredith for the Director of Public Prosecutions M J Byrne QC and M Woodford for the Defendant
SOLICITORS:	Director of Public Prosecutions Raniga Lawyers for the Defendant

[1] Jayant Mukundray Patel:

[2] The verdicts of the jury establish your guilt on charges of the unlawful killing of Mervyn Morris, James Phillips and Gerardus Kemps, and of unlawfully doing grievous bodily harm to Ian Vowles.

[3] The offences occurred between May 2003 and December 2004.

[4] You were then the Director of Surgery at Bundaberg Base Hospital.

[5] Earlier events have significance for the sentences.

[6] On 7 September 2000, you consented to an order by the Board of Medical Examiners of the State of Oregon, an organisation responsible for regulating and disciplining health care providers.

[7] This Order recited that:

- The Board proposed to take disciplinary action against you for violations of the Oregon Medical Practice Act;
- The conduct on which the case was founded arose out of an "extensive peer review" of many patient charts;
- Your surgical practice had been restricted under an improvement plan regime. The plan required you to:
  (a) get a second opinion before undertaking a complicated surgical case; and
  (b) to attend surgical meetings and continuing education courses on improving communication skills and preventing malpractice;
- You had made "surgical errors";
- Your conduct had contravened provisions of the Medical Practice Act concerned with unprofessional conduct.

[8] To resolve the disciplinary proceeding, you agreed to an Order that obliged you to obtain second opinions, pre-operatively, on "complicated surgical cases".

[9] Such cases included abdomino-perineal resections, esophageal surgeries and surgery on high-risk patients with severe co-morbidities.

[10] The Order was amended, with your consent, on 1 November 2000 to require that the second opinion be from a surgeon licensed in Oregon.

[11] The Order was not limited in time.

[12] It restricted your medical practice while you resided in Oregon.

[13] As a result, beginning in December 2000, your practice was, for practical purposes, limited to performing outpatient surgeries and seeing patients in clinic.

[14] Then, in February 2001, you ceased medical practice.

[15] Thereafter, you did not perform surgery until you started at Bundaberg Base Hospital on 1 April 2003.

[16] The Order did not affect your entitlement to practise as a surgeon in Queensland. It took effect in Oregon. Its operation did not extend to Queensland.

[17] Even so, the Order has present significance.

[18] Mr Vowles's proctocolectomy was an abdominal-perineal resection. The oesophagectomies that killed Mr Phillips and Mr Kemps were "esophageal surgeries". And Mr Morris's sigmoid colectomy was major surgery performed on a high risk patient with severe co-morbidities.

[19] Had those procedures been proposed in Oregon, the Order would have obliged you to secure a second opinion before proceeding to theatre.

[20] The Order did not require you to obtain a second opinion from an Oregon surgeon before performing those operations in Queensland.

[21] But, as you must have realised, the Order showed that there was respectable medical opinion that your level of surgical competence was such as to require, in the interests of patients, the restrictions stated and duties imposed in the Order: especially the requirement to obtain a second opinion before embarking on major surgery.

[22] The Order and your surgical misadventures in Oregon gave you good reason to reflect, before commending major surgery to Bundaberg patients, on pertinent deficiencies in your knowledge, judgment, aptitude and experience.

[23] Yet you told no one at Bundaberg about the Order: not the hospital administrators; not other medical practitioners, such as anaesthetists, who were to assist at the four operations; and, most importantly, not the patients you persuaded to submit to major surgery.

[24] And you did not seek a second opinion from a surgeon before performing the four procedures with which the charges are concerned.

[25] Mervyn Morris was 75 when you met him in early May 2003.

[26] Mr Morris had intermittent bleeding from his rectum.

[27] His medical history included acute myocardial infarction, prostate cancer that had been managed with radiotherapy, as well as right total hip replacement and gall bladder removal.

[28] Mr Morris saw a principal house officer at the Bundaberg Base Hospital, complaining of more than two years' bleeding from his rectum.

[29] His bright, rectal blood loss was probably attributable to radiation proctitis.

[30] Examination of the rectum by sigmoidoscope did not locate a bleeding site.

[31] You conducted a colonoscopy, which disclosed multiple diverticula, especially in the sigmoid colon and descending colon.

[32] But no bleeding point was found.

[33] Mr Morris was sent home with instructions to return if the bleeding continued.

[34] He returned complaining of three to four days of increasing bright red per rectum blood loss.

[35] Another digital rectal examination revealed no abnormality.

[36] An assessment was made of per rectum bleeding with an unidentified cause.

[37] The differential diagnosis noted on the chart was "diverticular disease, radiation proctitis, haematobilia and other".

[38] No proctoscopic examination was done.

[39] A barium enema revealed "localised segment of diverticulosis involving sigmoid".

[40] Your note on 20 May contained this plan: "If continues to bleed will need surgical colectomy and colostomy."

[41] By the following morning, there had been a small amount of bleeding.

[42] Your assessment was, as you wrote in the chart, "Bleeding diverticulosis".

[43] To arrest the bleeding, you decided on the sigmoid colectomy and colostomy.

[44] However, no bleeding point had been found when the operation was performed on 23 May 2003.

[45] The sigmoid colon was removed. A colostomy bag was put in place.

[46] It was a straight-forward procedure, without complications.

[47] Mr Morris's progress was satisfactory in the first week following surgery.

[48] That was to change.

[49] On 30 May, the surgical staples were removed.

[50] There was obvious wound dehiscence.

[51] Mr Morris went to theatre so that you could "repair" the dehiscence. The procedure went well enough.

[52] On 3 June, however, a nurse noted that Mr Morris had experienced a small per rectum bleed earlier.

[53] This was concerning. A week and a half had elapsed since the surgery that was supposed to stop the bleeding.

[54] Poor nutrition was leading to compromise of respiratory function.

[55] Mr Morris was not tolerating a full diet.

[56] By 6 June, his abdomen was distended and Mr Morris was "unwell looking".

[57] Probably, there was ascites: that is, fluid in the lungs, as well as in the legs and abdomen.

[58] On 12 June, a medical student noted shortness of breath and ongoing ascites.

[59] That evening, Mr Morris passed a small amount of fresh looking blood per rectum.

[60] Over the next two days, his condition deteriorated.

[61] Mr Morris's liver may have been contributing to his problems, including the ascites.

[62] By the early hours of 14 June, Mr Morris was unable to talk. He suffered respiratory distress, with laboured, irregular breathing. He looked to be at risk of spontaneously stopping breathing. He was transferred to the intensive care unit.

[63] On the morning of 14 June, all the intensive care unit supports of vital functions were working at their maximum.

[64] Even so, Mr Morris progressively deteriorated.

[65] He was pronounced dead at 9.45am on 14 June 2003.

[66] This was three weeks after the sigmoid colectomy.

[67] The sigmoid colectomy was performed competently.

[68] The prosecution case, however, was that the procedure was unnecessary.

[69] The jury has concluded that your decision to operate on Mr Morris both caused his death and involved criminal negligence: that is, such a great falling short of the standard to have been expected of a surgeon, and showing such serious disregard for the patient's welfare, that you should be punished as a criminal: in other words, that your decision to operate was so thoroughly reprehensible, involving such grave moral guilt, that it should be treated as a crime deserving of punishment.

[70] The other three surgical procedures were also performed competently enough.

[71] It is not how you carried out the procedures that matters.

[72] What matters is your judgment in deciding to commend the surgery to the patient and, having obtained the patient's consent, in taking him to theatre to perform it.

[73] Removing Mr Morris's sigmoid colon was inappropriate mainly because the bleeding problem that the surgery was to address was sourced in his rectum.

[74] As to the oesophagectomies performed on Mr Phillips and Mr Kemps, the primary prosecution case was that, in each instance, the patient's health was too precarious for the procedure.

[75] James Phillips was born in March 1957.

[76] Although not so old, he was frail, malnourished and not well.

[77] He was an end-stage renal patient who needed haemodialysis to survive.

[78] The renal transplant Mr Phillips received in 1994 had failed about five years later.

[79] In 1999, Mr Phillips had a heart attack.

[80] By June 2000, he had mild myocardial ischemia.

[81] In January 2003, Mr Phillips was found to have a dangerously high level of potassium – a condition called hyperkalemia.

[82] He was sent to Royal Brisbane Hospital to have his vascular access improved surgically.

[83] After that procedure, he was taken to the intensive care unit.

[84] There he experienced serious difficulties, including complicated pulmonary oedema.

[85] Those were distinct indications that, in any future surgery, Mr Phillips would be at significant risk.

[86] In April 2003, investigations disclosed that Mr Phillips was suffering from oesophageal cancer.

[87] You decided that an oesophagectomy, to be performed by you in Bundaberg, was appropriate.

[88] Dr Carter, an anaesthetist who was Head of the Intensive Care Unit at Bundaberg, knew Mr Phillips and about his medical complications.

[89] Dr Carter assessed Mr Phillips as a high risk patient.

[90] Even so, he thought him suitable for an oesophagectomy.

[91] Dr Carter was also content that his ICU could cope with Mr Phillips's situation.

[92] It was realised that Mr Phillips would need dialysis post-operatively. But that was not seen as a difficulty. The Renal Unit was highly regarded and familiar with Mr Phillips and his problems.

[93] Two other doctors, including a specialist anaesthetist, assessed Mr Phillips's suitability for an oesophagectomy. Both were satisfied that the operation could proceed.

[94] The oesophagectomy took place on 19 May. Mostly, it proceeded unremarkably.

[95] Mr Phillips, however, died two days later from an acute cardiac event.

[96] His heart failure was caused by potassium overload.

[97] The dialysis regime post-operatively had not removed enough potassium.

[98] You were not responsible for the dialysis. That was the responsibility of the Renal Unit, which was not under your direction.

[99] Nonetheless, the jury's verdict establishes both that the oesophagectomy caused the patient's death and that your decision to perform it was criminally negligent.

[100] Gerry Kemps was born in August 1927.

[101] For many years, he had been treated for impaired kidney function, although he was not on dialysis.

[102] In 2002, at Bundaberg, Mr Kemps had an abdominal aortic aneurism repair at the hands of a vascular surgeon.

[103] Post-operatively, in the ICU, he developed pulmonary complications.

[104] After a few days, Mr Kemps was transferred to Brisbane for specialist pulmonary care.

[105] Eventually, he did make a complete recovery.

[106] In late 2004, Mr Kemps was complaining of shortness of breath on exertion, dysphagia and melaena.

[107] An endoscopy found a cancerous growth at the lower end of the oesophagus.

[108] A CT scan was taken.

[109] The radiologist's report on the scan, which probably was not available to you when the oesophagectomy was performed, mentioned two enlarged lymph nodes in the mediastinum. It also identified at least four focal intrapulmonary lesions lying posteriorly in the right lower lobe, the largest measuring about 12mm in diameter and showing some spiculation of the margins.

[110] Those were indications of the spread of the cancer beyond the oesophagus.

[111] The physician, Dr Smalberger, planned to send Mr Kemps to Brisbane for treatment.

[112] You decided that he needed an oesophagectomy, to be performed by you at Bundaberg.

[113] Two anaesthetists at Bundaberg Hospital assessed Mr Kemps as fit for the oesophagectomy, from an anaesthetic perspective.

[114] Although two prosecution cases were advanced concerning the death of Mr Kemps, I take it to be established by the verdict that, by proceeding to perform the oesophagectomy, you were criminally negligent.

[115] Mr Kemps died from blood loss you were unable to arrest.

[116] The bleeding had started during the oesophagectomy. It was surgical bleeding.

[117] Mr Vowles's grievous bodily harm consisted of the removal of his large bowel.

[118] That removal was pointless at the time.

[119] Your perception, it seems, was that Mr Vowles was most likely suffering from familial colon cancer.

[120] But biopsies taken from a polyp in the bowel during a colonoscopy that you conducted were benign.

[121] Several considerations affect the sentences.

[122] Most importantly, three lives were lost; and Mr Vowles will suffer for the rest of his life.

[123] Victim impact statements from members of the families of Mr Morris, Mr Phillips and Mr Kemps speak of the great distress which the untimely deaths of their loved ones have wrought.

[124] Mr Vowles has succinctly described the complications in his life and for his wife because of the condition in which he is left.

[125] The fatal operations, as well as Mr Vowles's proctocolectomy, might so easily have been avoided.

[126] Had you sought a second opinion on whether to proceed with the operations, the indications are that another surgeon would have advised against them all: in Mr Morris's case, because the bleeding point had not been identified and other, non-invasive treatments were available; in Mr Phillips's case, because he was too frail and had too many complications for an oesophagectomy – in Bundaberg at any rate; in Mr Kemps's case, because the oesophageal cancer was too far advanced and other palliation treatments were preferable; and in the case of Mr Vowles, because the biopsies were benign and the polyp in his colon could have been removed without surgery.

[127] In view of the verdicts of the jury, there is no denying the gravity of your offending.

[128] The Court must make it clear that the community, acting through the Court, denounces your repeated, serious disregard for the welfare of the four patients.

[129] The charges do not involve an intention to cause harm. And absence of an intention to harm is a significant factor.

[130] In each of the four cases, however, the jury has found that your judgment in deciding to take the patient to surgery was so thoroughly reprehensible, involving such grave moral guilt, that you should be punished as a criminal.

[131] There are factors in mitigation.

[132] First, this is your first criminal offence.

[133] Secondly, incarceration is likely to be more than usually difficult for you.

[134] You are 60.

[135] More significantly, your family resides overseas and will not be here to support you through the ordeal of imprisonment, except for an occasional visit.

[136] Your notoriety will also make prison life stressful.

[137] Thirdly, you have already spent time in prison in connection with these (and other) offences.

[138] You were arrested in the United States on 11 March 2008 and incarcerated until your release on 21 July 2008 to facilitate the extradition to Australia – a process to which you eventually agreed.

[139] That 131 days in prison will be fully taken into account by reducing the head sentences that would otherwise have been imposed.

[140] Slight credit is allowed for the circumstance that your nearly two years on bail, reporting three times weekly, has been difficult because of abuse experienced in going about in public as a result of your prominence through media reports.

[141] I approach the sentences by forming a view about the overall criminality involved in all the offending, and imposing sentences to be served concurrently.

[142] Pursuant to s 159A of the *Penalties and Sentences* Act 1992, I declare the two days spent in pre-sentence custody on 29 and 30 June to be imprisonment already served under the sentences about to be imposed.

[143] On the grievous bodily harm offence, you are sentenced to imprisonment for three years.

[144] On each of the manslaughter offences, you are sentenced to imprisonment for seven years.