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Transcript of Proceedings

MR A J MORRIS QC, Commissioner

SIR LLEW EDWARDS, Deputy Commissioner

MS MARGARET VIDER, Deputy Commissioner

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IN THE MATTER OF THE COMMISSIONS OF INQUIRY ACT 1950

BUNDABERG HOSPITAL COMMISSION OF INQUIRY

COMMISSIONS OF INQUIRY (No. 1) 2005

BUNDABERG

..DATE 22/06/2005

..DAY 12

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THE COMMISSION RESUMED AT 9.30 A.M.

COMMISSIONER: Good morning, ladies and gentlemen. Yes, Mr Andrews?

MR ANDREWS: Good morning, Commissioner, I call Jennifer Ann White.

MR ALLEN: If the Commission pleases, I appear for Ms White.

COMMISSIONER: Thank you, Mr Allen.

JENNIFER ANN WHITE, SWORN AND EXAMINED:

COMMISSIONER: Ms White, please make yourself comfortable there. Do you have any objection to having your evidence photographed or filmed?-- No.

Thank you. Mr Andrews?

MR ANDREWS: Ms white, would you tell us your full name, please?-- Jennifer Ann White.

Have you prepared a statement dated the 31st of May 2005?-- I have.

And the facts within it, are they true to the best of your knowledge?-- There is some alteration on paragraph 33 that we have made.

Well, when we get to paragraph 33, I will ask you to correct that?-- Thank you.

And are the opinions expressed in that statement honestly your opinions?-- Yes, they are.

Thank you. I tender it.

COMMISSIONER: Thank you. The statement of Ms White, subject to her correction that you are going to tell us about in due course, will be Exhibit 71.

ADMITTED AND MARKED "EXHIBIT 71"

MR ANDREWS: Ms White, you have been employed at the Bundaberg Base Hospital since 1986 and in all of that time you have been working in the operating theatres?-- That's correct.

And, indeed, from 1990 until quite recently, you were the Nurse Unit Manager of the operating theatre?-- Correct.

In August 2004, you chose to step aside from the position of Nurse Unit Manager, but to continue working in the operating theatre?-- That's correct.

Now, Dr Patel commenced at the hospital in April 2003. Were you there when Dr Patel began?-- Yes, I was.

You didn't receive a copy of his curriculum vitae; is that of any significance?-- I guess it's in respect to what experience that he's had and what services we provide the hospital, and his clinical experience ought reflect what services we are going to continue to offer to our patients, and the types of procedures that he does, whether he does laparoscopic work or endoscopic procedures. Generally that's information that's passed onto the Nurse Unit Manager because our sessions are based on what the surgeons are, you know, going to do.

And would that be passed on usually by whom, the Acting Director of Medical Services?-- Usually the Director of Medical Services, yeah.

And at that time was that Dr Kees Nydam when Dr Patel began?-- Yes, it was.

About two weeks after Dr Patel commenced, he told you that he had been given the Director of Surgery position?-- Yes, he had. I had been informed through a meeting that we had two American surgeons that were going to arrive early in 2003, and Dr Patel was the first surgeon to arrive, and approximately about two weeks after he arrived, he came to me and he said he had been given the Director of Surgery's position, which I felt that was a bit strange. But it was the manner and way. He just laughed and said, "Well, it must be because I got here first." And I thought, "Well, where's the merit for the position?", or, you know, "There's been no applications or interviews," or - and, you know, generally the process is that people are interviewed for positions and he just seemed to be given the position, which I thought was quite unusual.

What sort of interview process are you talking about, a conversation over a desk or-----?-- No, the Queensland Health interview process, whereby there's applicants and applications for a position and interviews and a selection process.

Not being familiar with that process, can you tell me more about it? Does somebody come from within the hospital to interview the applicant, or does somebody come from outside the hospital?-- Normally for a Director of Surgery's position it would be, you know, perhaps someone from Queensland Health that would do the interviews.

Do you mean from Charlotte Street in Brisbane?-- Yes, in conjunction with perhaps a local AMA, or perhaps another surgeon from the town, and the Director of Medical Services.

When you say "a surgeon from the town", you mean a surgeon who is not necessarily a staff surgeon at the hospital?-- It would be a Visiting Medical Officer.

Now, when Dr Patel came, no doubt you observed the new Director of Surgery, what did you notice? What was his relationship with the nursing staff and junior medical staff like?-- I guess, initially, he was very friendly towards staff, but I noticed that when he was scrubbed that he was quite demeaning to his junior staff and-----

Do you mean medical staff or nursing staff?-- Medical staff - medical staff and quite critical of nursing staff as well.

Now, you tell us at paragraph 12 of your statement about a Theatre Management Meeting in June 2003 in which Dr Patel suggested an initiative; do you remember that?-- Yes, I do.

He suggested conducting a Staff Satisfaction Survey?-- Yes, he did.

Well, to an outsider that sounds like a proactive and useful thing to do, can you tell us whether it had any utility?-- He - the idea of conducting the survey was to gain satisfaction morale, work practices in general of both medical and nursing staff in the operating theatre, and he was given the job to actually develop and undertake and collate the results of the survey, which was decided at that Theatre Services Meeting, and when I received a copy of the survey, it wasn't a survey that was generated for our unit or - it seemed to be just something - because the questions related to more of just a general survey, not necessarily to an operating theatre, the questions, and I just gained the impression that he had taken - he found a survey on the computer and that's what he was presenting.

You say that you felt that he undertook the survey to undermine your position as Nurse Unit Manager; I don't understand how?-- I probably didn't explain that well enough. But I guess when the results were collated, the only results - the medical staff didn't complete the survey, so there was no results from the medical staff, and I think the nursing staff took an opportunity to air their workloads' issues and, of course, criticise your supervisor, who doesn't have a lot of control over your workload, and particularly when people like Dr Patel are generating huge workloads and lots of overtime, you know, working 20 hour shifts, and those sorts of things, so I guess that's where the staff had a bit of a backlash towards me.

D COMMISSIONER VIDER: Can I just take you back a bit? You mentioned the word "morale", was morale low in the operating theatre prior to Dr Patel's arriving?-- I guess morale is something - you know, it can be up and down, because we have had a lot of changes over the last few years with, you know, not having doctors or not having anaesthetists, and having, like, huge workloads and then really no workloads and staff

being deployed to wards and just a general uneasy time.

And the workload, this survey was conducted in June 2003 and the work had considerably increased in the preceding couple of months?-- Mmm.

COMMISSIONER: You mentioned the process earlier by which - the lack of process by which Dr Patel was appointed to the position of Director of Surgery?-- Yes.

Were you conscious of the fact at the time that Dr Patel was not qualified in Queensland as a specialist surgeon?-- Oh, no, no. I had no idea what his qualifications were.

D COMMISSIONER EDWARDS: Was it usual for somebody to be appointed to such a senior position in a hospital without interviews or applications being called?-- No, it's not usual. Normally, you know, the job was advertised and I know Dr Peter Anderson, you know, applied for the job and when he left, that job was, you know, opened, but it was - there had been - as far as I know there was no interview process for Dr Patel.

MR ANDREWS: Ms White, you would have been - because of your long experience as Nurse Unit Manager of the operating theatre, I suppose you would have been there at a time when there were VMOs, such as Dr Thiele and Dr Anderson, perhaps?-- Yes.

Even at a time when Dr Nankiville was there?-- Yes. Yeah. Nankiville was a staff surgeon. He was employed full time for Queensland Health. He didn't work privately at all.

Are you in a position to remember what the morale was like at the time when VMOs were undertaking surgery? If you can't remember-----?-- Well, no, morale was quite good. I mean, obviously we always worked fairly hard, but the morale was good, yeah.

And how do you contrast it with the morale at the time after the - when you had only staff surgeons operating at the hospital?-- Well, I guess when you're talking about VMOs, or the time when Dr Anderson was the Director of Surgery, it was fairly well organised. All specialties were fairly well organised. There was support, communication between nursing and medical staff. But I guess once Dr Patel came, he sort of became the Director of - a Director of Surgery, and even the other consultants, you could see that they didn't get on with him and mainly because of his attitude towards them. If he wanted to do his procedures first in times of - when we perhaps had reduced staff, or staff on fatigue leave, and he wanted to continue his list, their list always got delayed or rescheduled and that, you know, created some - I guess, some unhappiness from the other consultants.

D COMMISSIONER VIDER: So that list got delayed without consultation, he never went and-----?-- He would go to them, but he would tell them that's what was going to happen.

MR ANDREWS: Now, as Nurse Unit Manager, you would attend monthly ASPIC Surgical Services Meetings?-- Yes, I did.

In April 2004, by that stage a Nurse Unit Manager of the surgical ward, Di Jenkins, raised concerns at that meeting about the number of patients suffering from wound dehiscence; do you recall that?-- Yes, she did. Most definitely.

Now, I would like you to try to - your statement mentions Dr Patel being at the meeting, Dr Keating being at the meeting. I would like you to recall what the response was of Dr Patel when Di Jenkins raised her concerns about the wound dehiscence numbers?-- I do remember, because his response was he just laughed at us and said that we wouldn't understand what a wound dehiscence was, and, I mean, Di Jenkins, Gwenda McDermid from Day Surgery, myself, we had been nurses for 30 years and we do know what a wound dehiscence is and we know there is varying degrees of wound dehiscence, and he was - his instruction was that we needed to go off and do some research and find out what a wound dehiscence was. And usually if you have any type of, like, wound dehiscence, total dehiscence, the patient returns to theatre, and that is one of the clinical indicators that we monitor is the returns to theatre, and I can only remember, you know, in the times that I have been recording those returns to theatre, like, a wound dehiscence, complete dehiscence, was probably one or two in 10 to 15 years. So to have - when Di spoke, Di Jenkins spoke about it, I immediately was quite concerned, because I was checking to make sure people had been recording patients coming back to theatre, it was one of the clinical indicators to collect, and if some of the staff hadn't been reporting it, I needed to know. So it was definitely something I was concerned about.

Did you gain the impression in April 2004 that there had been wound dehiscences in the surgical ward that weren't being reported to you?-- That's right.

D COMMISSIONER VIDER: Were these wound dehiscences of the severity that would have required a return to theatre for resuturing?-- Some of them were, yes

Where was the resuturing going on?-- The resuturing - I will just clarify that. As far as I was concerned, my staff hadn't been recording the patients were coming back to theatre because she had 12 patients that they were talking about.

Yeah?-- And I wanted to be sure they were reported, because it is something - one of our clinical indicators. But there was probably out of that 12, I'm not sure, but there was probably only one or two that came back to theatre for resuturing.

MR ANDREWS: If only one or two came back, does that mean that the other 10 or 11 had only the most minor of wound dehiscences?-- To varying degrees, and there were various ways of treating that too. The wounds can just be - instead

of being completely closed, they can be left open and left to heal themselves.

I see. So even if a wound dehiscence doesn't require surgical resuturing or stapling-----?-- Yeah.

-----it can be significant-----?-- It can be significant.

-----for the patient?-- Yes, it can, and you can look at their extended length of stay.

Now, Dr Patel, you've told us, laughed. Dr Keating was at that meeting, do you remember what reaction Dr Keating had or what Dr Keating said?-- Well, I guess he was in support of Dr Patel and-----

Well-----?-- As in he didn't urge that it needed further investigation, other than, you know, at that particular time. We were all pretty shocked to be laughed at.

Yes, but I'm interested in precisely what Dr Keating did. Your statement suggested that Dr Patel and Dr Keating laughed-----?-- Yes, they did.

-----as I understand it?-- And nothing more - nothing really was - Dr Keating didn't add anything then in support of us nurses or he was supporting Dr Patel.

Well, I want to be certain about whether Dr Keating sat passively by while Dr Patel laughed, or whether you recall that Dr Keating also was amused?-- I recall Dr Keating also laughed.

D COMMISSIONER VIDER: Was recognition given to the fact that in that room there were a number of surgical nurses who actually talked about the fact they knew what a wound dehiscence was?-- No, there was no recognition.

Because in actual fact, the closure, the decision not to fully close your wound, to let that heal by secondary intention, that would be documented, so when that patient returned you would know that that's the approach for that particular wound healing that the surgeon is undertaking, and, you know, my understanding would be there would have been suturing of lower layers, so you wouldn't expect the whole thing to come apart?-- No.

And it, therefore, necessarily would have constituted a statistic for a wound dehiscence if that was an approach that had been taken?-- Yeah, I guess so. Di Jenkins was collecting data on all patients that had some sort of, you know, wound breakdown.

Dehiscence, yeah.

MR ANDREWS: Now, in your experience, what factors need investigation if there has been wound dehiscence?-- Well, generally you look at your suture material. If there's been,

you know - there could have quite possibly been a faulty batch of material and - but I hadn't had any complaints from any other consultant who used the same material, and the other thing you would look at is the surgical technique.

Now, can you tell us whether either of those - well, whether surgical techniques remained a valid suspicion in your mind?-- I guess I did notice that. I didn't do a chart audit, but I noticed that Dr Patel did allow his junior staff to close wounds and that was discussed at the meeting.

And does that mean inexperienced staff, or just persons less senior than Dr Patel?-- I guess they're staff that are learning.

D COMMISSIONER VIDER: Would Dr Patel remain in the theatre so that they were suturing under his supervision?-- Not - not all of the time. He would perhaps write notes and then he would leave the theatre and then he would return and ask if they had any problem.

But the suturing by junior doctors wasn't necessarily done under his supervision?-- No, he might have unscrubbed.

MR ANDREWS: Now, at that meeting there was general discussion and it was decided that Di Jenkins would research the definition of "wound dehiscence"?-- Yes.

That she would conduct a chart audit and prepare a report?-- Yes, she did.

As part of that project, you were to gather data on the number of patients who returned to theatre for treatment for wound dehiscence?-- Yes, I did. Yes.

Were you to gather the data for the period after April, or were you trying to source data prior to April?-- I guess I was looking at data prior to April.

Now, by the June meeting, you tell us there was a suggestion of Dr Patel's to use an ICD-10 code for identifying wound dehiscence?-- That's a code used that the coders can use to document, which is they code patients from the procedures that they have off their Discharge Summary, and if that ICD-10 code - if the wound dehiscence wasn't documented on the Discharge Summary, well, then, the coders would not have been able to pick up that code as part of the complication of that particular procedure, which a wound dehiscence is, it would be a complication and it would change the ICD-10 code.

So that I understand that, if there was wound dehiscence, was someone to write down on the chart "ICD-10"?-- No, they would - I guess, the staff, if they were completing the Discharge Summary, they would write down the procedure the patient had and any complication and when the coders go to look at that, if you go in for a hernia repair, that is one particular ICD-10 code, it comes under a list, but if you have got a wound breakdown, then that is a different code and then

our stats would then pick up those codes.

So Dr Patel was suggesting that someone use a particular code to show the incidences of wound dehiscence?-- Yes.

D COMMISSIONER VIDER: Did you pick up from - I don't want to be jumping ahead, Mr Andrews - but from the chart review, using the ICD-10 coding, were you able to do any cross-referencing? If there were patients that the staff knew had had a wound dehiscence, but it wasn't recorded on the Discharge Summary, were you able to do a cross-reference of that?-- No, I just - I didn't cross-reference it. I just saw the two reports from - because by the time I saw the report, I had stepped down from the Nurse Unit Manager's position, and I saw the two reports and they didn't seem to collate. There was too - the reports from Jenny Kirby from DQDSU and Di Jenkins' report were different in the numbers.

Was that because Di Jenkins had particular knowledge?-- Because she had done the chart audit and she was talking from experience that she had seen the wound dehiscence, she had seen the patients, she followed them up, followed the charts up.

Rather than documentation purely on the Patient Discharge Summary?-- Yes.

Jen Kirby's figures and Di Jenkins' figures were different?-- Yes.

Di Jenkins, having targeted particular patients, and Jen Kirby no doubt being someone who collated data that was handed on to her, a person who didn't necessarily visit patients?-- That's true.

And is it the case that Ms Kirby's data showed fewer instances of wound dehiscences than Di Jenkins' data?-- Yes, it did.

Now, for Dr Patel, at June 2004, to be suggesting the use of a particular code for identifying wound dehiscence, does that mean that prior to that time that code had not been used?-- I couldn't really answer that. I mean, in real - I mean, ideally that would be where it would make - instead of having to do chart audits all of the time, using those codes would be an easy way to look at your stats.

Now, if a patient's wound opened some time after surgery, it would happen probably in the surgical ward or perhaps the ICU and they might be dealt with there or they might be sent back to surgery for reclosure?-- That's correct.

Let's assume that someone was sent back to the theatre for reclosure. Who would document that there was a wound dehiscence? Would it be somebody in the ward where the wound opened, or would it be somebody in the theatre where the wound was closed?-- No, it should be documented on the operating notes of the patient's, diagnosis of wound dehiscence and secondary closure, and that information would be transcribed

into our theatre record and onto our Theatre Management Form, which is our way of collecting data as well for Queensland Health.

Now, it was decided at the June meeting that the collection of data relating to wound dehiscence would be referred to Jenny Kirby of DQDSU and Di continued to collect her own data?-- Yes.

And there was another meeting a month later, July 2004. You attended that. You can refresh your memory by looking at paragraph 23 of your statement?-- Yes, I was at that meeting.

Was it only then at that meeting that it was decided that Adverse Event Forms would be completed if wound dehiscences occurred?-- Yes, I think Toni Hoffman actually brought it up, as part of risk management that any patient that returns to theatre there should have been an Adverse Event Form completed and we hadn't done that in the past and that was something that was decided at that meeting.

D COMMISSIONER VIDER: For any unplanned return to the operating theatre-----?-- Yes.

-----you had not routinely filled out an Adverse Event Form?-- No.

MR ANDREWS: That was Toni Hoffman's suggestion and she was the Nurse Unit Manager in the ICU. Had there been literature or information brought to the attention of you as - when you were Nurse Unit Manager of theatre that it was appropriate to fill in an Adverse Event Form for such a thing as wound dehiscence?-- I guess that wound dehiscence is a complication of surgery, and in the past, no, we have never been - you know, it's never been suggested that he - that we - that it should be collected.

Now, you then stepped aside from the position of Nurse Unit Manager and no longer attended those meetings. Is that the position?-- That's correct, yeah.

On the 14th of May there was - 2003 - there was an incident reported to you by one of the staff in theatre?-- Yes, there was.

That's one of the nursing staff who was obliged to report to you?-- Yes.

That Dr Patel had performed a gastroscopy on a patient of Dr Kingston where that patient had not been booked for a gastroscopy but for an epididymectomy?-- That's correct.

COMMISSIONER: Can you enlighten me as to what an epididymectomy is?-- Yes, it's a procedure on the scrotum.

Right. I am glad I asked.

MR ANDREWS: Does a gastroscopy go anywhere never that area?-- A gastroscopy is a procedure whereby you pass a telescope through a patient's mouth into their oesophagus and into their stomach and into their duodenum, and it's just an investigation under sedation and local anaesthetic, whereas the other operation is done under either a general or local anaesthetic.

That would have come as a great surprise to the patient, I expect?-- I couldn't actually - I'm not sure of the patient. I think he was quite surprised.

In any event, you immediately notified the Director of Nursing?-- I actually phoned - telephoned her and told her that there had been - a patient had received the wrong procedure.

And the Director of Nursing at that stage, do you recall who it was?-- Was Glennis Goodman.

Did anyone in theatre fill out an Adverse Event Form in May 2003 relating to this patient?-- Yes, there was an Incident Form completed, and it was completed by the nurse who had collected the patient and the surgery staff, nursing staff.

COMMISSIONER: Can you assist me as to what procedures should operate to prevent a patient undergoing the wrong procedure?

Certainly it's been my experience that before your operation at every stage from your bed to the operating theatre and back again and you are asked to confirm your name and your arm band and what procedure you are undergoing, and the anaesthetist checks and the scrubs nurse checks and the surgeon checks, and there are, at least in my experience in private hospitals, very, very strict and rigorous procedures to make sure that a patient being operated on or undergoing a procedure is the right patient undergoing the right operational procedure. How should it have worked at Bundaberg?-- The particular day there - we had patients booked for the afternoon general surgery list, which this patient had been booked on to, and we also had patients booked for endoscopy procedures as well. Normally the endoscopy patients don't sit - don't stay in a bed, they are just sitting in armchairs, recliner chairs.

Yes?-- And they have their - they go from those chairs to the procedure room, then to recovery, and - which is done on a trolley, sorry, and then they - they are taken to recovery where they recover, and when they are awake they go back to their armchairs and, you know, further recover in an upright position. This particular patient - because there was so many patients booked for endoscopy there were patients in beds and nurses who collected the chart from the day surgery desk, she just went to the patient and called him by his first name, and of course there was two P74s and one P74 answered and just went along with the nurse, and I guess at that time for endoscopy the checklist wasn't done, which is a list that you go through where you check the patient's identification, you check their arm band, you ask them their full name and ask them what procedure they are going to have, and - you know, test they have had - you check their allergies, and that wasn't - that list wasn't completed.

I don't want people to think I'm leaping to the defence of Dr Patel, but it sounds as if on that occasion it wasn't entirely his fault?-- No, it was a succession of faults, but what I'm saying, Dr Patel never met that patient before and wouldn't he have spoken to the patient and checked his name and asked him what he was there for and checked his identification?

Yes?-- The same with the anaesthetist.

That's what I'm wondering. I would have expected that for this situation to arise at least three people would have to make mistakes, the nurse-----?-- Three people did.

-----the anaesthetist and the surgeon?-- On the day surgery staff didn't hand over to my nurse and my nurse didn't check his identification and didn't check his full name, the procedure, and then Dr Patel didn't speak to the patient or check his name and check his ID, and neither did the anaesthetist.

D COMMISSIONER EDWARDS: Are you aware of any other cases in your time there where there was mistaken identity for the surgery to proceed?-- Never. I have never experienced - from

1974 until that day I never experienced any patient having an incorrect procedure in any hospital that I have worked in or any operating theatre. So I was quite devastated.

COMMISSIONER: What are we to learn from this incident? Was it that Dr Patel was pushing the staff too hard, trying to get through too many patients, or that there just weren't enough staff or that the systems were a bit lax? What?-- I think it's the system's problem. Where there was a lot of patients booked on that particular list the staff were anxious to get through the procedures so they could go home on time, and at that stage endoscopy patients, there wasn't a checklist completed for them.

An endoscopy is not done under general anaesthetic?-- It's done under local anaesthetic and sedation.

And what about the procedure that was in fact the gastroscopy?-- The epididymectomy.

Yes?-- That's performed under a general.

D COMMISSIONER VIDER: Whose was the epididymectomy? Was that Dr Kingston's?-- Yes.

So the endoscopies at Bundaberg are done in the operating theatre?-- No - well, they are done in our suite, but it's a separate procedure room and you access it from the corridor.

So that afternoon you had Dr Kingston-----?-- Yes.

-----with a surgical - a general surgery list, and you had Dr Patel with an endoscopy list?-- Yes, I did.

COMMISSIONER: Thank you.

MR ANDREWS: You called the patients or two patients who were confused P74. In fact, do you recall that their names were P74?-- Sorry, yeah.

And if I put the name of one of them on the patient key, can you confirm if I'm correct? I will hand you the patient key in a moment. I will insert a name at P74 which seems to be a vacant space. As I understand it, Ms White, that's the name of the patient who received the unintended gastroscopy?-- Mmm.

Thank you.

COMMISSIONER: That can be passed up to the Bench. We'll update our copies, thanks. Mr Andrews?

MR ANDREWS: In about June of 2003 there's another event. You will recall it involved Dr Patel where he alerted you that there'd been a traffic accident about 13 kilometres from Bundaberg and he was keen to assist. As he understood it, someone was trapped and he was prepared to travel to do the amputation?-- On the side of the road, yes.

Now, can you tell us about that event? Was there anything unusual about that, apart from the fact that it was-----?-- A very unusual episode. Yes, I received a phone call from Dr Patel and it was quite - you know, a frantic phone call, that - you know, "I have got to go out to this accident site and I am going to need equipment to amputate limbs.", and, of course, I sort of swung into action and thought, "What's he going to do?", and collected our amputation - you know, we have got a battery operated power source and collected that - that equipment that he would need, and I notified CSD, who provided the packs, and we sort of just put in a big plastic container instruments, the saws and sutures and blades and - you know, skin prep and things that he would need, and shortly after that I'd had everything ready and the lift doors opened and opened directly into our waiting area and Dr Patel arrived with - by that stage he'd had two PHOs, two interns and two medical students with him, and they just all emerged out of the lift all in scrubs, and I thought, "My goodness, this is" - and he was busy saying, "Where's the equipment? Where's the equipment?" So I said, "Look, I have got all it all here in a trolley.", and then they proceeded to - basically all - you know, herd back into the lift. I said, "Look, you are in the wrong lift." There's two lifts. One goes up and they wanted the one going down, and of course he's busy yelling at all the staff and saying, "Come on, we have got to get going." I am say, "Dr Patel. Dr Patel. You are in the wrong lift.", and he just ignored me, and the next minute they go up and they come down and get in the - you know, get in the right lift and head off. Prior to that I was a bit concerned because I was sending expensive equipment out in the field. I asked one of my nurses to quickly - you know, get changed and go with him and I think he actually went in scrubs as well, and so he went with the staff to - you know, look after the equipment with Dr Patel. And it was probably only a short time, 15 minutes, later, 10 to 15 minutes later, that my staff member came back and he said, "Oh, no", he said, "the ambulance or the Emergency Services have freed the victims from the vehicle and they are being transported to hospital and - you know, we're not going out there." But, I guess - so when I sort of thought about it and had time to sit for a moment and I sort of thought he didn't - he hadn't notified any anaesthetist or taken any drugs or any - you know, any equipment to actually - you know, provide any local anaesthetic or anything for the patients, and I thought that that was rather unusual.

Thank you.

COMMISSIONER: Is there an emergency procedure or something that should be followed in those cases?-- We have got a disaster program which is generally followed, and I was concerned that, you know, maybe every time there was an accident Dr Patel was going to request equipment and be going out to the field, so-----

D COMMISSIONER VIDER: Without an anaesthetist.

MR ANDREWS: You have a disaster problem. Do you mean that

the protocol-----?-- It's coordinated with Emergency Services and that - you know, discuss what they need and - you know, who would be going. It's a coordinated thing, it's not just - you know, perhaps someone - you know, deciding they are going to go out into the field.

Emergency Services, that's-----?-- Ambulance and police and-----

I beg your pardon?-- Emergency Services, the ambulance, and the police. They coordinate disaster outside the hospital.

Emergency Services is a unit independent of the hospital, isn't it?-- Yes.

And it's usual for Emergency Services to coordinate, that is to ask the hospital or advise the hospital what help Emergency Services need?-- Yes, they do.

D COMMISSIONER VIDER: Just further to that, in terms of the organisation of the Emergency Services, would the Emergency Services in the case of a disaster like this, when they contact the hospital who is their point of contact, the Director of Medical Services?-- Yes.

Who then would organise internally the-----?-- Yes.

The communication would come from the Director of Medical Services?-- Yes.

MR ANDREWS: Now, you didn't receive any complaints or incident reports from the nursing stuff about Dr Patel's surgical ability?-- No.

Do you have an explanation for that?-- Well, for general procedures - I mean, there was no - there was no complaints or any comments from staff, but when he - Dr Patel, when he did scrub for a procedure he would often have a PHO, an intern, and a medical student scrubbed with him as well. So, it made it very difficult for any scrub nurse to actually see what he was doing, and if there was any - any adverse events happening to patients the scrub nurse wouldn't have been able to see.

Do you mean there were too many bodies in the way?-- Yes.

Is there a tendency of - that you have noticed with nurses about criticising doctors?-- Nurses in general do not criticise medical staff and do not report perhaps incidents that they see to medical staff.

Is that out of loyalty?-- I guess it's just a general - well, I guess it's loyalty. It's a general expectation of a nurse that you respect what the surgeon's doing and they respect what you are doing.

You wished to correct paragraph 33 of your statement?-- I guess it's in reference to the position of Director of Medical Services. In the past I have always had basically an open

door - you know, approach to the Director of Medical Services. If I had any issues with - from requests for more equipment or a problem with overbooked lists or discussions about a problem I may have had with a medical staff that - I would always go to the Director of Medical Services, but probably about in 1998 the Elective Surgery Program began and that involved employing an Elective Surgery Coordinator who came under the umbrella of Director of Medical Services, and I found that probably from the time that John Wakefield left the communication between the Director of Medical Services to myself as a Nursing Unit Manager, the communication had ceased and most of the communication was done through the Elective Surgery Coordinator, which I guess made it hard to - because I was seeing the big picture between workloads and emergency procedures and medical staff I found it - having access to the Director to discuss it with him I found I had no way of communicating.

So, as I understand your evidence, from about the time Dr John Wakefield-----?-- Left.

-----left. Was there a system that predated Dr Keating's system?-- Yes.

Did you have less access to the Director of Medical Services than you had in years gone by?-- That's true.

D COMMISSIONER VIDER: Were you able to discuss that with anybody, because, I mean, I hear what you are saying, that the Manager of the Elective Surgery program deals with the organising of lists predominantly-----?-- That's correct.

-----not what's actually going on in the operating theatre in terms of either instrumentation, staffing levels, scope of procedures, whatever?-- But I think it even got to the stage where the Director of Nursing asked that the Elective Surgery Coordinator to review the staffing of the operating theatre, and I think that was something that came from Mr Leck which meant that he could look at the number of sessions that we were going to have and then decide what staff that I needed with complete disregard to any time allotted for in-service, education, conference leave or any of those things. And so I - my staffing eventually decreased, and even recently, even after I stood down from the position, the Acting Directors of Nursing that have come to Bundaberg cannot believe what work we are doing with so little staff, and I should have another three - well, I should have had another three full-time equivalents, and as - you know, that's - I guess, I have - my staffing had been pruned without consultation with me.

MR ANDREWS: The staffing workloads caused you to prepare a business plan in 2003/2004 to detail your staffing needs?-- Yes, that's correct.

And you submitted that business plan to the Director of Nursing at the time?-- Which was Mrs Goodman.

And Mrs Goodman did what about it? Anything?-- That - my

business plan was - particularly with the staffing numbers was compared to what I had previously had in the previous years and they looked at our activity and actually just like patients and numbers of procedures, and I was told that, no, I wouldn't - you know, get - gain any more staff.

Mrs Goodman told you that?-- Yes.

Right. Mrs Goodman eventually was replaced by Linda Mulligan as Director of Nursing?-- Yes.

And you e-mailed Ms Mulligan on the 26th of May 2004-----?-- Yes.

-----outlining the problems you were experiencing with staff?-- Yes.

Was she able to do anything more for you than Ms Goodman had done?-- No, no. No.

D COMMISSIONER VIDER: Were you able to demonstrate that your workload had increased?-- We were, because of our overtime. The amount of overtime that we were doing, yes, had increased.

D COMMISSIONER EDWARDS: Was the workload increase associated with increased operating by Dr Patel?-- Yes.

COMMISSIONER: We have heard suggestions - I don't think there's any direct evidence of this yet - but suggestions that the increased amount of elective surgery performed by Dr Patel resulted in some hundreds of thousands of dollars coming into the hospital. Are you aware of that? Is that something within your knowledge?-- Oh, yes, the elective surgery total, definitely, yes.

And do you have some idea of the figures involved?-- No, which - in the past when John Wakefield was Director of Medical Services we were given actually data on what total we had to meet, so you would generally know that you were meeting your targets monthly. But I found over the last few years that information wasn't - I wasn't given that information, and we would get to March, which happened March 2004, that I was told we hadn't - we weren't going to meet our elective surgery targets, so then we had - like, I guess with - the elective surgery team looked at what procedures would gain us the most rate of separation, which is the funding, to meet the elective surgery targets, so we did some extra total joints, and we did extra laparoscopic cholecystectomies and we did some extra neurology procedures because they were the procedures they targeted, could gain us the money that we needed, you know, to - to meet our targets.

No doubt at some stage we will be getting more specific evidence about these - the way the system operated, but am I right in understanding that the more complex the operation and the more susceptible the patient the more money the hospital received from performing that surgery?-- Yes, that's correct.

So if it was a relatively simple operation on a healthy young man or woman, that didn't get much money at all?-- No.

But if it was a complex procedure on an elderly person or a person with other debilitating illnesses and that sort of thing, then a significant amount of money came into the hospital for performing that surgery?-- Yes. Well, that was why the laparoscopic cholecystectomies were targeted and the neurology procedures were targeted.

We have also heard a fair amount of evidence from other witnesses about oesophagectomies. Were they a well-paying type of operation as compared-----?-- Yes, because they were very complex.

And because, I imagine, they were usually performed on patients who were extremely ill in any event? A person doesn't have-----?-- No.

-----an oesophagectomy unless they are-----?-- No, it's got to be - you know, extremely serious - serious reason to have an oesophagectomy, yes.

D COMMISSIONER VIDER: But the meeting you had to review the targeted elective surgery lists at that stage contained things that were well within the scope of the Bundaberg Base Hospital?-- That's correct.

For example, laparoscopies and hip replacements and the neurology procedures, joint replacement?-- Yes.

COMMISSIONER: I guess what I was getting to is this: my understanding of the system so far as it goes is that if you are performing a lot of elective surgery, more than the hospital would be expected to perform, the hospital receives additional funding for that?-- Yes, we do.

But that additional funding is supposed to pay for additional staff in the theatre and elsewhere to assist in performing this elective surgery. It almost sounds to me from what you are saying as if your nursing staff were performing this extra work, bringing more money into the hospital, but then not getting the benefit of that money in terms of extra hands to help around the operating theatre?-- There's very little education for operating room nurses or there's no time to - you know, there's no allocation for conference leave and things like that. So, no, we weren't gaining any benefits from - but the other thing is Dr Patel and all these elective - extra elective work is that emergency procedures were then done after hours, but we don't have emergency team to come in after hours. So, you could be working from 8 o'clock in the morning till midnight or till 4 o'clock the next morning without a break without - you know, without leaving the hospital.

I think the-----?-- And that's where, you know, the - unsafe practices and dangers, you know-----

The other thing that I would like to have clarified, we obviously have heard a lot about elective surgery and I guess people outside the medical system like me tend to assume that elective surgery means something - you know, cosmetic or something that is totally unnecessary, it's for the patient's choice rather than the patient's benefit. But what we continue to hear is very serious procedures described as elective surgery simply because they are not emergency situations?-- That's correct, yes.

They are called elective. Am I right about that, that almost anything can be an elective procedure, treated as an elective procedure unless it's necessary to save the patient's life then and there?-- Yeah, that's true.

So when we are talking about reducing the length of the elective surgery waiting list, we're not talking about facelifts and-----?-- No, we don't.

-----other sort of cosmetic things, we are talking about things that people need to keep them alive?-- Yes.

That they just don't need with desperate urgency?-- No. We are talking about hysterectomies, laparoscopic cholecystectomies, hernia repairs and that sort of surgery-----

Things that no-one-----?-- -----total joint replacements, arthroscopies. You know, they are not life threatening and they can be booked, you know. But elective surgery is - it's also, I guess, categorised into three levels of category, one, two and three, and category 1 is a procedure that can impact on that patient and it can become an emergency so it should be within to one six weeks, and category's 2 not quite as urgent, can be done within six weeks and can perhaps a wait a little bit longer, between say six weeks and two months, and the category 3 - sorry, six - six weeks and six months, and category 3 are the - could wait perhaps for 12 months.

But if by chance anyone in Charlotte Street actually owned a dictionary and looked up the word "elective", none of these procedures are elective in the sense that they are procedures that the patient elects to have rather than not have, they are all procedures that the patient actually needs-----?-- They do need them, yes.

-----for their ongoing health?-- Yeah.

D COMMISSIONER VIDER: Your concerns about the long hours that staff were working-----?-- Yes.

-----that became a apparent from what you were saying?-- Yes, it did.

If the Elective Surgery Program Manager is the one that's doing the staffing, what avenues were open to you to go and discuss your concerns about that workload issue and, secondly, the hours that staff were working? Who could you go and

discuss that with?-- Well, I tried to discuss it with the Director of Nursing and the nurse managers who also - like, look - worked after hours. They were familiar with the amount of hours the theatre staff were working and it was documented in reports every day of our overtime.

Yes?-- So it wasn't - you know, look, I mean, everyone was well aware of what hours that we were working, and it's reported monthly on - I was reporting it in my budget report, the amount of overtime that staff were working and the hours.

So that wasn't able to be used to demonstrate the fact that you needed more staff?-- Well, I did demonstrate it but I didn't get any more staff.

MR ANDREWS: You have said you tried to talk about it with the Director of Nursing. Which director?-- I also spoke to - I had spoken for years to Mrs Goodman about it, and she had brought it to me meetings, I guess, without any effect and, yeah, I did speak to Linda Mulligan about the staffing issues.

You've sent an email to Ms Mulligan as Director of Nursing on 26 May 2004 outlining problems you experienced with staff levels, saying that you needed to increase the staff to match the increase in workload?-- Yes, I did.

Did you speak with Ms Mulligan after that?-- No.

COMMISSIONER: What response did you get to that email?-- Well, I didn't get any response. I mean, you just have to make - you know, do the best you can with the staff that you've got.

But did you actually receive any response at all?-- No.

Do we have a copy of that email? I'm not sure-----

MR ANDREWS: I don't have a copy of it, no.

COMMISSIONER: Do you know where we might be able to put our hands on a copy of that email?-- Probably on my computer at work.

All right. I won't trouble you now, but through the Nurses' Union solicitors, I wonder if you could make a copy of that available to us at a later time. Thank you. Mr Allen, you can look after that?

MR ALLEN: Yes, thank you, Commissioner.

MR ANDREWS: If you had no response to your email, why didn't you follow it up with the Director of Nursing by seeing her?-- She was, I guess, very difficult to see. She was obviously quite busy. She'd come in to our hospital after quite a lengthy break between the previous Director of Nursing, and we'd had Acting Directors of Nursing in between, but I guess she had a lot to catch up on, but I found that she was non-accessible. You couldn't ring her. You had to go through - you always had to go through the clerical support people to actually speak to her, and they would drill you about what did you want to see her for. Even if it was something personal you had to explain to them what you wanted to see, and then they would relay the message to her about why you wanted to see them and then she'd make a decision whether she'd see you that day or next week or, you know, two weeks away sort of thing, and I found she just wasn't available to talk to. Sometimes, I guess, if you've got a situation where you really need to speak to her because you're at crisis with workloads or having adequate staff and you need her support to either look at how we could reschedule some procedures - in the past I had been able to ring Glennis Goodman and just say, "Look, I need to have a meeting with you urgently. We've got a problem here with too many emergencies booked. We do not have adequate staff."

Why didn't you ring Ms Mulligan on her freeset?-- That was always - it was always directed through the support people anyway.

I don't understand. I thought a freeset had its own number?-- I think - well, I don't know. She'd never answer it.

I see.

D COMMISSIONER VIDER: With this workload that had now become a trend, did any staff leave because of this or did - you didn't have an attrition rate that was attributed to the workload demands?-- No, not really, no.

At that stage?-- Not at that stage. Our sick leave was probably the thing that was demonstrating our workloads, and people would regularly take sick leave.

So there were some of the usual predictors that were coming through?-- Yes.

MR ANDREWS: Why are you no longer Nurse Unit Manager? Why is it that you stepped aside from that position in August 2004?-- Well, I guess I got to the situation - I had a staff that - staff member that took a grievance out against me, and based - a lot of that had come from workloads and my inability to address the workloads, and Linda Mulligan actually just called me to her office and handed me a letter to say that this person had taken a grievance out against me and I was going to be investigated and my workplace behaviour was going to be investigated, and I guess the most upsetting thing was that she stated in the letter that I would receive disciplinary action if I discussed this issue with any of my staff or any of my colleagues. I could speak to the staff support people and I could speak to her, but I'd really only known her a month, so I really didn't think I could discuss anything with her.

You'd known who a month?-- Mrs Mulligan.

I see?-- So I didn't really have any rapport with her, and I was - I guess from that time on I just felt that the Nurse Unit Managers can then be under the systems that if anyone makes a complaint against you, you can be a target, and you can - and I'd been a Nurse Unit Manager for 14 and a half years. She didn't obviously look at my record. She didn't suggest any mediation with my staff member. It was just straight to an investigation of my work practices, and I felt that was unacceptable.

COMMISSIONER: What were the actual terms of the grievance or the complaint?-- As in the reason?

Yes?-- It was because I - I've just forgotten the word. I had not given him opportunities to act up as a Level 2. It's just gone out of my head.

Without going into the details, was it essentially a rostering issue or a staffing issue?-- It was a management practice issue, yes.

Was this all before or after you had sent the email to Mrs Mulligan raising your concerns about staffing numbers for which she never even gave you a reply?-- It was before.

Right.

MR ANDREWS: Yes, I-----

WITNESS: I'm sorry, the grievance was about I'd supposedly discriminated against this staff member and I was investigated by two Bundaberg Health Service staff members and I was found not to be guilty of any of these allegations. Then I was asked to go to mediation with this particular staff member who claimed that the report was incorrect and full of lies. I had to sit through mediation for several hours with this person who still had not - still believed that I was guilty of discriminating against him, and I just felt that if this is the processes that Nurse Unit Managers are going to be subject to, well I think it's time that there's a new person take on the role.

COMMISSIONER: I know I'm jumping ahead, but I notice later in your statement you refer to a situation where you had a bit of a run-in with Dr Carter, and on that occasion you were told by the Human Relations Manager, your two senior nursing staff members, to grow up and go back and speak to Dr Carter and sort it out. To be totally candid, I don't have a problem with that. That strikes me to be a very sensible solution. It just seems to me absurd that that same solution wasn't applied when you had the grievance brought against you, that someone didn't say, "Look, come on. You two have to work together in the nursing theatre. Just sort it out between yourselves and let's not have all these silly mediations and investigations and procedures."?-- Well, that would have been nice, yes. Well, it didn't happen. But that's - I mean, as a Nurse Unit Manager I had - Toni Hoffman was Acting Director when I had that problem with Dr Carter, and that was a series of three events, and one event he actually swore at me in front of staff, so I thought it was a fairly sensitive issue and I really wanted to know from Cathy Fritz how you deal with that sort of - you know, because I had to - Dr Martin Carter was the Director of Anaesthetists and Intensive Care so we worked pretty closely together, and he hadn't approached me to apologise for anything, so I went to her for just some pointers in how to help. So I guess she gave me the direct answer, yes.

I guess the point I'm making to you is that it almost comes across as double standards that when you as the Nursing Unit Manager is the subject of a complaint, you're put through the wringer?-- Yeah, I was.

But when you make a complaint, you're told to grow up and sort it out yourself?-- Yeah, you're not listened to and you've got no support, and that's the thing I find for the Nurse Unit Managers at this hospital. There is no support for them.

D COMMISSIONER VIDER: Just clarifying that, back to the incident we're talking about with the grievance against you, am I right in saying then that the first you knew about that formally was when you were called to Linda Mulligan's office, to the Director of Nursing's office?-- That's true.

The Director of Nursing did not come to the theatre-----?-- No.

-----at any previous-----?-- No.

-----time prior to calling you to her office-----?-- No.

-----and say, "There's been a grievance put in against you." It was straight into the formal process?-- It was.

MR ANDREWS: As I understand from your statement, the sequence is that the grievance was presented in April 2004 and it was on 26 May 2004 that you emailed your Director of Nursing to detail your staffing problem?-- Yes.

A patient P70, could you-----

COMMISSIONER: Perhaps before you move on, we might take the morning break now, Mr Andrews.

THE COMMISSION ADJOURNED AT 10.40 A.M.

THE COMMISSION RESUMED AT 11.01 A.M.

JENNIFER ANN WHITE, CONTINUING EXAMINATION-IN-CHIEF:

COMMISSIONER: Mr Andrews, patient P70.

MR ANDREWS: Yes, Commissioner. Ms White, because you stood aside from the position of Nurse Unit Manager for operating theatres and acted then as a Level 2 registered nurse in the operating theatres, that gave you an opportunity to observe procedures that you'd not had?-- That's correct.

On the 1st of October 2004 were you able to watch Dr Patel's technique as he performed a procedure?-- Yes, I did.

Perhaps you could pronounce it for me?-- The procedure was an abdoperitoneal resection, and it's a procedure whereby the patient's bowel is resected and the rectum is actually closed and a colostomy is formed. So it's a major procedure, major bowel procedure.

You were the scrub nurse?-- I was.

It was your first opportunity to watch Dr Patel's technique since he'd arrived almost a year and a half before?-- I had opportunities to scrub for him before, but I guess in the nature of this particular procedure whereby I could actually - the patient's positioning enabled me to actually see what he was doing, and it was probably one of the first case that I actually had an opportunity to do that.

You say in paragraph 36 that you found for most of the procedure he had poor exposure. What does that mean?-- When a surgeon is undergoing a procedure, they obviously want to work in a certain part of a patient's body and you need to actually expose that part of the person's body to be able to perform the procedure, which is - or resect the piece of diseased tissue or bowel out of the patient, and to get good exposure we use retractors, and retractors are used to retract other parts of the body away from that particular organ or area of tissue, and the normal procedure that I found working with other surgeons and doing this type of procedure is that you would actually put packs around your wound edges and then you would use retractors to visualise the area that you wanted to work in, and I found that with Dr Patel, that when I did hand him the packs, he sort of basically threw them back at me and he said, "That's an old-fashioned idea. We don't do that here - we don't do that in America", which I was a bit - found it a bit unusual, and using the packs actually protects a patient's healthy tissue and your skin edges.

It protects them from what, the protractors which are otherwise pulling against the healthy tissue?-- Yes.

Now, have you seen other surgeons, apart from Dr Patel, working within Australia so that you can comment on whether other surgeons accept packs and sponges from scrub nurses?-- It is the normal procedure and I have worked with surgeons in Victoria as well as here in Queensland, and I was trained that you always hand the surgeon a pack to pack the wounds after the wound was opened and the peritoneal cavity was open. You would always be ready with your sponges to hand to him so that he could place them in the areas that he wanted them.

So, that's one problem I think I understand - the failure to use - well, one was poor exposure. Is the failure to use the packs and sponges a second problem?-- It relates to the exposure.

And you found that he removed the affected bowel in a rough manner. Surely once it is resected, the removal - the roughness of the removal doesn't matter, does it?-- As far as - his resection was very rough, and often surgeons can use their fingers to actually resect tissue away from that, but it was literally dragging the bowel out that disturbed me.

Had you ever seen such roughness before?-- No.

D COMMISSIONER VIDER: Mr Andrews, can I just ask a question there? You talk about the fact that he did not ligate bleeders or use diathermy to minimise blood loss. We have heard evidence elsewhere of patients bleeding post-operatively. Was that a routine thing - that he did not ligate a bleeder - tie off a vessel that was bleeding?-- Initially when he is commencing his procedure and going through the fat and the muscle and the peritoneum, he will use diathermy, but when the patient - after he had exposure and he was resecting the patient's affected bowel, he didn't use diathermy a lot, and there was a lot of blood around and increase in blood loss, which I felt was perhaps - more than I normally - you know, for that procedure that you would normally expect to see.

MR ANDREWS: You say that there was no identification of ureters, bladder and urethra?-- If you understand the area he was working in - he was taking the lower section of bowel - it is routine to always identify the - well, obviously the bladder and the ureters, because they are on either side, and they need to be protected, and normally the surgeon will - during a procedure of that nature, they would hesitate and even say to the assistant, "Here's the ureter and here's the left one and here's the right one.", and would actually identify them, and you would hear that normally every day when you scrubbed for surgeons.

But Dr Patel didn't do so?-- No.

Does that put the patient at risk - at risk of, perhaps, those

- the ureters, the bladder or the urethra being nicked or-----?-- Nicked or severed.

Now, patient P70, you say that that patient's resected bowel was sent away for histology and a report revealed certain things. Can you tell us those things that were revealed in the report which we see at paragraph 37? Do they have any relevance to Dr Patel?-- Well, the patient - the patient had the procedure for villous adenoma, which is a pre-cancerous condition, and then when I looked at the histology report - and I'm not a pathologist and I'm not an expert, but I had just - when you look at the report, you would wonder if that particular procedure was necessary at that particular time in the person's life, particularly as the nodes were all negative, and normally if there's a cancer there, the nodes are positive, and even though I only had limited knowledge, I suggest that maybe that patient's procedure was not necessary.

I see. So, the resection was for villous adenoma?-- Yes.

Did you say that was for suspected cancerous-----?-- Cancer cells in the bowel.

COMMISSIONER: Pre-cancerous?-- Yes, pre-cancerous cells in the bowel.

MR ANDREWS: Was the histology report good news for that patient?-----

COMMISSIONER: It would have been.

WITNESS: If he didn't have the operation, it would have been.

D COMMISSIONER EDWARDS: Do you know if a biopsy was done on the adenoma prior to surgery to-----?-- I didn't investigate it, but I assume he would have had a colonoscopy, and that's how they would have made a diagnosis of the villous adenoma.

He had a biopsy?-- Would have had a biopsy, yes.

MR ANDREWS: You observed this patient has ongoing bladder problems which require ongoing treatment at the hospital?-- Yes.

And are those bladder problems consistent with a complication caused by the procedure performed by Dr Patel?-- Yes.

COMMISSIONER: Ms White, I'm not sure whether what I'm about to put to you is a technical use of language within the medical profession, but I understand a distinction is often drawn between clean surgery and dirty surgery?-- Yes.

Dirty surgery involving those parts of the anatomy which are likely to have infections involved with them?-- Well-----

That's roughly right, is it?-- Yes.

Obviously bowel surgery would be regarded as dirty surgery

then?-- I think under - if a patient has had a bowel prep and it is done electively - the procedure is done electively where there is no faeces left in the bowel, that is semi-clean, whereas if it is a patient that comes in with some sort of bowel obstruction and you do an emergency procedure, then it would be dirty, because there's still faeces left in the bowel.

All right. I am just concerned about the reference to the amount of blood and the failure to ligate bleeders and so on - whether that was a more acute problem, given the part of the anatomy that was the part of the surgery - whether that could lead to infection spreading throughout the abdomen and to otherwise healthy organs?-- I guess my concern was that if you don't ligate bleeders, you are having unnecessary blood loss, not so much from an infection point of view, but because patients would be losing blood, and this was not a young person. It was a reasonably elderly gentleman in his 70s.

MR ANDREWS: Now to patient P38. On the 11th of February 2005, you were again the scrub nurse for this patient's procedure?-- Yes, I was.

And you observed Dr Patel to make a three to four centimetre incision in that patient's healthy bowel?-- Yes, I did.

That wasn't what Dr Patel was supposed to do, was it?-- No.

You called it an accidental cut?-- Yes, it was. This patient had had previous surgery which often predisposes to adhesions forming, and this lady did have a lot of adhesions, and in the past with other surgeons I had worked with, they would have been very cautious when, I guess, going through the bowel and going - freeing the adhesions - they would have been very cautious not to actually nick the bowel, because if you do nick the bowel during the procedure, it can lead to faece spillage and things like that. So, it is something that generally - that people are very cautious about when there's lots of adhesions around.

We see the result?-- Yes.

Dr Patel made the unnecessary incision. Would you be able to observe whether he appeared to have taken precautions before this event?-- No. What actually concerned me was that he didn't notice that he had actually made quite a cut in the patient's bowel and it was the intern who had only been working at the hospital a short time that actually alerted him to the fact that he had made a cut in the bowel, and I just thought, "Well, it could have been something that Dr Patel - you know, if he hadn't have been alert, could have missed.", and I think that is something, as a surgeon, when you do make a cut in someone's bowel, you should not miss - not to that - because it was quite a considerable cut.

Now, he repaired that incision?-- Yes, he did.

Does that mean he used staples or sutures?-- He used sutures.

But then he allowed the intern to perform a hand anastomosis of the bowel. What is an anastomosis? Is it the removal of a section of the bowel and a rejoinder-----?-- It is where you rejoin. You take out the diseased bowel and you rejoin the bowel, and normally it is quite a technical procedure to reanastomose - I guess you are putting basically two tubes together, so it is quite difficult, and an intern who is not on a surgical program and is just beginning to learn suturing techniques and perhaps being involved more in minor procedures on, perhaps, skin, I thought it was quite unusual that he asked her to do the procedure.

D COMMISSIONER EDWARDS: Is this a small bowel operation?-- Large bowel.

MR ANDREWS: And if that procedure - that anastomosis is not done properly, can it cause complications for a patient?-- Oh, definitely.

Why, because it leaks?-- Yes, and then you have got-----

It leaks faeces and causes infection?-- Then you have got faecal fluid leaking right throughout the patient's abdomen and causes abscesses and infection and all sorts of problems.

You saw this happen on the 11th of February 2005?-- Yes.

And as I understand it, there were two things about this procedure that you were disturbed by: one was that Dr Patel had cut the bowel-----?-- Yes.

-----without even noticing it?-- Yes.

And, two, was that he allowed an inexperienced intern to rejoin two sections of bowel after an anastomosis?-- Yes, that's correct.

Did you see that patient again after the 11th of February?-- Yes, we did. She returned to theatre on the 20th of - she returned again on the 20th of February.

Well, that was nine days later. Was that an anticipated return?-- No.

Or an unexpected one?-- An unexpected emergency return to theatre. It was on a Sunday.

For an exploratory laparotomy?-- Yes.

What is that?-- Exploratory laparotomy is where you go - you make an incision in a patient's abdomen again and you investigate what the problem is with the patient.

COMMISSIONER: You do that with a laparoscope or-----?-- No, it was an open procedure.

Right.

MR ANDREWS: Were you present when that open procedure was performed?-- Yes, I was. I wasn't scrubbed, but I was present. I was the anaesthetic nurse in that particular procedure, and because I had scrubbed for the first procedure, I did make it a point to actually observe the findings when the patient's peritoneal cavity was opened.

Now, you say you were shocked. Why? What is it that you saw?-- The patient's bowel was just a brown - horrible brown mess and fairly smelly.

Did you see any infection?-- Well, it was very difficult to actually see - I mean, the whole lot - everything was infected and covered with just this - you know, brown fluid.

And is that the sort of thing you expect if the anastomosis had been performed without sufficient expertise?-- Yes, I would.

COMMISSIONER: I notice that later operation was performed by Dr Gaffield?-- That's correct.

Wouldn't it be normal for the doctor who had performed the initial operation on the 11th of February to then do the follow-up procedure on 20 February?-- Not necessarily. If a patient is still in hospital and she developed complications over the weekend, Dr Patel wasn't available, and Dr Gaffield - he was on call for that weekend, and he was called to see the patient on the Saturday morning and I think he decided to - or he decided to operate Sunday afternoon.

Yes.

MR ANDREWS: After Dr Patel had made the accidental incision in the bowel, do you recall whether he filled in an adverse event form, or whether anybody else did?-- No, but he did record the incident on the operating - in the operating notes.

Was there no obligation by 11 February 2005 for Dr Patel or anybody else to fill in an adverse event form for such a thing?-- No, because the lady did have so many adhesions that you would expect that an incision - an accidental incision in the bowel - it could have - it is a complication. It is something that could happen, and it could be - you know, it is highly likely to happen; so, no - and I've never known a surgeon to fill out an adverse event form.

Is there a protocol about who is supposed to fill out an adverse event form if the event occurs in the operating theatre?-- It is not normal practice for nursing staff to fill out adverse event forms by, again, documenting a surgeon's practice, and I guess you would expect if it is something untoward that's happened to the patient, it should be documented in the chart - like, in the operating notes.

Do you mean to say that so far as you are aware, if there is something that falls within the definition of adverse event

and it occurs in surgery, instead of anyone filling out an adverse event form, it is simply documented in the surgical notes?-- That's correct.

D COMMISSIONER VIDER: That would be standard normal practice?-- Yes, it is.

MR ANDREWS: Now, you are speaking, of course, of standard normal practice at the Bundaberg Hospital, rather than elsewhere?-- No, I think in my career that any adverse events have been documented in the medical notes.

Would you tell us, please, about patient P71?-- This patient had an abdoperitoneal resection. I wasn't the scrub nurse on this occasion, but this procedure was undertaken, or - the scrub nurse was a clinical nurse called Karen Smith, and after the procedure, she was cleaning up her instruments and I spoke to her and she told me she was quite shocked at how Dr Patel had removed the bowel from that particular patient. It was the same operation, and she - her words were that he literally ripped the bowel out - again, which I had experienced the same sort of feelings - and as she is another experienced scrub nurse, I thought that Dr Patel's practice was perhaps not acceptable.

Now, you did have personal experience with this patient upon the patient's return on 28 April 2005?-- Yes, I did.

You scrubbed for that procedure and Dr Anderson performed a flexible cystoscopy on the patient?-- Yes.

Dr Anderson, would that be Dr Pitre Anderson - P-I-T-R-E?-- Yes.

That procedure was performed at the Bundaberg Hospital?-- Yes, it was.

Dr Patel, of course, had departed by the 28th of April?-- Yes, he had.

And what did you - well, did you see anything during that procedure?-- No, because Dr Anderson was using a flexible cystoscope to look through the patient's urethra.

And you recall in the notes, Dr Anderson reported that he had found a dead end in the patient's urethra?-- Yes.

Now, is that consistent with poor procedure four months earlier?-- Yes, I see it as a complication of his original procedure, in that the first procedure, Karen had said that Dr Patel had nicked the bladder, and now we have a patient who came in to theatre and he had a suprapubic catheter, which is a catheter going directly through his abdomen to his bladder to drain his urine, and Dr Anderson was investigating what the problem was with his urethra, and that's what he was doing - the flexible cystoscopy - and his comment was that there was just a dead end in his notes - that there was a dead end in the urethra, meaning that patient, there was a problem, and

the patient would then have to continue through life with a suprapubic catheter in.

Do you mean that that catheter is now permanent for that patient?-- Yes, unless he undergoes corrective surgery.

And it is caused as a result of the procedure performed by Dr Patel in January 2005?-- Yes.

D COMMISSIONER VIDER: Does the patient know that?-- I'm sorry, I couldn't tell that you. I don't know whether it has been discussed with them.

COMMISSIONER: Dr Pitre Anderson is a local-----?-- General surgeon.

General surgeon, in private practice?-- Yes.

Following Dr Patel's departure, was some arrangement made for Dr Anderson to fill in as a VMO?-- He fills in as a VMO looking after our urology patients. He has a special interest in urology. He is a general surgeon who has a special interest in urology and he visits once a week and sees patients on one session and he operates on another session.

Apart from Dr Anderson, are there any other local private surgeons that you have worked with over the years?-- I have worked with most of the private surgeons here in Bundaberg.

We have heard reference, for example, to Dr Thiele. He is a local private surgeon?-- Yes, I have done many procedures with Dr Thiele.

Are there many other local surgeons in private practice?-- Dr Kingston. Dr Mareny is a general surgeon here. When I first came to Bundaberg in '86, I worked with him, and Dr De Lacy does work - he does on-call at weekends, and so we do have an opportunity to work with him as well, but he doesn't do sessions at the public hospital.

Do you have any knowledge regarding the availability of these local private specialists to act as VMOs at the hospital, particularly in a situation where the hospital doesn't have its own qualified specialist surgeon?-- Well, I think that, basically, situations have arisen within the hospital that these particular surgeons have left feeling quite frustrated with the system and taken up private practice and are quite busy in their own practices, and I don't know whether they would be amenable to continuing - you know, offering services to the public system.

What are the causes of these frustrations so far as you are aware of them?-- I know Dr Thiele used to get frustrated, simply because he would be rostered an intern to assist him and normally with a vascular surgeon you would expect that your intern would have some idea of what the procedure was going to be, had spoken to the patient, looked at investigations, or even contacted Dr Thiele in his rooms to see if there was any extra tests that needed to be done for that patient. But often Thiele would arrive and there would be no assistant to help him and he would obviously ring the Director of Medical Services and someone would come, but they would have no idea of what procedure he was going to do, or, you know - and I guess as part of working in a team, that intern really needs to be familiar with that patient, particularly vascular patients, they are quite complex and the surgery is quite complex.

See, we've heard evidence in earlier sittings - for example, from the President of the AMA - saying that there are a lot of private specialists, not only surgeons but in other areas of specialisation, who would be willing, even very keen to assist in the public system but they feel they've been driven out by management practices, scheduling issues, and just a lack of cooperation to make that possible. Are you able to comment on the local situation here in Bundaberg?-- Probably not to that extent, but I do know that there has been - like, surgeons have left because of frustrations with the systems within Queensland Health and, you know, lack of - I guess lack of organisation and perhaps coming to a hospital where, you know, to do a session and there being delays, or, you know, patients haven't been - the tests haven't been done and anaesthetists will delay their session and obviously they want to, you know, use the time that's allocated to them to operate because they've got commitments elsewhere and they find that frustrating.

Yes.

D COMMISSIONER EDWARDS: Would it be fair to say that one of the frustrations could be for a surgeon that there was no intern in theatre for a public patient to assist him?-- That's true. Very true.

D COMMISSIONER VIDER: Who's responsible for doing the allocation of staff for the medical staff? Is that also the Manager of the Elective Surgery Program?-- No, it's the Director of Medical Services' job normally to allocate the interns to the specialists, to consultants.

On a daily session basis?-- I think it's done on a roster basis.

Yeah.

COMMISSIONER: Thank you.

MR ANDREWS: You observed Dr Patel to perform four laparoscopic cholecystectomies?-- Yes, I have.

What did you notice about his technique?-- Generally he prides himself on being very speedy and I guess laparoscopically he likes, you know, to have that procedure done very quickly. But one of my concerns was bile is very corrosive to healthy tissue and in the past with even open gall bladder procedures, surgeons have been very mindful not to spill any bile into the peritoneal cavity, not to have the tissue contaminated. After the gall bladder has been delivered, the gall bladder itself is actually delivered through the umbilical incision, which quite often is a small incision, and it's there that I noticed that Dr Patel seemed to have quite a bit of difficulty in getting the gall bladders out through that incision and in the process would spill a lot of bile from the gall bladder, which concerns me. But he didn't seem to take any precautions for that, you know, to even like extend the incision so that the bile wouldn't spill and he just seemed to be happy to, "Oh, well, you can irrigate later so it doesn't matter." But I thought once the bile had been on healthy tissue, it being fairly corrosive, it would start then and there.

And you say he did not cannulate the common bile duct or perform x-ray intra-operatively. Does that have any adverse consequences for a patient?-- It could. If there was a stone further down the duct it could.

And would other surgeons perform differently in your experience?-- In the past, every gall bladder procedure with surgeons I had worked with had always cannulated the duct and taken X-rays, but it is not done for every - like for every patient.

You mentioned that Dr Patel used an exceptional number of gastric and bowel staples. Is that something with consequences for a patient, or is it just a comment about the difference between his technique and others?-- I guess it's a comment about his technique and others, that he seemed to use an exceptional lot of staples doing bowel procedures.

D COMMISSIONER VIDER: Just going back to what you commented on earlier in relationship to wound dehiscence and talking about closure, what was Dr Patel 's technique for wound closure? Did he do that routinely by layer or-----?-- No, usually a mass closure where he would close many layers together.

Is that common practice?-- It is these days, yes.

It is?

MR ANDREWS: The procedure of a colonoscopy, you have some comments to make about Dr Patel's technique?-- Yes, I do. He commenced at Bundaberg Base Hospital and commenced doing colonoscopies and it has been rumoured that he learnt to do colonoscopies at Bundaberg Base Hospital.

Did you ever see him perform any?-- Yes, I did.

And did he perform them as if he had a long experience?-- No, because he often would get the intern or the PHO to actually control - to use the controls and he would just actually push the scope through the patient's bowel.

How would another competent surgeon do it?-- Well, we've got two visiting gastroenterologists that come weekly, they alternate, but they come to Bundaberg weekly, and they control the scope, the controls and actually the insertion tube going into the patient themselves, and I've - it's not normal practice to have two people controlling the scope.

And does having another person to control the scope create any risk for the patient?-- It does, because if there is a loop in that insertion tube through the patient's bowel and there's a lot of pressure and you can perforate the patient's bowel and that's a complication.

Well, did Dr Patel ever perforate a patient's bowel in your experience?-- Yes, he did.

How many times?-- Three to four times. I can't be exactly sure, but it was three to four times.

While performing colonoscopies?-- Yes.

I have no further questions.

COMMISSIONER: Thank you, Mr Andrews.

D COMMISSIONER VIDER: Could I just ask a question?

COMMISSIONER: Yes.

D COMMISSIONER VIDER: You've documented here some of your concerns about Dr Patel's surgical technique?-- Yes

Were other operating theatre nurses concerned as well?-- I've never received any documented complaints, but generally, in conversation, nurses have made some complaints about his technique.

Would that have been the subject of, say, department meetings, nursing staff department meetings?-- No, no.

So it didn't come up in any formal forum?-- No.

Thank you.

COMMISSIONER: Mr Allen?

MR ALLEN: Thank you, Commissioner.

EXAMINATION-IN-CHIEF:

MR ALLEN: Ms White, perhaps following on from what the Deputy Commissioner just asked you, you gave some evidence that nurses in general do not criticise medical staff and do not report incidents regarding medical staff and you said that one aspect of that would be loyalty?-- Yes

And that there is an expectation that there be respect for the surgeon?-- Yes. We work with professionals and you respect the work that they do and they respect the work that we do.

In paragraph 30 of your statement, when dealing with that aspect, you also seem to suggest that there's another reason, and you specifically refer to the possibility of reprisal; what were you referring to there?-- Well, nurses - well, I guess that if you criticise a surgeon, they may request that you don't work in the operating theatre any more, and Dr Patel was quite capable of doing that. I mean, one instance I can remember where a nurse couldn't find a particular suture that he wanted, and I'd actually gone off to another theatre to look for it and didn't hear his comment, but later she was quite upset because he said, "If I find that suture" - "If the Acting Nurse Unit Manager finds that suture on Monday morning, you'll be getting the sack." So that's the sort of, you know-----

Because obviously adverse comments by a surgeon about a theatre nurse could result in them either being removed from theatre and, therefore, blocking that aspect of career advancement-----?-- Yeah.

-----and could reflect upon their ability to obtain work in other hospitals or in the private system?-- Oh, probably not, no. But it would - you know, perhaps they may have to work in another area, and nurses either choose to work in public systems or private systems, and if you want to work in the operating theatre in the public system you would have to move to another town.

Right, okay.

COMMISSIONER: Just to follow up on that - in fact, Deputy Commissioner Vider was mentioning this to me during the break - that in Brisbane if you lose your position in one hospital, or choose to leave more commonly, there are a lot of other options both in the public and the private system and also in other forms of nursing, in home nursing-----?-- That's true.

-----and that sort of thing. But in Bundaberg if you, for example, were to lose your job, there aren't that many other options around for someone with your training and background?-- No.

MR ALLEN: So the real problem or fear would be that for a

nurse who wishes to continue working at the Bundaberg Base Hospital, an adverse comment by Dr Patel, for example, could mean that they can no longer work in theatre in that hospital?-- Yes, if you made a complaint against him.

You also mentioned in paragraph 30 in your statement, in this context, that, "In this environment it is rare for a nurse's opinion to prevail" and I expect it should read "over that of a doctor."?-- Yes.

Is that your experience, and who do you refer to when you're referring to someone preferring the opinion of the doctor over that of a nurse?-- I guess you're talking about the Executive of the hospital would take a doctor's word against a nurse.

I see.

COMMISSIONER: Just going back for the moment to the issues of reprisal, we were talking about it a moment ago in the context of whether you people lose your job or your options of career advancement or continuing in theatre, but there just evolves a myriad of other ways in which reprisal can take place, whether it's getting overtimes, or shifts at the times you want them, or, you know, all of those sort of work-based situations where you want to stay in favour with management rather than run counter to management?-- Oh, I think in - at a unit level nurses control their own - you know, they control their own, you know, rostering systems and their own environment. I don't think that would - there wouldn't be any reprisal at that level.

No?-- I guess it would be - it would only be higher up if Dr Patel made a complaint against a nurse. Obviously that nurse would have to explain and I guess Dr Patel's word would be taken over the nurse.

Right.

MR ALLEN: Would there be a more immediate fear of reprisal too, in that there could be a fear of the behaviour of the surgeon towards the nurse following such a complaint, such as bullying behaviour?-- Intimidation, comments that he would make. I mean, I've seen him be very demeaning and rude to his own staff, so I guess I-----

Had you heard reports of him freezing out people if they voiced concerns about him, not talking to them again?-- Oh, definitely. I mean, I found that he would talk to the staff or the clinical nurse in the theatre rather than discussing, you know, cases being added onto his list, and it wasn't until some later time in the morning or afternoon that I would find out that there would be two other cases added to his list because he wouldn't speak to me.

You sought to correct some things in paragraph 33-----?-- Yes.

-----of your statement. And am I right in understanding that

what you wish to correct was the suggestion that Dr Keating's commencement as Director of Medical Services coincided with the commencement of the Elective Surgery Program?-- The Elective Surgery Program had commenced many years before he arrived.

I see?-- And the Elective Surgery Coordinator's position was obviously created when that program began.

Yes, all right. But was there still some change in relation to your access to the Director of Medical Services regarding elective surgery after Dr Keating commenced in that position?-- Everything would have to be directed through the Elective Surgery Coordinator, and even if I discussed issues with her by saying that, "Look, these lists" - surgeons are notorious for overbooking their list and underestimating the time they're going to take to do a procedure, and when you've got lists following on, or another session following on in the afternoon, and if your morning one overruns, it means staff don't get to lunch, and afternoon sessions start late and that upsets other consultants. So we try and look at and measure the surgeon's anticipated time and the cases that need to be booked into that particular session. But I would only have access to the Elective Surgery Coordinator and she would just say, "This is what the surgeon has put down." But she and I both know that he may put down it will take an hour, but he could take two hours and therefore-----

D COMMISSIONER VIDER: Did the Elective Surgery Program manager, that position-----?-- Yes

-----did that person have a clinical background?-- Yes, she did, she's an operating room nurse, a very competent nurse.

MR ALLEN: How does that situation described compare to how things happened before Dr Keating became Director of Medical Services?-- Well, I guess there was more of a round table discussion, and if I felt that there needed to be a patient rescheduled because we did not have the time to do it, that could happen. But when Dr Keating commenced, he basically stated that no elective surgery patient, no patient could be cancelled off an elective surgery list. Which then created problems for me because of session overruns, which would then impact into the evening and staff would be on overtime, and staff object to being on overtime for elective cases and that meant it was really hard to manage staff in that way.

It's not only an imposition on the staff though, it can have effects on clinical care surely?-- It does, yeah, and in ward areas because they haven't allocated enough staff and it's impacting on the surgical ward in the evenings.

Just in relation to the elective surgery targets, because you've spoken about the situation that you confronted as Nurse Unit Manager of the operating theatres - you'd now stepped down from that role in August 2004?-- I did.

But you continued as a nurse in the operating theatres?--

Yes.

So were you, therefore, on the ground and aware of the type of workload that was being imposed in relation to elective surgery following on from August 2004 through to earlier this year?-- Until now, yeah.

Okay?-- Because I'm at the grassroots now and I'm the one that the workload impacts on, I'm the one that's staying back to midnight, whereas as the Nurse Unit Manager, unless I was on-call for that particular evening, I wouldn't have been.

Well, given your experience, you may be able to translate this document for us. If I could put it on the visualiser?

D COMMISSIONER VIDER: While that's document going up, how many operating theatres are in the operating theatre suite?-- Four, and one procedure room, and we're staffed for three, two theatres and the procedure room or three theatres.

What's the normal - do those three theatres operate Monday to Friday?-- Yes.

Morning and afternoon lists?-- Yes.

Morning lists starting?-- 8.30.

Afternoon lists?-- 1.30.

And finishing?-- In the morning we finish at 12.30 and the afternoon at 4.30.

MR ALLEN: Now, did Gail Doherty take over the position of Nurse Unit Manager of the operating theatres?-- Gail and - Gail Doherty and David Levings actually share the position at the moment as temporary. They don't actually work at the same time, but they work a month apart - a month about and I find that generally both of them are off the floor.

I see. All right. Now, this e-mail from Dr Keating to Gail Doherty, dated the 8th of February 2005, what in the first line is "TMG meeting"?-- Theatre Management Group Meeting.

And who does that meeting involve?-- The Nurse Unit Manager, the Director - Elective Surgery Coordinator, Darren Keating, and the Director of Anaesthetics and ICU, Dr Carter.

Okay, and-----?-- And, sorry, the Director of Surgery, Dr Patel.

The next paragraph, "At the present time BHSD" - now, I take part of that is Bundaberg Hospital?-- Service District.

Service District?-- Yep.

"Is 92 wtd separations"-----?-- That's weighted separations.

What are weighted separations?-- For a particular procedure

you are given so much money. So if you are doing a - and that depends on - it's worked out on the length of stay that that patient should have in hospital.

I think you told the Commission the complexity of the surgery as well?-- Yes.

Okay. So what does it mean that the Service District could be 92 weighted separations behind target?-- That it's considerably behind the target, and I can't actually put it in a dollar - a dollar term as to what that would be, but roughly I think one weighted separation is probably - I think it's around $1,000.

And do you know who sets the target?-- It's set through Queensland Health with the Elective Surgery Program and it's set each year for individual hospitals within Queensland.

So the e-mail goes on, "The target is achievable. Bundaberg Hospital Service District must achieve the target", and there's reasons expressed. The next paragraph, "Should the target not be achieved, Bundaberg Hospital Service District will not get another chance to upgrade the target and hence lose flexibility and significant dollars". So was there some system whereby if the hospital met the target, the target then next be upgraded?-- Yes.

To a higher target?-- Yes.

"Therefore it is imperative that everyone continue to pull together and maximise elective surgery thruput until June 30. All cancellations should be minimal with these cases pushed thru as much as possible." Is that consistent with the situation as you understood it to be in early February?-- Yes, and this is the situation that has happened in previous years as well.

And it continues, "To this end, as per draft policy, all elective surgery cancellations are to be discussed by Dr Patel, Dr Carter, Muddy and Acting Nurse Unit Manager OT." Who is Dr Muddy?-- Muddy, that's a nickname for Karen Smith, who is the Elective Surgery Coordinator.

I see, not a doctor?-- No.

And should there be a problem, final decision to be made by Dr Keating. Can you help us as to the draft policy that's referred to in that paragraph?-- We've always had a policy of how you go about cancelling patients for elective surgery, because it is distressing for a patient who may have come from a distance and made arrangements with their families to have surgery and it is very inconvenient to cancel particularly on the day of surgery. Often if they can be phoned the night before at home, it would be - in the ideal world that would be preferable. So we were finding with workloads that sometimes patients were being cancelled, and we developed this policy while - even while I was Nurse Unit Manager - that what would be the process of cancelling a patient, and it could be

cancelled for many reasons, as in a surgeon's sick, not having, you know, a bed available for that patient and those sorts of things.

I see?-- So this policy was developed whereby obviously the Nurse Unit Manager in theatre was probably the first one at work and I would ring the bed coordinator and she would say, "Look, I'm sorry, we haven't got any beds." So, we need to look at, you know, how we are going to manage the elective surgery list. Then - but in general it was the elective surgery person's role to actually look at who could be - if there needed to be somebody rescheduled, who could be rescheduled, and often we would look if there were patients from Bundaberg or Eidsvold, quite a distance from here, somebody like that, and also look at what category the patient was in the urgency of elective surgery, whether they be category one, two or three, and perhaps if they were category three they would then be rescheduled to a later date.

COMMISSIONER: Ms White, obviously I come from outside this system, so I don't pretend to understand it, but by simply reading this e-mail I'm physically sickened by the thought that patients are being treated as units of commerce that are to be pushed through to get extra money. Is this something - you've been in theatres for over 20 years, haven't you?-- I've only noticed this from the time the Elective Surgery Program begun and-----

Am I overreacting, or is that-----?-- No, in the past surgeons would see patients and book their own lists. But over the years this has - the Elective Surgery Program has evolved whereby the surgeons do not book their lists any more. Patients, they fill out a form, they categorise the patient, and then the theatre lists are made up from that, from those forms, and the surgeons don't have a lot of control over who's on the list.

If you carry this type of thinking into its logical conclusion, you are 92 weighted separations behind target, so you go and find a few people who are dying of cancer, rip out their oesophagus, because that's complex surgery anyway, so you've got weighted separations for that. If they don't survive the procedure, that's a bonus because you don't have to give them a bed afterwards. That's the sort of approach this e-mail seems to be adopting. And let me make it clear, I'm not directing this at Dr Keating as the author of this, I mean, he is just part of the system as well everyone else?-- Yes, that's true. I think I spoke before how they would target certain weighted separations, which - as in the procedures they would do. Like, the laparoscopic cholecystectomy, those patients generally only stay overnight, but I'm not too sure how many weighted seps you collect for them, but it's a reasonable number. So by having a week in which Dr Patel would just target and perhaps do eight of those in one week, when we normally would perhaps do two, that would then gain him more money than doing a hernia repair, and so we would have like a blitz type of thing.

Meanwhile, if there's an 80 year old lady with pneumonia, that's not going to get you any money for elective surgery, that doesn't become a priority at all because there's no money in doing that?-- No.

D COMMISSIONER EDWARDS: Now, are these targets set by the Health Department or within the hospital, do you know?-- In conjunction. Locally at-----

At-----?-- Yes, at the hospital, but through corporate office and through the Elective Surgery Program, so it doesn't matter what the waiting list is. The targets are set according to what - the targets are, I guess, set, but the waiting list is managed in conjunction with that.

D COMMISSIONER VIDER: How many elective surgery cases would have been cancelled a week?-- I couldn't tell you. Not many.

So it was not common for a patient to be prepared for theatre and to have to be phoned to say, "Your surgery won't be happening tomorrow", or, "today"?-- Well, generally it does happen on a daily - well, it does happen quite frequently actually. It could happen daily if - particularly over the winter when you have got a lot of sick leave. We don't have access to agency staff here, and so you can't - you can't control that.

Can I just ask you another question about this memo, and it's to do with the preparation of the budget. When you were the manager in the operating theatre, did you prepare the department's budget?-- Yes.

So you would have done the operational budget in terms of if - you look at the starting requirements but you also would have looked at what the capital expenditure would have been for equipment?-- Yes, and clinical supplies.

And clinical supplies. Do you do that budget worked out on what you need that to be or do you have to take into account that to get equipment you have got to get - that revenue's got to come out of this program?-- That's true. Your-----

So, the budgeting process to some extent is changed because the revenue stream is different?-- Well, our budget's worked out on our previous - on our activity for the previous 12 months.

Yes?-- And then if it's - if we can assume that our activity's going to be greater in the next 12 months, then they try to do - put - to inbuild some extra funding.

But to some extent, the equipment that you get, the education you offer to staff, et cetera, depends on the amount of money coming out of this revenue stream?-- Well, in this memo it says it does but in reality it doesn't.

COMMISSIONER: I think the reality, you told us earlier, is that even if you achieved the target and make three quarters

of a million dollars for the hospital, that doesn't guarantee you one extra person in theatre to-----?-- No.

To help with that workload?-- No, and equipment as well. Like, a piece of equipment can break down, like - say an electric saw or a tourniquet, and - you know, like when you have to sort of say, "Look, this needs to be replaced", there's a lot of - a lot of problems with that happening, and you - you basically have to do a business case to say why you want that piece of equipment.

Mr Allen, you will be tendering that e-mail?

MR ALLEN: Yes. It has been verified by the statutory declaration of Gail Doherty supplied to the Commission. So I will tender that document.

COMMISSIONER: Exhibit 72 will be the e-mail from Dr Keating to Gail Doherty, dated the 8th of February 2005, headed "Theatre Activities.", and I would like to emphasise again that my perhaps intemperant comments weren't in any sense directed at Dr Keating as the author of that memo. I recognise that he, like everyone else in the hospital, has to work within the system and it would be grossly unfair to hold him personally responsible for the system which he has to operate. That's Exhibit 72. Thank you, Mr Allen.

ADMITTED AND MARKED "EXHIBIT 72"

MR ALLEN: You mentioned in the course of your evidence concerning workload pressures in the operating theatre that it meant there was very little time for education and conference leave?-- Yes.

You weren't referring to some type of perk of heading off to the ski fields or over to Europe for conferences, you were talking about something-----?-- No.

COMMISSIONER: That's just barristers, Mr Allen.

MR ALLEN: Yes. I was wishing to draw the distinction, Commissioner?-- No. Poor old nurses, we're lucky to attend - theatre nurses are lucky to attend a Preoperative Conference that's held in the Gold Coast or Brisbane each year.

Okay. They are directed towards very important further education, staying current-----?-- That's right.

-----with the current best practices?-- Mmm.

So that they can be directed towards patient care?-- A lot of our education that we gain is gained in our own time at weekends.

I see. Okay?-- And with conference leave, I think it is a Queensland Health directive that there can only be one person from that unit to go to a conference, and the Director said you come back and disseminate the information you have gleaned from that conference.

I see. So the attendance of one person at the conference is actually of benefit to the whole team?-- Well, it would like to be, but, I mean, it seems to be - you know, fairly unfair that perhaps more than one couldn't go to a conference, because it - there's a lot to be gained.

Paragraph 34 of your statement, you refer to the grievance that was presented to you by Ms Mulligan and if you could look at this document, please. Perhaps it could go on the visualiser, the first page.

COMMISSIONER: Mr Allen, I didn't express any reservations about this paragraph when Mr Andrews took us through it but it does seem to have only the most tenuous connection with the Terms of Reference, the dealings between Mrs Mulligan and this witness.

MR ALLEN: Well, the important aspect is that which appears in the third and fourth last lines of page 8 and it's something which has been touched upon in Ms Hoffman's evidence which has been referred to by this witness in her evidence

COMMISSIONER: Well, that appears in those lines. Is there any point in going any further about this?

MR ALLEN: Well, I would like the witness to see the final paragraph on page 1 of this document.

COMMISSIONER: All right, yes.

MR ALLEN: Because it's the best evidence as to the terms of the direction given to her, and I have no problem if, in fact, perhaps it could be moved so that the other contents aren't visible.

COMMISSIONER: There's no need to do that, but-----

MR ALLEN: Yes.

COMMISSIONER: I'd ask you and, indeed, everyone else to bear in mind what I said yesterday with reference to Mr Leck's position. It may be that individuals here will have issues to answer and that could include Mrs Mulligan, it could include Mr Leck, it could include Dr Keating, but when it comes down to systemic problems, we're not here to make scapegoats of the individuals, and I should say that even applies to Dr Patel. If there's a problem with the system, it's not the individuals who should bear the blame. It's the system that is to be blamed for that, and again if Mrs Mulligan is simply working within the system as it currently exists, she's got a procedural manual and it says that as soon as you get a complaint you set off an investigation system and this is how

you handle it, you know, we're not here to criticise Mrs Mulligan for doing essentially what was her job.

MR ALLEN: And there is helpful evidence in relation to those systemic problems.

COMMISSIONER: Indeed, and I'm happy to receive the evidence on that footing, but I - I think it would be helpful in a sense to depersonalise it if we're talking about systemic problems. Let's not identify it as so much what Ms Mullins did or what Mr Leck did or Dr Keating did, but this is how the system operates and this is just one example of it.

MR ALLEN: Do you need to see the rest of the document to be able to identify it as the grievance that was presented?-- Yeah, I - no.

Okay. All right. So you are able to identify that as the document which you received. Now, we can go back to the last paragraph on page 1. Does that, in fact, in black and white set out the terms of the direction which is expressed as the lawful direction that you not discuss those allegations with any other staff member?-- It does.

MR FARR: With respect, Commissioner, it's, "Any other staff member who had made this allegations against you or who in fact may be a witness in this investigation being undertaken".

MR ALLEN: We will go to the actual terms there.

COMMISSIONER: It speaks for itself. Why don't you tender it and it's then on the record and we can go on to something else.

MR ALLEN: Yes. I will tender that document.

COMMISSIONER: That will be Exhibit number 73, a confidential letter dated the 2nd of April 2004 from Ms Mulligan, District Director of Nursing, to Ms Jennifer White, Nurse Unit Manager. Thank you.

ADMITTED AND MARKED "EXHIBIT 73"

MR ALLEN: Were you requested by the Commission in the course of your evidence to see if you could locate a communication between yourself and Ms Mulligan which you referred to in paragraph 32 of your statement as being an e-mail sent on 26 May 2004?-- I think after talking that was actually a letter and not an e-mail that I - I made a communication with the Director of Nursing, Linda Mulligan.

All right. Well, I will ask you to look at this document on the visualiser.

COMMISSIONER: Is your e-mail to Ms Mulligan?-- I actually didn't e-mail it, though, I actually - I actually sent her a copy of the letter.

MR ALLEN: All right. So it's the letter to Ms Mulligan dated the 26th of May 2004?-- Yes

Does it discuss certain matters which you have in fact dealt with in paragraph 32 of your statement?-- Yes.

And it refers to some matters regarding a suggested trial of late shifts, suggested by Dr Patel, and discussed it where in your statement?-- Yes. That trial of late shifts was, I guess, not amenable to most of the theatre staff because it wasn't going to gain us any more staff. We were just going to shift hours from morning to evening so that - then Dr Patel could have an all-day list working into the evening, and staff weren't happy with that.

Okay. And towards the bottom of the screen, the second last paragraph, you state, "My concern is that there hasn't been any discussions with you about increasing theatre staff numbers to enable me to commence a late shift trial in July." I think it's clear from your earlier evidence that you, in fact, didn't receive any reply to this correspondence?-- No.

I will tender that letter dated the 26th of May 2004.

COMMISSIONER: Yes. That letter from Ms White to Ms Mulligan, 26th of May 2004, will be admitted and marked as Exhibit number 74.

ADMITTED AND MARKED "EXHIBIT 74"

MR ALLEN: Finally, you were asked about your reasons for stepping down as Nurse Unit Manager of the operating theatres and you referred to your unhappiness with the way the grievance mentioned earlier was dealt with. In your statement you also mentioned some other reasons?-- Yes, I did

What were they?-- About - well, I guess I was just feeling unsupported, I felt like I didn't have anyone really to go to if I had a problem. I had staff who had - were unhappy with their workloads, they were unhappy with the amount of overtime that they were working, and I felt that I was unable to make any changes and when I had asked for assistance I hadn't gained any.

Has the situation in operating theatres improved at all in the last couple of months?-- No. Workloads are still an issue. Overtime's still an issue.

What needs to be done?-- We need to have more staff.

More staff?-- Yes.

Okay. Thank you.

COMMISSIONER: Mr Allen, ladies and gentlemen, I did mention yesterday afternoon I have a lunch date so I was planning to adjourn now and if it doesn't inconvenience anyone too much to resume at 2 o'clock. Is that all right, Ms White? Is that convenient for you? And Mr, Andrews, I think at this stage you can inform Mr Martin that he won't be needed until next week.

MR ANDREWS: Certainly. I do agree with that, yes.

COMMISSIONER: Thank you.

THE COURT ADJOURNED AT 12.15 P.M. TILL 2.30 P.M.

THE COMMISSION RESUMED AT 2 P.M.

JENNIFER ANN WHITE, CONTINUING:

COMMISSIONER: May I just mention, ladies and gentlemen, one matter which was raised with us over lunch concerns attendance allowances for people who aren't employees of Queensland Health. It's apparently not widely known or understood that people such as patients or members of patients' families are entitled to attendance allowances when they're coming to give evidence.

Mr Springborg brought to my attention the fact that a number of people in that situation are from families where there's only one wage earner or where there are other difficulties involved. If you go to the Inquiry website, there's a document called "Practice Direction", and included in that are details of the arrangements which exist to reimburse people for the income they lose for having come to the Inquiry, and other expenses such as travelling expenses and, where necessary, accommodation expenses.

If anyone has any difficulties, please approach the Inquiry secretary, Mr David Groth, who is over there, or indeed any of the Inquiry staff will be able to assist you with that issue.

Mr Allen, you had finished, hadn't you?

MR ALLEN: I had, thank you.

COMMISSIONER: Mr Mullins?

CROSS-EXAMINATION:

MR MULLINS: Ms White, my name is Gerry Mullins. I act on behalf of the patients. I just have a few questions for you. Firstly, the series of meetings, the ASPIC meetings between April and July 2004, you mentioned that Di Jenkins raised this issue of wound dehiscence in a meeting of April 2004?-- That's correct.

And it's the case, as you have described, that Dr Patel, you say, laughed at the issues that she raised?-- That's correct.

Did she have a report of some form or examples of patients that she presented?-- I think she had a rough copy of numbers of patients that had had wound dehiscence, but it was not in any formal document or anything.

When you say she had a rough number-----?-- Well, she'd obviously - it had been brought to her attention and she was aware that there had been a number of wound dehiscences and she had some documentation, but she didn't present it to the meeting at that stage.

You say that after general discussion it was decided that Di Jenkins would research the definition of "wound dehiscence", conduct a chart audit and prepare a report. Was it ever raised during the course of that meeting that there had been some complaints about wound dehiscence 12 months prior?-- No.

Did you know that Gail Aylmer had in fact raised with the executive some issues in respect of wound dehiscence in the preceding six months or so?-- I think Gail had discussed it with me that there had been some wound dehiscence, but not in any formal meeting.

Are you aware that prior to these meetings in mid-2004 that there had been any investigation into wound dehiscence within the hospital?-- No, only from just discussions with Gail that she was monitoring any wound dehiscence and that she'd been notified of from the wards and suggested if any patient had returned to theatre, that I would notify her.

May the witness please see Exhibit 66? While that's being obtained, Ms White, you mentioned during the course of your evidence the suggestion by Dr Patel that the ICD-10 code should be used for identifying wound dehiscence?-- Yes.

I just didn't quite hear precisely what the methodology would be for using this code. Can you just describe that again?-- Well, all procedures, when the patient is discharged, are coded, and within Medical Records, the coders work and they go through the patient's chart and look at the Discharge Summary, and what is documented on that Discharge Summary is how they code the patients and-----

All right. So the code is recorded on the Discharge Summary?-- Yes.

And the person-----?-- Not the code. That's how they develop - that's where they get their information to put a code - you know, to code that patient.

So somebody goes through the charts-----?-- Yes.

-----makes a note on the Discharge Summary-----?-- The medical staff that are discharging the patient from that particular surgical team would document on the patient's Discharge Summary what procedure the patient had and they would then - if there had been a wound dehiscence it would be a complication, so that would be documented as well on the Discharge Summary. Then someone who is not - that doesn't work in the clinical area, from Medical Records, would then take - look at the patient's chart and they would code that patient from that document - what was documented on the Discharge Summary.

So when you say they look at the chart, they look at the Discharge Summary?-- Yes, in the front of the chart.

Can I ask that page 13 of Exhibit 66 be put on the overhead. This is the chart of Ian Fleming. Sorry, his nursing notes. There's a record here of 4 June 2003. We can see that there's a reference to D16, reference to 16 days' post surgery, and then we see D5, which we understand is Day 5, "post wound breakdown", and "dehiscence" is crossed out and replaced with "infection", and the initials FB, which I think is Dr Britten, are recorded next to it?-- Well, under "F Britten", that's - "med" means medical student, and a third year medical student. That's the person that's changed that documentation.

All right. What I'm interested in is this - we don't know when that was changed, whether it was changed at the time that the note was initially made or at a later time. What I'm interested in is the person going through the chart for the purposes of making the notes and the Discharge Summary would no longer treat that as wound dehiscence, but treat it as an infection?-- That's written in the patient's inpatient notes, and you'd have to look at the Discharge Summary to see what's written on the Discharge Summary for the coders to be able to pick that up.

COMMISSIONER: The coders wouldn't work through all the notes to find-----?-- No, they would only look at the Discharge Summary.

MR MULLINS: That's right, but the people who prepare the Discharge Summary would look through all the notes?-- They should, yes.

Would you like to have a look through those notes to see if the Discharge Summary is contained in Exhibit 66?-- On page 21, yes, the Discharge Summary.

On page 21?-- Yes.

That's the Discharge Summary?-- Yes.

Is there reference there to the wound dehiscence?-- No. It states, "Principal diagnosis. Wound infection post-sigmoid colectomy for diverticular disease", and it just - it talks about symptoms, signs and presentation and principal procedure.

Can you just put that on the overhead, just so I can understand where we would expect to see the reference to wound dehiscence so it would be included as part of the coding or accounting process. Where would you expect to see it?-- You should see it either in "Principal Diagnosis" or "Principal Procedure". I would have thought "Principal Diagnosis" if this patient has returned to the hospital with a wound dehiscence, or it should be "sigmoid colectomy wound dehiscence".

Thank you. Just briefly in respect of patient 70, you described the surgery that was undertaken as an abdoperitoneal resection for villous adenoma. Was that an elective procedure?-- Yes, it was.

In respect of patient 38, you mentioned that the patient - can I clarify your evidence. On 11 February 2005 the first surgery was undertaken?-- Yes.

Did you say that the patient had significant adhesions at the time of the first surgery?-- Yes, she did.

If the-----?-- That was due to previous surgery that she'd had years ago.

But every time a patient is operated on thereafter, if the person has significant adhesions, they are likely to get worse?-- Yes, that's true.

And that's the importance - one of the reasons why the anastomosis needs to be performed properly, so that the person doesn't have to undergo further surgery and the adhesions get worse again?-- I'm not medically qualified to answer that. I think that - I think adhesions form anyway.

Thank you, Commissioner.

COMMISSIONER: Thank you, Mr Mullins. Mr Devlin?

MR DEVLIN: Thank you.

CROSS-EXAMINATION:

MR DEVLIN: Ms White, my name is Ralph Devlin. I represent the Medical Board of Queensland. You spent a long time there as the NUM in the operating theatre area. Can you just tell us who the Directors of Surgery were in that period from 1990 through? I haven't got a complete picture of that. Have you got that picture in your mind or is it more complicated than that?-- No. Dr Derrick McGregor, he was our only Staff Surgeon. The Director of Surgery job wasn't - there wasn't a position-----

Designated at that time?-- Yes. Then-----

He was a staffer?-- Yes. Dr Russell Bennett joined him.

He was a Staff Surgeon?-- Yes.

COMMISSIONER: Sorry, what was the surname?-- Dr Russell Bennett.

MR DEVLIN: Yes?-- Dr Pitre Anderson.

Staff Surgeon or VMO?-- Dr Pitre Anderson came as a Director of Surgery.

Yep?-- And Dr Charles Nankivell came as a Staff Surgeon.

Came as a what, sorry?-- Staff Surgeon.

Yep. Who was after Dr Nankivell?-- Dr Lucky Jayarseka.

What was his status?-- Staff Surgeon.

Yes?-- Dr Sam Baker.

Sam Baker?-- Yes.

What was his status?-- He stood in an acting position of Director of Surgery.

Who was after that?-- We had a succession of locum surgeons, and then Dr Patel.

Of those, do you know which of those were overseas trained doctors and arriving there on the Area of Need Certification? Are you in a position to know those sorts of things?-- No, I don't think any of those surgeons would have been.

Would it be fair to say that Dr Patel was the first that meets that description that operated as the Director of Surgery?-- Yes.

Thank you. Go to paragraph 8 of your statement. It will be quicker and easier to take you to various paragraphs. You said in evidence that your belief was that there was no interview for the position of Director of Surgery. In your position, how would you ordinarily get to know whether or not there was an interview with a person for the position?-- Well, you would see the ad to start with in - either in the local papers and through QHEPS - not through QHEPS, through our advertising of positions in Queensland Health.

Are you saying you saw no such reference?-- No.

Are they the only ways by which you get to know whether it's likely that somebody has or has not been interviewed?-- Well, it's general knowledge throughout the hospital if there is applicants for a position and people have applied for it, and then as Nurse Unit Manager of the operating theatres you'd be told that there was a process in place.

Is part of that the fact that somebody will turn up and obviously be at the hospital and be there for that purpose for an interview, and that becomes generally known or what? How do you get to know whether or not a person has actually been interviewed?-- Well, I guess as a Nurse Unit Manager you don't directly know, but you just - you're actually informed by - the Director of Medical Services would inform you that the position was going to be advertised and there was an interview process going on.

I see. And would you say that in your time in your position since 1990 that was routinely communicated to you?-- Yes.

When you knew there was a vacancy-----?-- Yes.

-----in the position, you were routinely informed of the selection process being undertaken?-- Yes.

Are you saying that in this case that was an exception?-- It was.

You did not receive such information?-- No, but originally we had been told that there was two surgeons coming from America and they were going to be on 12 month contracts.

And that's-----?-- That was the information I was given.

And that's not what transpired?-- No.

Thank you. Go to paragraph 18 - 19 in fact. The April 2004 ASPIC meeting, are you able to recall who was present at that meeting? You've mentioned Di Jenkins, Dr Patel and Dr Keating. Does your memory tell you now who else was present?-- I can't be sure, but I know that Gwenda McDermid, Di Jenkins, myself, and I think Toni Hoffman was present at that meeting.

Gwenda McDermid?-- Who is the Nurse Unit Manager of the Day Surgery Unit, Di Jenkins-----

Day Surgery Unit?-- Yes.

Thank you. Now, it then seems from paragraph 23, where you say, fourth line from the bottom, "I was not aware of any forms that had been completed from the operating theatres", it appears that in the period April, when the matter was first raised so far as you're concerned, if I understand you correctly, and the July, whilst you were still NUM, there were no steps taken to provide incident forms relating specifically to wound dehiscence. Is that what we can take from all of that?-- That's correct, yes.

So the background to what was happening at that point was, so far as you are aware, Di Jenkins was doing a chart audit-----?-- Mmm hmm.

-----but there was, nevertheless, likely to be some debate about what constituted a wound dehiscence. Is that a fair statement?-- Yes, it was.

There seemed to be a difference of opinion at least emanating from - what, Dr Patel?-- Yes.

As to what constituted a wound dehiscence?-- Yes.

Was it your position that the fact that Di Jenkins was doing the chart audit was a sufficient attempt to identify the

problem more formally?-- Yes, it was.

Is that the way you saw it?-- Yes.

Did it cross your mind that it would have assisted - I'll ask the question again. Would it have assisted for the staff in the operating theatre area in particular to be alerted to quickly identify and record what they suspected was wound dehiscence in the months that followed April 2004?-- Well, we routinely did that anyway, because we record in our operating record any patient that returns to theatre for wound dehiscence, and we actually put a code in like - an "R" in a column which then I can - that I check through on a monthly basis to look at, and that's where I pick up patients that return to theatre, and that's the information that I have - the method that I had used to collect - to pick up patients that had returned to theatre, and generally, because we're only a small unit, any patient that has returned to theatre with a complication, I'm notified about it by my staff and then I would have collected that information for Di Jenkins. So that was already being done even though we didn't fill any forms - complete any forms.

So that method of collecting the data was sufficient for your purposes as you saw it at the time?-- Yes, it was, yes.

And so you would have been satisfied that that method of collecting the data in such a small unit would have dealt with any arguments or debates that might arise later as to what a wound dehiscence was, because you were having first-hand accounts from your staff-----?-- Yes.

-----as to the reasons for the return to theatre?-- Yes.

Is that right?-- That's correct.

D COMMISSIONER VIDER: How long have you been collecting that clinical indicator, unplanned return to theatre? For a long time?-- Many, many years. I can't exactly remember how many, but it's - from-----

Is there any evidence that that figure changed substantially from 2003 onwards, unplanned return to theatre?-- I reported it monthly, so there is evidence, yes, on my budget reports. It was something that I reported each month.

Who do you report that to?-- The Director of Nursing, and often I'd provide an explanation on some occasions of what that return to theatre was for, whether it be for a wound dehiscence or a haematoma or perhaps a patient that had returned to theatre for repeated dressings, say an orthopaedic patient that needed wound dressings, a young child or something.

Did you have explanations for the reports that were generated for the unplanned return to theatre since 2000 - since Dr Patel's commencement in the position?-- I did - every time there was a return to theatre I investigated it to see the

reason why they were coming back to theatre.

Were you ever asked by the Director of Nursing for an explanation about those statistics?-- No.

So nobody ever asked you if you had a comment or a concern or what was happening with this increase in the unplanned return to theatre?-- When you have an increase of patients returning to theatre, it's the Nurse Unit Manager's job to flag it and to bring it to the Director of Nursing's notice, and then it would be passed on to the Director of Medical Services, or I would pass it on to the Director of Medical Services. "We've got a problem here. There's patients coming back to theatre", which is unusual when you perhaps have one or two patients returning per year, and then to have, you know, like - even four in a month would be considered not normal.

COMMISSIONER: Did you do that? Did you ring the right alarm bells?-- Mmm.

Yes. Am I right in thinking that within hospital administration, both unplanned returns to theatre, unplanned returns to ICU, and even unplanned returns to the hospital by patients who have been discharged, they're all regarded as sort of early warning systems that something is going wrong?-- Yes.

MR DEVLIN: You mentioned at paragraph 26 the incident of the 14th of May 2003 where a wrong patient was the subject of the wrong procedure. We have the benefit of a document relating to that incident which is Exhibit 16 to the statement of Leonie Raven. I'd ask you to take this in hand, if you would. Perhaps Mr Groth has a copy of the statement. Perhaps whilst the witness has the hard copy, I've one for the visualiser perhaps, so we can all see it as well. The witness can have the hard copy because it can be a bit hard to read. I want to take you to a few of these report forms, because they emanate from the area in which you were the NUM. This is the first of them. I'll be as brief as I can be. Do you see up in the right-hand corner that it does appear to emanate from the Theatre Department?-- Yes, it does.

And it's in relation to the named patient P74?-- Yes.

And down in the third box from the bottom, "How did the incident occur" - and forgive me for my trying to interpret medical writing, but we'll have a go at it. Just correct me if I get it wrong. "Directed to bed by DSU", and a nurse is named. Correct?-- That's Day Surgery, "DSU staff".

"DSU staff", sorry. So it's not a nurse's name. "Patient's first name was P74, as was the name of the patient first on operating list. Had the right chart, but wrong patient. Procedure of OGD"-----?-- OGD, which is a gastroscopy.

-----"performed on wrong patient". That seems to be reported by a couple of nursing staff?-- Yes, and Dr Martin Carter has witnessed it.

Then go over the page. "What sequence of circumstances contributed to the incident? (What happened prior to the incident): Normally endoscopy patients wait in chairs in DSU."?-- Yes.

Day surgery. A nurse is named. We needn't go into that. "Was directed to the patient in bed by DSU staff without a nursing handover."?-- That's correct.

"When she greeted the patient, calling him P74, he responded as his name was also P74, but did not query the nurse as she walked with him into the scope room." I presume that's an area set aside for endoscopies?-- Yes.

"Patient's ID armband was not checked by anaesthetist or surgeon before commencing procedure."?-- That's correct.

Then, "What action has been taken?", further down the page, the answer is, "Review of checking" - and accepting, presumably that means - "patients into the endoscopy room and main theatres. Unit meeting discussions."?-- Yes.

And then down the bottom, "Further comments?", "This incident should not have happened. Staff instructed to investigate fully.", hence the typed incident report. So, we get an appreciation from an actual recording of the incident at the time of the levels on which the mistake was made?-- Yes.

And it wouldn't - it would be accurate to say that the mistake was made by at least a couple of staff and Dr Patel; is that right?-- Mmm.

Just to put it in its correct context. You wouldn't argue with that?-- No.

Now, the next incident that you describe at paragraphs 28 and 29, we need to understand the context here. Dr Patel is relatively new to the hospital, having arrived, from memory, in the April. So, he's been there April, May, perhaps a couple of months, perhaps a bit over?-- Yes.

And the description you give, graphic as it is, would appear to be contrary to disaster or major accident protocols of which you would be aware in your position as the NUM, Theatre?-- Yes.

I'm interested in - and I keep coming back to this - either the cultural or the organisational considerations as to why somebody relatively new to the hospital wouldn't be then pulled up and a report made - and I'm not suggesting you should make it - I'm going to explore who might make such a report of some kind to management - because clearly there could have been real problems arising out of a failure to follow the protocols by a relatively new arrival at this hospital - at Bundaberg Hospital; would you accept that or not? Would you answer more "he should have known anyway"?-- Well, I guess even the PHOs that were with him would have thought that's not normal practice for doctors to leave the hospital - that amount of doctors to leave the hospital to go to an accident site. That's not normal practice in Australia.

All right. Let's just pull that apart, if we may, and examine it. Can we assume that by then that Dr Patel was impressing himself among the staff as a fairly overly confident doctor, to use as neutral a term as I can?-- Yes.

So, is it just that somebody in your position or somebody - anyone in the nursing staff who saw the potential for problems in the future if this wasn't dealt with, is it simply the fact that nurses would not make a formal report because they would not want to be seen to criticise a doctor in Dr Patel's

position; is that the cultural or organisational situation you would embrace, or are there some other reasons why some documented corrective action would not have been taken to prevent this happening again?-- Well, I guess as my role, I probably should have been - I should have been proactive, I guess, in reporting the incident, but, I mean, I did report it to the Director of Anaesthetics in Intensive Care where I thought maybe he would have taken it further.

So, a verbal report?-- He was in the operating suite when it was all going on.

Dr Martin Carter?-- Yes.

So, a verbal report to Dr Martin Carter, is that what you recall doing?-- Yes. When my nurse came back, and first time I met with Dr Carter that afternoon, I said - well, I told him about the incident - that I thought it was inappropriate for a surgeon to be going to a crash site, and he made the comment about, you know - about that he had not been notified that they would require an anaesthetist and anaesthetic equipment.

So, a nurse of your seniority and experience would be content with that on the basis that you would expect - or at least hope - that the matter would be dealt with doctor to doctor?-- Yes.

Dr Carter to Dr Patel, "Hey, look, you just can't do that. Let me show you the emergency protocol." You seem to be agreeing with that?-- Yes, and as part of a new surgeon's orientation, I guess that he should have been shown the disaster plan fairly early in his employment.

Very well. So, you would have considered it sufficient to voice your concerns to another doctor - fairly senior doctor in the system - in the hope that informal things were said-----?-- Yes.

-----to that doctor and/or the PHOs that also found themselves caught up in it?-- Yes.

Because it is just as important for them to get the message, too, I take it?-- Yes.

Right. Now, then, we go to paragraph 30 where you say you didn't receive any complaints or incident reports from the nursing staff about Dr Patel's surgical ability on the basis that nurses tend not to criticise doctors because of the possibility of reprisal. Is it not more just a very longstanding culture that nurses would complain about a doctor in only the most serious of events?-- Yes, that's true.

Fear of reprisal is a bit simplistic, isn't it? Hasn't this divide been present for as long as there have been nurses and for as long as there have been doctors, or don't you see it that way?-- There has been the division between the two and, I guess, the imaginary line between, you know, what you would say about a doctor or - I mean, doctors are quite critical of

nurses. That side of it is quite different. From a nursing point of view, nurses don't criticise doctors or complain about their work or-----

Much less go on paper about it?-- That's true.

Now, this Commission will grapple with - we would expect - models of dealing with lack of clinical competency in one area or another. Across the board clinical competency is one thing, but a medical practitioner may be deficient in a particular area. One of the models that operates interstate is a non-adversarial model; that is, matters are brought formally to the attention of the relevant authority, and one looks at fixing up the competency if one can, rather than turning it into an inquisition into the doctor's general competency or even specific competency; do you get what I mean?-- I have seen it happen here in Bundaberg, yes.

You have seen it happen?-- Yes.

In a less formalised way?-- Yes.

You saw it as happening effectively when it was handled well?-- Yes, extremely.

Does that sometimes start, in your experience, on the complaint or on the observation of - on the report, to use a neutral term - on the report of a nurse who has observed this apparent lack of competency?-- I think, generally, that lack of competency in medical staff would probably come from a junior member of the medical team or perhaps another consultant - I guess of the same specialty - may consider that perhaps another doctor on that team is perhaps lacking in some skill and it needs to be addressed.

Now, I want to take you - thank you for that. I think it is a helpful response from someone so experienced. Can I take you to LTR4, still in that bundle. This seems to be the Adverse Events Management document, just in blank, I think - policy and procedure document?-- Sorry, which one am I looking at?

LTR4. If you hand it back to me, I'll find it for you. This seems to have been effective since 1 June 2004. So, you are the NUM - operating theatre's - only until August?-- That's true.

I don't expect you to know lots and lots about this, but just what it says on its face, it is called "Adverse Events Management", and even just to look at the first page - it is said to be a new policy - and even on the first page, the description is, "Outlines the process for reporting, investigating and documenting adverse events at the Bundaberg Health Service District." Then underneath there are definitions of, "Incident" - "An event or circumstance which could have or did lead to unintended and/or unnecessary harm to a person and/or a complainant, loss or damage." Then there's a definition of a near miss. Then there's this open disclosure: "The processes of open discussion of adverse

events that result in unintended harm to a patient while receiving health care and the associated investigation and recommendations for improvement." Then, down the bottom, the policy I ask you to look at, "Improved Patient Care". "Outcomes and safety are key objectives of the Bundaberg Health Service District. All clinical adverse events and near misses are to be reported and evaluated in a consistent manner that considers all contributing factors, with an emphasis on prevention of recurrence and on communication with all affected parties in a context of open disclosure." They are lofty aims, aren't they?-- Very much so.

They are lofty aims, and I suppose if an organisation doesn't set lofty aims for itself, it might as well give up, do you think? But how, as an experienced theatre nurse, where one imagines it all happens in theatre under a lot of pressure - you see people at their best and their worst - and by that I mean everyone contributing in the team - how do we reconcile that lofty statement of aims and make it happen for staff? What are the ingredients that have been missing, in your experience, so far that could be injected to see that those aims are met as far as they can?-- There has to be - open lines of communication is probably the best thing and there has to be some feedback that when these forms are completed and they are sent off to the appropriate people, that there's feedback to those people of what has actually been done about that problem, but I think you'll find this general culture that nothing does get done so people think, "Why fill out this form if there's not going to be any result?"

And the Commission will be looking at - signalled already that it will be looking at some form of independent clearing house for reports, presumably of a significant nature?-- Yes.

Not a trifling nature. Does an independent clearing house, applying to all Q Health hospitals in particular-----?-- Yes.

-----does that present as a possible means by which nursing staff or junior medical staff could be made to feel more confident, together with a regime that was not punitive but educative in the main?-- I think people have to be educated on the importance of being able to document, say, a near miss, and they have to have time to do it - to actually document it.

That's another aspect?-- That's a really important thing. Sometimes if something does happen, if you don't document it straightaway, you lose the finer points of the event.

Absolutely?-- And if you document it a week later, the information is probably - it is someone's opinion, it is someone's - what they saw, but something could be missed.

Yes?-- And I think that that needs to be - there needs to be a system that - and there needs to be - there needs to be adequate staff in areas so that the documentation can take place.

Because one of the things that any staff in any large

bureaucracy would consistently complain about would be there are a lot of forms to fill out already?-- There is.

But I'm not sure that you have given any full response to my proposition that could an independent clearing house applying to Q Health - so we don't just rely on internal resolution - in the more serious cases, staff know they have recourse to elsewhere where the result may be educative, not punitive?-- Yes, I think that's a good idea.

Do you see that as being a possible vehicle for-----?-- Solution, yes.

-----improving the reporting of incidents, apart from anything else - that directly impact?-- Provided it doesn't become too unwieldy.

Yes. Often these incidents directly impact upon the future of a patient - the health and the welfare of a patient, which is the core duty-----?-- Yes, that's true.

COMMISSIONER: Mr Devlin, I don't want to interrupt you, but if I can pick up on one aspect of that? I gather one thing that is very important for you to know is if you utilise the complaint system, whatever it is, that you will be supported?-- I think that's an important point - that anyone that does make a complaint or has an issue or - that they feel that they can-----

Perhaps you will get feedback as well. Is that important?-- That is probably the main things that my staff would complain about - is if you don't see anything happening from a complaint that you have made, people will not complain. They think, "Well, no-one is going to do anything about it, we may as well leave it to the system."

Thank you.

MR DEVLIN: Then when you do something about it, it might be one of those informal things, such as you speaking to Dr Carter - no criticism implied there - in the hope that there's a resultant action?-- Yes.

Doctor to doctor?-- Mmm.

And, of course, that necessarily leaves management out of the loop?-- Yes.

It is being done at an operational level?-- That's where it should happen.

Fair enough. If there's mounting evidence for the unsuitability of someone, management does need to know?-- Of course. If the situation was repeated, well, then, I would have - if, you know, Dr Patel went out to another crash site, I would have been reporting-----

I see your point. You would feel justified then to go on

paper?-- Yes.

Very well. Can I take you now to LTR15? Again, the operator seems to be quicker at this than anybody, so he will assist you to find these exhibits. We will go very quickly through them, because they are incident reports which, as I understand it, are pre-February of 2004, and they do seem to emanate almost entirely from theatre, and I want to read to you what the witness, Ms Raven, says about them. She says - paragraph 54 - "In preparation for providing this statement I've also undertaken a search of the patient/client incident reports, which is a paper-based system utilised by the hospital prior to the introduction of the Adverse Event Monitoring System in February '04 outlined above. These reports were not inputted into the Adverse Events Register and were retained by the Assistant Director of Nursing in her office. I have identified 10 reports which contain Dr Patel's name. Of the 10, five relate to equipment failure reported by nursing staff where Dr Patel was the surgeon involved.", and they are LTR15 - which I'm going to take you to - 15. Then there's the one about the wrong patient, which I've already taken you to. That's LTR16. And we will look at the last four quickly as well. Firstly, LTR15, it would appear that a piece of equipment did not work, and the surgeon on duty, the medical officer, noted on the form - up at the top, thanks - is Dr J Patel, but would you agree that the narrative of the incident seems to simply involve nursing staff and the failure of some equipment?-- That's true.

Thank you. Next one, the medical officer is J Patel, then-----

COMMISSIONER: Sorry, Mr Devlin, I take the force of the point you are making that none of these really reflect on Patel's clinical competence. I think we can satisfy ourselves of that without taking the witness to all of them.

MR DEVLIN: Thank you. I have taken the witness to 16. There are just one or two points about 17, 18 and 19 which I think might assist, Mr Chairman.

COMMISSIONER: Of course.

MR DEVLIN: Go to LTR17, which is a few pages on. This also emanates from the operating theatre and it follows the one we spoke about with the wrong patient. This one has an explanation down the bottom-----

COMMISSIONER: Whilst that's being taken out, I will remind the press and media there's a standard direction not to publicise the names of the patients without their consent or the consent of next of kin or family members in the case of a deceased patient. Yesterday I identified a number of patients that had been excluded from that and the ones that we are looking at at the moment are not ones that have been excluded, so they are covered by that current direction.

MR DEVLIN: Thank you, Chairman. "How did this incident

occur?", is the box. "Whilst" - and I can't pick up that word?-- "Oversewing splenic vessels, an atraumatic needle broke. Left inside patient as deemed unsafe to retrieve as patient haemodynamically unstable at the time."

Thank you. Then we just need to go to the Department Head's response to that. Does that read, "Unfortunate incident, but understandable reason", next page, bottom box?-- Yes.

So, it is looked at up the system and a judgment is made whether there needs to be any greater response than that?-- Yes, that's true.

Then, the next one is LTR18. This seems to come from Surgical, so that would not be you - it would not be the theatre?-- No.

But that appears to be on the observations of Dr Patel about a staff member not reporting on a drop in urine output for the patient; do I understand that correctly?-- Yes.

And then the response of management after it has gone up the chain "agree with doctor's diagnosis" or "report"?-- Yes.

LTR19, next one, a clip - "A towel clip, whilst a patient was being draped, was inadvertently clipped to the patient's skin by Dr Patel." That's the report, correct?-- Yes.

Then after it has gone up the chain and examined by a number of people, including the supervisor, "unfortunate incident" is the judgment?-- That's correct.

Just one of those things that can happen?-- Yes.

So, there we see at least the ones that made it into the records as recording in a fairly routine way any adverse incident that nursing staff felt obliged to report?-- Mmm.

Either on the report or on the encouragement of the doctor, him or herself, but also of their own motion, correct?-- Mmm.

And at least those forms have the capacity to make it into records somewhere, so if Dr Patel was - well, I won't restrict myself to Dr Patel - if a particular staff member was showing consistent lack of competencies, something - some pattern might be identified?-- I think you need to look at the fact that with those - those incident reports really had nothing to do with surgeon's technique.

Yes?-- Or any incident whereby a patient was injured.

Yes?-- These were just merely things where equipment had failed and those sorts of things that needed to be documented.

Thank you. So, let's just then examine that other side, because you have got - you made - and that's how I was going to conclude my questions of you - go to paragraph 36 and onwards.

COMMISSIONER: That's in the witness's own statement?

MR DEVLIN: In the witness's own statement, thank you. You form - would it be correct about P7 - I will return to the point you make - I haven't forgotten what you have said?-- Mmm.

Would you have said about P70 that you observed poor surgical technique, yes?-- Yes.

This is your opinion of what you saw?-- Mmm.

Arguably an unnecessary procedure?-- Well, I guess that's really not up to me. I'm not qualified to say that, but-----

You flag it as a concern?-- Yes.

As a nursing concern?-- Yes.

If not a medical one, because you are not qualified there, and an adverse outcome to the patient is something you felt happened?-- Yes.

Well, if you were at that point, what's the reporting process for that kind of concern - if the incident reports were meant to deal with the situations you just outlined-----?-- Why didn't I complete one?

No, I'm not really - I don't, for a moment, mean to be accusatory, I'm simply trying to understand how you would report that or deal with that?-- I guess if we had perhaps another surgeon, that I would, you know, talk to another surgeon, or talk to the Director of Medical Services about my concerns.

So-----?-- And I would obviously talk to my line manager.

Your line manager being the DON - no-----?-- Well, at that stage my line manager became the Nurse Unit Manager, because-----

COMMISSIONER: Your previous position?

MR DEVLIN: Sorry, we have moved on. You are now a scrub nurse?-- Clinical.

Clinical nurse?-- Yes.

So, there's reporting it to your line manager in the nursing sense?-- Mmm.

And, of course, a missing ingredient here is we don't have another senior surgeon working routinely side by side with Dr Patel at this point; is that right?-- We have another surgeon, but he tends not to do a lot of major bowel procedures.

Who was that at the time?-- Dr Gaffield.

Doctor?-- Gaffield.

Yes. But if, for example, Dr Patel had been an SMO and there was a Director of Surgery above him-----?-- Yes.

-----you would have felt quite confident?-- Yes.

Going to the more senior doctor?-- Yes.

So, there's a missing ingredient that we have indicated which might have otherwise brought on a report?-- Yes.

From you?-- Or otherwise it would be brought to the Director of Medical Services.

Very well.

COMMISSIONER: Ms White, going back to the forms that Mr Devlin took you to - I don't mean to look at them again, but just talking about them, I guess from your position when you are in charge of the theatre or when you were working simply as a nurse in the theatre, it is very easy, isn't it, to fill in a report saying a piece of equipment broke, because you are not - you are not then making any clinical judgment about a medical issue, you are simply saying, "Well, this piece of equipment broke and this happened." It is a lot harder for you to point a finger of blame at a doctor than fill in a form saying the doctor's technique is bad-----?-- Because a piece of equipment breaking is not going to harm a patient, whereas a doctor's technique could.

Yes. I think that's what both Mr Devlin and I are concerned about, that the reporting system seems almost to focus on the trivia - things that aren't going to harm a patient - whereas there seems to be no routine for reporting matters that are serious?-- That's true.

And Mr Devlin emphasised - and I would also like to emphasise - that none of this is meant as criticism of you, we simply want to explore the system and how it worked, but it does seem to me that if you are observing poor technique, there would be people - if you will forgive me for saying so - better qualified for making that assessment, such as the anaesthetist, who is also in the operating theatre and should be making exactly that same observation?-- I believe so.

And so it is not merely a matter that you chose not to put in an Adverse Incident Form or a report, but other people better qualified than you to make that assessment weren't putting in those sorts of forms either?-- No. But doctors very rarely fill out an incident form. I can't remember ever seeing an incident form filled out by medical staff.

All right. Mr Devlin?

MR DEVLIN: Thank you. Go to P38 now. I won't be much longer. Just to refresh your memory, P38 had a nicked bowel by Dr Patel, and you believe the intern rejoined the bowel. You were aware of an unexpected emergency return nine days later for investigation. You were the anaesthetic nurse and you formed the view that everything was infected once the laparotomy was performed?-- There had been a big leak.

Sorry?-- There had been a big bowel leak and there was fluid right throughout the patient's peritoneal cavity.

Just listen carefully to my next question then. Do you unreservedly offer - the nursing opinion, at any rate - that the infection was the result of the performance of the anastomosis, the hand anastomosis?-- I can't see any other explanation for it.

And the question must therefore be: what observations did you actually make to lead you to the view that the anastomosis was poorly performed by whomever performed it? Do you see the point?-- Yes.

Are you just working backwards from the result and saying, as you just said, "I can't think of any other explanation for such a large perforation."?-- It would have to be the anastomosis breakdown or where the accidental nick had broken down.

And that's the best you could do in the circumstances confronting you?-- Well, the condition of the patient's bowel was then just a solid conglomerate mass of just a bowel and tissue and abscess formation and, like, Dr Gaffield didn't even - all he did was irrigate and put two large drains in, he did not attempt to even try to find out where the problem had arisen from.

Why was that?-- He probably would have caused more harm to the patient.

Yes, I see. I guess I'm just coming to this then, that the opinions you offer there, in a nursing sense, are a combination of deductive reasoning from what you saw-----?-- That's true.

-----rather than seeing anyone physically do something like - I will be specific - like the hand anastomosis? You did not actually observe who did it and how it was done, you just-----?-- In the first procedure I was scrubbed and I saw it being done.

COMMISSIONER: But I think Mr Devlin's point is that you didn't actually see anything go wrong with the anastomosis? You had concerns about the way it was done, but-----?-- No, I was concerned that the junior intern, who had only been there a few weeks, was doing the hand anastomosis and it's quite a technically, difficult thing to do.

But the real point is that from where you were standing, you couldn't observe that person actually making any mistakes?-- No.

Your concern was that an intern shouldn't have been doing that, and then when you learn 10 days later that this patient is suffering from serious infection, you put two and two together and say, "Well, it must be either the anastomosis that caused that or possibly the nicking of the bowel."?-- That's true.

They're the only obvious explanations?-- They would be the only explanation.

So really what you are saying to Mr Devlin, you can't as an eyewitness say that you saw something, you saw the mistake that caused this problem, you can simply deduce that it must have been one or other of two causes?-- Mmm, and from comments from Dr Gaffield as well.

Yes.

MR DEVLIN: Thank you. Thanks, Chairman. Then if we can go quickly then to patient 71, and to refresh your memory, my note of your evidence is the patient had a nicked bladder. Now, we have a patient with a dead end in his urethra. Listen carefully again to my question: do you offer the nursing opinion that there is no other cause for the patient's current problems other than Dr Patel nicking the bladder; is that your considered opinion?-- Because he didn't have any other surgery.

Yes, thank you. You speak generally about the bowel perforations during colonoscopies, which you estimate occurred three to four times when Dr Patel was the surgeon. I take it you cannot relate a patient identity to any of those instances of which you speak in a general way?-- No, because the patient would have a colonoscopy and then later on in the evening the patient returned to theatre for a laparotomy, for oversewing for the perforation.

You can't relate that to a specific patient?-- No, I haven't investigated that.

Thank you. Elective Surgery Programs, are you saying that in your view, from a nursing perspective, surgical priorities are being set more by commercial considerations than other considerations; is that the way you see it?-- Yes.

You are prepared to stand by that view?-- Just - well, to some degree. Not completely.

To some degree?-- Yeah.

Okay. And by that, are you saying that from your observation, as an experienced nurse, there are patients who might in the past have been correctly prioritised by the surgeons who had

more control over their own lists, now that's less of the case?-- Yes.

Is that what you are saying?-- Because surgeons come and you talk about patients on the list and they will tell you, "I don't have a clue what's on my list today," it just comes out, you know.

But is that what you are saying?-- Yes.

That there is the danger or potential-----?-- To some degree there is not the communication between Elective Surgery and the surgeon as to what's on their list.

And does that in turn-----?-- It doesn't happen on every list, but on lots of lists it does.

All right, that's a fair response. Does that in turn mean that there is the risk that proper prioritisation procedures doesn't happen on occasions; is that what you are trying-----?-- Particularly when you were getting towards the financial year when they realise elective surgery targets haven't been met.

Right. Again, my questions are not aimed at any particular person, we're looking at how the system works now, how it's grown to that. You are simply saying that on some occasions there is the danger of a misreading of surgical priorities; is that what you are saying?-- Yes.

Thank you. That's all I have.

D COMMISSIONER VIDER: From your register of unplanned returns to the operating theatre-----?-- Yes

-----would you be able to collect data relating to patients who required admission to the operating theatre having had a bowel perforation during the colonoscopy; is that a category on the unplanned admission to theatre?-- Yes.

So you could extract those statistics if necessary?-- Yes. Yes.

COMMISSIONER: Just going back to a question Mr Devlin asked you. He referred to your discussion with Dr Carter and how that was sorted out between the two of you, one clinician to another without troubling the people in the Executive offices to resolve it, and you said that's how it should be sorted out?-- Yes.

Does that suggest that in your view there should be greater involvement of Executive management in being present on and visiting and making decisions within the clinical areas of the hospital, rather than the situation that we seem to be hearing that there's Executive up in their offices and they stay there and if they want to speak to someone they send for you, rather than being involved in the day-to-day decision-making on the hospital floor?-- That's what has happened, yes.

And your own view, based on your many years of experience, is that that's not a desirable way to run a hospital?-- Well, I think it's - the lines of communication are fairly restrictive in that way. Often if you see someone perhaps in a corridor and you've got a concern, you can actually just have a discussion with them, rather than make a formal appointment, and, you know, perhaps have to wait a week, you know, to actually see someone.

Thank you.

D COMMISSIONER EDWARDS: It seems to me that there may be that there are forms for everything that somebody has to fill in within the system. Do you think there should be a general review of those forms and systems so that there is less paperwork and more action?-- I guess that's a fairly broad question about the documentation. I think there has to be documentation. There has to be a path where the patient is tracked from their time of admission to the time that they leave the hospital. So it would be difficult to, I guess-----

Could the forms be simplified, I guess I'm saying, to see that less time is spent on filling out numerous forms, numerous details, when often there has been no incident, just a routine process?-- Yeah. I think in clinical areas there's no real clerical support in any clinical area, and as a Nurse Unit Manager you're expected to do all of your own documentation and that's fairly time consuming.

COMMISSIONER: Mr Morrison, was there any - Mr Diehm - any preference?

MR MORRISON: I don't care. I will stand up.

COMMISSIONER: Thank you, Mr Morrison.

CROSS-EXAMINATION:

MR MORRISON: Nurse White, I'm Phil Morrison, and I act for Linda Mulligan?-- Thank you.

I just want to ask you some questions about this. Clear something up for me, if you wouldn't mind. On the business about Dr Patel heading out with the team to the accident site, I thought I understood you to say that you spoke to Dr Carter about that?-- Following, yes.

After they came back?-- Yes, I did.

And he said he hadn't been notified that they would require an anaesthetist?-- That's true.

Right. It's evident from that, isn't it, that Carter knew

that this operation was on, that they were going out?-- Well, he may have heard it on the grapevine. He didn't tell me that.

Right. Okay. Was he to do anything about it himself? Did you discuss what would be done about this apparently inappropriate approach?-- Well, I spoke to him about it and I assumed that-----

From your point of view, that was sort of your job done, you know, you had flagged it to him?-- Yes.

Was there any suggestion from him to you that he would then be doing something about that?-- No, I guess I just assumed.

You assumed he would, okay. All right. Now, can I ask you one other thing, just to get rid of a couple of areas. You mentioned that monthly returns went up from theatre and other areas to the DON?-- It would only go from the operating theatre.

Oh, from the operating theatre, okay. That would include some stats on unplanned returns to theatre?-- That was the stats. The unplanned returns to theatre is one of our clinical indicators that we collect.

Okay. Sorry, let me understand. Was that the only stat that went up on a monthly basis, or was there a bunch of other things?-- A bunch of others things.

And there was an opportunity to make comments on that about that particular stat, the unplanned returns?-- Yes.

Such as what?-- The reasons why the patient returned.

Okay?-- As I said, if a patient returned for repeat dressings.

A clinical explanation, as it were?-- Yes.

I assume from what you said that your comments on it wouldn't be to compare, for instance, that month's with the same month the previous year?-- No.

Or period to period, or anything like that?-- No. But I would take my report to the Director of Nursing, Glenys Goodman, and would speak to her and say, "Look, we have had an unusual amount of returns to theatre," and give the reasons why.

Okay. All right. Now, can I ask you something else? It's just this thing at the end of your statement where you refer to the incident with Dr Carter-----?-- Mmm.

-----when he was rude to you. Did you put a date on it for me or for the Commissioner earlier on? It says on about dates close brackets, or date, so I assume when this was being compiled you couldn't remember the date. Could you tell me

whether it was 2003, 2002, 2004?-- 2004.

Okay. And Toni Hoffman was Acting Director of Nursing?-- Yes.

So it's the very early part of 2004?-- Yes.

Right. Okay. You were quite incensed by the response of Ms Fritz, the HR person?-- I guess, in general, is that when you go to someone, you actually are going - you are looking for some sort of guidance, some sort of help. But when we got to her office - I know Toni and I both went to together. I spoke to her previously and she said, "What I would you like to do is document"-----

Sorry, Toni Hoffman said that or Ms Fritz?-- Yes, she was Acting Director of Nursing at the time.

I wasn't sure which of the two said to document it?-- Yes, she did. Document - Toni asked me to document the incidents that I had with Dr Carter, and I took that completed to her, and she asked me what I wanted to do about it and I said, "I would like to - I just need guidance as to how to deal with it." And Toni said, "Perhaps we should be talking to Cathy Fritz, she is the Human Resource Manager and trained in that area." Toni actually made an appointment and asked to see her the next week. When we got to her office, she was obviously busy on her computer and we stood outside for quite considerable time. Then eventually she called us in and we had to, like, clear seats to sit down and she continued to work on her computer.

So it was really she didn't seem to be paying attention to you, rather than her telling you-----?-- When I handed her the document, she just flicked through it and basically that was her response. So, I guess when someone at that level does that to you, it's fairly demeaning, so I guess that's why I was quite annoyed and-----

I wanted to understand. It's not that she said, "Listen, you two are senior people, why don't you go back and talk to Carter," it wasn't so much that-----?-- She could have said it in a nicer way-----

I didn't catch the rest?-- And she could have given us the time of day.

So what I'm getting at though, is it is the way in which she led up to her recommendations, more than the recommendation itself, mainly going to talk to Carter and sorting it out?-- Yes, it was the whole process, I guess.

COMMISSIONER: Mr Morrison, if I could interrupt. Was it something beyond that, was it also a sense, well-----?-- Who do you turn to?

Yes?-- When you've got a problem, if you can't talk to the Human Resource Manager, who do you talk to in our environment?

MR MORRISON: Mind you, if she had sort of sat down and given it a long consideration and listened to you and everything else, she could have still ended up saying, "Listen, this is what I suggest."?-- That's fine.

You wouldn't be upset at the outcome?-- No.

Just the manner?-- Yeah.

Okay, I understand?-- Because I wouldn't say that to my staff.

Right, okay?-- If two of my staff members had a problem, I wouldn't tell them to grow up and sort it out themselves, that would not be my approach.

Right. Okay. Now, just a couple of other things. On that occasion, and the one you mentioned - no, that occasion will do. That was from where you took a - let's call it a complaint, it doesn't have to be seated any particular definition, but you took a complaint to Toni Hoffman as Acting DON, who basically said, "You will have to document it and then we will do something about it."?-- Mmm.

Okay. And that's a reasonable approach?-- Yes.

All right. Now, I want to ask you about the business with Ms Mulligan. You said it was difficult to gain face-to-face access to either her - paragraph 31, if you wouldn't mind turning to it. Because you were there so long, you acted under a number of DONs?-- Yes, I did.

In fact, some of your interaction, we have heard about, was with Ms Goodman?-- Yes.

So is it Ms Goodman that you are talking about here?-- No, at this stage it was-----

Linda Mulligan?-- Linda Mulligan.

And the Director of Medical Services is Dr Keating?-- Dr Keating.

Right, okay. It was difficult to get face-to-face access to either of them, and the DON worked by appointments is basically what you are saying?-- That's correct.

Okay. But, of course, you would have appreciated, no doubt, at the time if there was something truly urgent - let's say a clinical situation was unfolding urgently - you wouldn't have doubted that you could have gone to see her with an appointment, or none, you could find your way in?-- Well, I sometimes - sometimes I doubt that. You know, you were faced with a barrage of questions from an admin person and-----

Yes, but you are only talking about an admin person?-- Yes, I know.

You were a very senior nurse in a very important area of the hospital, quite critical in fact. If you said to that admin person, "Listen, this is extremely important. It's urgent I see her now," do you really doubt that you would have got in?-- Oh, probably after a lengthy explanation I may have and, you know, discussions with - between the admin person and Linda Mulligan.

Let's take another hypothetical. If you had said to that admin person, "Listen, Dr Patel is killing patients, I have to see the DON now," do you think-----?-- I think I would have got in in that case. I think personally I would have been knocking on Dr Keating's door.

Dr Keating or the DON?-- Or the DON.

You would walk over the admin person to do it, wouldn't it, it's that important?-- Yes.

Now, you would have appreciated - and I think you actually said it today. In all fairness, I'll just make sure what my note is. It was proposed this business about speaking to the DON, she was obviously quite busy, she had come to the hospital after you had had a period of a number of Acting DONs?-- That's true.

And that's disruptive really, isn't it, in the sense when you get changing personnel things tend to either lapse or the follow-up doesn't happen?-- Yeah, things don't get dealt with.

The continuity isn't good. She had a lot to catch up on, and then you mentioned business about going through secretarial staff. All right. Now, you corresponded though, I think, with the DON by e-mail over various issues?-- Generally not. I didn't use e-mail a lot.

You did a bit though and with her?-- On the odd occasion I would, but very rarely.

And you did speak to her by phone on occasion as well?-- Yes.

And you did have meetings with her?-- Yes.

I'm going to read you a list of meetings, if I may, and you tell me if any of these ring a bell with you?-----

COMMISSIONER: Mr Morrison, why don't we have the afternoon break and you can show the list to the witness so that she can think about it.

MR MORRISON: Sure.

COMMISSIONER: We will take a 10 minute break.

THE COMMISSION ADJOURNED AT 3.20 P.M.

THE COMMISSION RESUMED AT 3.43 P.M.

JENNIFER ANN WHITE, CONTINUING CROSS-EXAMINATION:

MR MORRISON: Ms White, I have given you a list of dates and times which you have had a chance to look at. Does that accord with your general recollection of meetings with Ms Mulligan?-- Yes.

I will tender that document, lest perhaps the last two and a half lines in parenthesis. They are not really dates and times. Evidence about that will be given by Ms Mulligan in due course.

COMMISSIONER: The document speaks for itself. The document headed, "Meetings with Jenny White, Nurse Unit Manager"-----

MR ANDREWS: Unit Manager, I think.

COMMISSIONER: Sorry?

MR ANDREWS: Should be Unit Manager, I suspect.

COMMISSIONER: Yes. That will be Exhibit 75.

ADMITTED AND MARKED "EXHIBIT 75"

MR MORRISON: Thank you, Chairman. Now, can I just direct your attention - I think I had you at 31 in your statement anyway?-- Yes.

Page 7. Do you see the last line, you say in your view when problems like this - when problems arose like this you needed to talk to the DON straight away, not a week later, because by then people had moved on. The problems arose like this. Are you referring to the previous paragraph about the bullying and intimidation? Is that what you are talking about?-- No. I was talking about-----

Just general concerns?-- Just general, and if you look at that list of meetings that I had with her, a lot of those meetings referred to the grievance procedure, the grievance

that was taken against me, and another appointment was when I actually rescind my position and informed her I was going on holidays, and so those meetings probably didn't relate to any clinical requests that I - meeting that I had with her.

Well, we will examine that in a moment. Can I ask you this then. In 32 - I just want to ask you this. You refer there in the third line to having prepared a business plan for 2003/2004. Now, one assumes from one's experience that when you do a plan for '03/'04 you do it earlier than '03/'04?-- Yes, that would have been with Mrs Goodman.

Yes. That is what I was going to ask you about. Now, let's deal with what's left in 32 for a moment, if I may. You mentioned - said in your statement that was an e-mail that turned out to be a letter?-- Yes.

Which you now had a look at - I can't remember its exhibit number, Mr Chairman.

COMMISSIONER: 74.

MR MORRISON: 74, thank you. I want you to look at a couple of other documents about that, if I may. Can I just show you this document. I am happy for it to be put on the screen if you like, but I don't think we need to at the moment. Is that a copy of your letter signed by you? I didn't mean to take it away from you. Can you go down to the signature? Keep going. That's your signature?-- Yes, it is.

Okay.

COMMISSIONER: That's really a signed copy of what's already Exhibit 74, the document we were looking at earlier?-- Yes.

MR MORRISON: Yes. If you just go back to the top of the document, Mr Operator, you will see it's got a, "Date Received" stamp, 28 May 2004. Okay. Now, I want you to assume for me, just assume for me, that's the date it was received by Ms Mulligan, received into her office on the 28th?-- I assume that.

Now, I want to suggest to you that on the 3rd of June you had a meeting with Ms Mulligan about this letter and what it raised face-to-face in the meeting with her?-- Mmm-hmm, yeah.

Do you accept that or not?-- Yes.

And in relation to that, what she told you was that there would be consultation with the Queensland Nurses Union over what you raised?-- Yes.

About - or there was a need or would be consultation about the rationale for the change?-- Yes.

Including workloads - including workloads, the trial, that is the trial of the late shifts?-- Mmm-hmm.

And there was - and the need for indicators to assess the trial?-- Yes.

Do you agree with me so far?-- Mmm.

Not just financial indicators, and you were to update Ms Mulligan about that. In other words, you were to go and consult the QNU about this on these - with these suggested areas and then update Ms Mulligan about the consequences of that or the results of that?-- Yes.

Do you agree with that?-- To a certain extent, yeah.

D COMMISSIONER VIDER: Could I just be clear about that, the Nurse Unit Manager was to go and negotiate with the Union, not the Director of Nursing?

MR MORRISON: Is that what Ms Mulligan told you?-- I assumed.

COMMISSIONER: Is that what you are suggesting?

WITNESS: I can't quite remember because I would assume that she would have spoken to the union. That's not our role to do that.

MR MORRISON: All right. And the trial was to begin on roster after the 18th of July 2004?-- That's when it was predicted that it would.

And did you know or were you made aware of the fact that Ms Mulligan did speak to QNU representatives Auriel Robinson and Vicky Smyth or Smith, however you pronounce it-----?-- I didn't receive any feedback from that meeting.

-----about this matter, and the consultation would occur with them over this issue?-- Well, it should have done, yes.

All right. Now, did you receive or did you contact Ms Mulligan by e-mail about this matter, that is to say, the subject matter of your letter-----?-- I can't remember, I'm sorry.

-----on the 7th of June by e-mail? And I will just get you to have a look at this document. Perhaps it can go on the screen. I will tender the copy of the stamped - perhaps it should go the other way.

COMMISSIONER: Yes. That copy will become part of Exhibit number 74.

MR MORRISON: I just want to show you this - what might be called an e-mail header from you to Linda Mulligan. Now, just accept from me for the moment - we don't need to debate it - that it's the American style of dating, so it's in fact the 7th of June, not the 6th of July, subject "Late Shift Triallings." "Hi, Linda. Is attached okay to send?" Can you remember sending Ms Mulligan an e-mail with an attachment requesting her confirmation about whether it was okay to send

it on the topic of the late shift trial?-- Yes, I did.

Put the attachment on, please. Let's have a look at it. And what you had done was to draft a letter to Vicky Smyth of the QNU dealing with this issue of the theatre staffing, the need to reduce them due to fatigue and the trial of the late shifts, and that's what you had drafted, isn't it?-- Yes.

I will tender the attachment - the e-mail and the attachment, Mr Chairman.

COMMISSIONER: Yes. The e-mail from this witness to Mrs Mulligan of the - is it the 7th of June 2004, together with the attached data will be Exhibit 76.

ADMITTED AND MARKED "EXHIBIT 76"

MR MORRISON: Did you get a reply from Ms Mulligan on the 9th of June in relation to the - that document? Can you recall?-- I assume I did, but I - I assumed that I did but I-----

Can you have a look at this document, please. And do you see that that is an e-mail from Ms Mulligan to you, again accepting the American style of dating, it's 9 - American style of recording the date, the 9th of June 2004. You will see your original request is at the bottom?-- Yeah.

"Hi, Jenny. I would chat to Vicki", that's Vicki Smyth or Smyth, "rather than send this first. Normally do not send letters re trials. Also no need to send to Albert at this stage. Call me if you have concerns. L.", for Linda. Do you recall getting this?-- Yes, I do.

That was passing comment upon your draft to the QNU dealing with this issue that you raised in your letter of the 26th of May; correct?-- Yes.

I tender those two documents, or that document. Can you recall-----

COMMISSIONER: Sorry, Mr Morrison.

MR MORRISON: Sorry. Am I going too fast?

COMMISSIONER: No, no, you are just obviously far quicker than I am. The e-mail of the 9th of June from Linda Mulligan to Jennifer White will be Exhibit 77.

ADMITTED AND MARKED "EXHIBIT 77"

MR MORRISON: Can you recall having e-mailed contact with Ms Mulligan over this topic shortly thereafter in relation to the theatre staffing issue and the need for you to provide information to her?-- No.

Can you recall that?-- No.

Have a look at this document, please? Can we just centre it please, Mr Operator? Can you shrink it a bit so it all fits on? That will probably do. If you just go up a bit, please, Mr Operator. No, other way. See, it's an e-mail, Linda Mulligan to yourself, and now you will see why it's the American style of recording the date. 30th of June, "Re Theatre Staffing Issue". Down the bottom - pull it up, please, Mr Operator - "Hi Jenny, I need to have this info by Wednesday afternoon as I am meeting with V Smyth. Can you please have to me by then (Amelia/Cheryl). Please bring to my attention Wednesday afternoon so I can read ASAP. Ta, Linda." That was requesting information from you for the purpose of the DON's meeting with the Queensland Nursing Union over this issue, wasn't it?-- Yes.

Did you supply that information to her for the purpose of advancing this issue?-- I don't know that I can recall that actually.

I tender that e-mail.

COMMISSIONER: That e-mail from Mrs Mulligan to Ms White, the 30th of June 2004, will be Exhibit 78.

ADMITTED AND MARKED "EXHIBIT 78"

MR MORRISON: Thank you, Mr Chairman. Now, in the light of that, Ms White, what you say in the last paragraph - last sentence of paragraph 32 is just plainly wrong, is it?-- No.

You say there that the DON did not even have the courtesy to acknowledge receipt of your e-mail, but you accept now that you had a meeting with her within a few days after that on this topic and then corresponded with her by e-mail over the next couple of weeks?-- Yeah, I guess the outcome of it that nothing was ever done-----

That's a different matter?-- Yes.

Let's just look at the last sentence, paragraph 32. It is just not true to say that the DON did not have the courtesy to acknowledge receipt of your e-mail, assuming it wasn't a letter. It's not just true, is it? You met her and dealt with it?-- I guess because we didn't have an outcome. I

guess that was probably the reason why I had written that. But, no, I'm sorry, that's correct I - she had responded but-----

And what's more, it is just not true to say that she didn't respond to the concerns you raised, as you say in the last five or six, seven words of that line, is just not true? Isn't that right?-- Well, yes, the - what I'm saying is that there's still no - there's still no outcome. There's still no extra staff. There was still no-one looking and helping me.

Hang on?-- So I guess she responded but there was no action.

Yes?-- She had responded but there was no result.

It is just not true to say what you have said in that sentence, is it?-- Well, I guess not, no.

And what's worse, Ms White, may I suggest to you, is that you throw in the gratuitous phrase in the middle, "And of course she did not respond". That's what makes it worse. You know, this is just an exaggeration, isn't it, this particular aspect?-- Yeah, but I guess if you can understand my position at that time that I was requesting extra staff and I was expecting something to move very quickly and nothing was happening.

Yes. But-----?-- And I had staff who were constantly working long hours, doing lots of overtime, rosters were coming out and we were supposed to start this trial and I was getting nowhere.

Yeah, but, Ms White, this statement's not prepared back then, this statement's prepared to be put before this Commission on the basis that it is true, and you said in your evidence it was true and this particular part is just not true, more than not true, it's an exaggerated falsehood, isn't it?-- That's your opinion but it's - in my opinion that - what I am saying is that again I still had problems that weren't being addressed by the Director of Nursing, and at times when you did attempt to speak to her, she was not available.

But you accept, of course, that she had other people that she had to attend to apart from you?-- Of course.

Mmm. In fact, a lot of people that she had to attend to, apart from you?-- Well, we all had our own-----

Her-----

COMMISSIONER: How many unit managers were there reporting to the Director of Nursing?-- Approximately 15.

And-----

MR MORRISON: Plus-----?-- Not all with staff though.

Can I suggest if you add in all the other people that were -

reports that went in from the NUMs you get up to a total of 25 to 28 direct reports to the DON?-- No, not that many.

Okay. Now, let me just deal with something else you mentioned in your statement, paragraph 34. Just before I leave that, just before I leave that last topic, I just want to give you the opportunity to respond, if you wish to, to one final date in that sequence which I omitted to give you, and that is on the 24th of June Ms Mulligan attended the staff meeting in theatre, Vicky Smyth was there, and that was for the purpose of progressing the trial arrangements. You may not know about it or perhaps you may?-- I know about it. That was correct.

And it took place?-- Yes, it did.

All right. Now, you mention in paragraph 34 the grievance issue. Let me just ask you a couple of things about that. You knew when that issue was raised, didn't you, that there was a set process that had to be followed if someone initiated a formal grievance process?-- I knew there was a process.

And that that process is not confined to Queensland Health, but Statewide across the Public Service?-- Yes.

And that your protagonist, the nurse officer level 1 who had complained, had initiated that formal process?-- Yes, he had.

And if somebody initiated that formal process it was not up to someone like Linda Mulligan to ignore it or to put it to one side or to forget it, she had to follow the process, didn't she?-- I guess. In the past if you looked at Directors of Nursing, that approach wouldn't have taken place.

It-----?-- That there would have been - mediation would have been the first step and not just straight to investigation, and Linda, I feel, had-----

Jumped past mediation?-- Jumped quite a few steps.

Jumped past mediation for a start?-- Yes.

All right?-- Yes.

Let's look at a couple of documents. Can we actually look at this one first on the screen? Just before you put it on, the name of the protagonist is on this document. I don't know whether that's a matter you need to deal with or not.

COMMISSIONER: The only ruling I have made or been asked to make relates to patients' names.

MR MORRISON: I am not urging any course.

COMMISSIONER: No. I mean, it may be that Mr Allen represents the - I think it was a male nurse, the gentleman in question.

MR MORRISON: Perhaps if I could take a second I will speak to him.

COMMISSIONER: Yes.

MR MORRISON: Apparently it's not a problem.

COMMISSIONER: Yes.

MR MORRISON: Thank you, Mr Allen. Now, the purpose of showing you this document, Ms Smyth - Ms White, I'm sorry, is to show you the front. Can you turn the document to the next page, Mr Operator? You recognise this as the grievance form?-- Yes, I do.

And you see it's date-stamped the 1st of April?-- Yes, I do.

Can I ask you to assume with me, please, that that's the date stamp of Ms Mulligan's office. Pausing there, Mr Operator, you will see it's also dated the 1st of April in the typing at the top?-- Mmm-hmm.

All right. Now, I don't particularly wish to show you any bits of it. The grievance concerned in short order something to do with not letting that nurse officer act up in a more senior position?-- That's correct.

Matters of that sort. All right. Now, can I ask you to look at this document, please. I'm content to tender these or not.

COMMISSIONER: I will leave it entirely to you. I certainly don't want to clog the record with these things.

MR MORRISON: No, I don't think it's necessary. I just want you to look at this document, please, Ms Smyth, which is the letter from Linda Mulligan to Mr van Zanten and you will see it's on the 2nd of April, so it's the next day. I want you to concentrate, please, on the second paragraph. "Thank you for meeting with the Manager, Human Resources and Payroll Services and myself today to assist in determining whether mediation is likely to resolve the grievance. The District rejects your view that mediation is unlikely to assist in resolving the grievance and will now proceed to the stage of investigation." Doesn't it explain that in - albeit with Mr van Zanten the question of mediation was raised and Mr van Zanten did not think that mediation would help?

COMMISSIONER: Were you ever shown this document or-----?-- No.

This is a mystery to you?-- Mmm.

All right?-- After the investigation and the report was made and I was found - you know, there was a 13 page report to find that I was not guilty of any of these allegations, I was told that it was an expectation of Queensland Health by Linda Mulligan, that it was an expectation of Queensland Health that I attend mediation with this person.

When you are cleared of these all allegation?-- There are two

different stories here.

MR MORRISON: We will come to that in a moment, if I may. I intend to come to that question.

COMMISSIONER: Indeed, yes, then. But just dealing with this document, it may well be the case, as Mr Morrison is saying, that someone, whether it was Mrs Mulligan or someone else, canvassed with Mr van Zanten the option of mediation and he said that believe that that was successful by not letting that nurse act up in that position.

But your evidence is that at the early stage you weren't given that option and you weren't told that that option had been canvassed?-- No.

You were simply told that a complaint was made and it was going to be investigated?-- Yes, she just handed that previous document that has been put to the Commission to me across the desk.

MR MORRISON: But would you agree with me that if she had, in conjunction with the Human Resources officer, met van Zanten and van Zanten thought - or was of the view that mediation was no good, that might explain why mediation wasn't attempted at the start. Would you agree?-- But how would I know that?

COMMISSIONER: I think the point, Mr Morrison, that's being made is that Ms White should at least have been given that information, been told that, "Here's the complaint. We've canvassed mediation and van Zanten doesn't want mediation. So it's now going to proceed as an investigation."

MR MORRISON: All right. That may be so, but I'm asking you, as it were, a hypothetical. You need two parties to mediate, don't you. There's no point one of you turning up and the other not?-- No.

Okay. And so if one of you wants to mediate and the other doesn't, it's all a bit pointless to try and mediate, isn't it?-- That's true.

So if you thought mediation was a good idea and van Zanten thought it was a bad idea, then it's not really-----?-- Yes, but what I'm saying is I was not given that option. I was told at the end of all the allegations, the report, that it was an expectation of Queensland Health. So as a Level 3, I was told it was my expectation that I should attend mediation, when at that particular time I could not see the sense in it because - but I was told it was an expectation of Queensland Health, so I just went ahead and attended the mediation. Now, is there double standards? Isn't an expectation that mediation should be looked at as a first for all nurses?

But-----?-- It's an expectation of Queensland Health that this is the process?

But isn't it clear to you-----?-- Well, I feel that I was intimidated that I had to go to mediation, so, you know - I mean, this is where I'm coming from.

But if this letter is right, isn't it clear that mediation was examined and one party wasn't willing to be party to a mediation?

COMMISSIONER: Mr Morrison, the point being made is that later on when Ms White wasn't keen to mediate, she was told that she had to. Now, you said you were going to come to that, so let's come to that.

MR MORRISON: And we will. And we will. Can you look at - it may already be tendered. I'll tender that. Yes, I'll tender that letter to Mr van Zanten dated 2 April '04

COMMISSIONER: The letter of the 2nd of April 2004 from Mrs Mulligan to Mr van Zanten will be Exhibit 79.

ADMITTED AND MARKED "EXHIBIT 79"

MR MORRISON: And I think the letter to Ms White was tendered - I don't remember - of the same date. I just don't remember its exhibit number. It's on the screen now, in any event.

COMMISSIONER: Exhibit 73.

MR MORRISON: Thank you. This is the letter that you received, and you would have noted on Mr van Zanten's letter - you probably don't need to go back to it, but each of you was told what's in the last paragraph on that first page, "To ensure the integrity of investigations" and so forth. Each of you was given that information?-- Yes.

Now - and you will see in that letter that two people had been appointed to conduct the investigation?-- That's true.

That's Ms Fritz and Ann Robinson. Ms Mulligan was not going to be conducting the investigation at all?-- No.

So isn't it - in the light of that, you can hardly criticise her for not taking into account your unblemished record of 18 and a half years of service. She wasn't conducting the investigation?-- No, but I guess as a Director of Nursing, before - when they were - when it was at the initial mediation stage, maybe if there was some discussions and she had bothered to set up a meeting between Albert van Zanten and myself, maybe this was not necessary. That would have been the approach - the normal approach that I have experienced with - in other situations, that normally if there is a problem between two staff, that they sit down and discuss it, and if they can't, they go to the next line manager and they sit down and discuss it, before it becomes a formal investigation and that process.

Had Mr Van Zanten raised these issues with you before he started this process?-- No, no. He had brought to me - he was on our Workplace Committee - Workloads Committee at the hospital, and he had brought to that committee many instances of complaints about excessive workloads.

Now, once the process is initiated though, you agree that it's not for Ms Mulligan to ignore it?-- No, but I think that in normal - what I would have expected in the past from other Directors of Nursing, and nursing directors of the future, that they will sit down with the staff and talk to them. This

is about communication, isn't it? And this is where I felt - I just said it was a heavy-handed approach. That was in my notes.

But if Mr van Zanten had initiated the grievance process under the policies, don't you agree that once he's done that, it's not for Ms Mulligan to ignore it. She's not allowed to.

COMMISSIONER: No-one's suggesting that she ignore it. I think that's where you and the witness are at cross-purposes. I think the witness is simply saying that after so many years in the job she was entitled to be treated with a bit more courtesy than being handed a piece of paper saying, "There's this investigation under way." Now, if you want to suggest that that's not how it happened, then that's entirely a matter for you, but I think the answer has repeatedly been she didn't like the way it was done. She's not arguing with Ms Mulligan's duty to follow the standard protocols.

MR MORRISON: On 2 April, when you were given that letter, you met Ms Mulligan. She explained to you what was happening?-- She did.

She gave you a description of the process?-- She did.

She listened to your comments about this matter and what she'd just said to you. You had some comments to make?-- Well, when someone has just handed this - you're in a state - as a nurse - I was in a state of shock.

Did you make some comments to her?-- I was distressed. I can't even remember what I said to her. I was quite distressed.

You may not remember. I'm not interested in the content of it. Did you make some comments to her about the process and/or the justification or otherwise of what van Zanten was saying?-- I said - at that particular time I got - my mind was in a blur. I'd just received something that I was going to be investigated on. I really didn't understand what my role - what the process for me was then. I guess I was quite confused. I was very upset.

Okay. In fact the report cleared you entirely?-- Yes, it did.

Didn't it?-- Yes.

And what happened after that was that Mrs Wallace became involved. Is that right?-- Yes, for mediation.

And in fact Mrs Wallace called both - certainly called you - you may not know whether she called van Zanten, but called you to see whether you were willing to proceed with mediation and you agreed?-- That was after Linda Mulligan had told me it was an expectation of Queensland Health that I attend mediation.

And the outcome of that mediation was unsatisfactory because van Zanten continued to assert that he was right and the findings were wrong?-- That's correct.

COMMISSIONER: What was the point of having a mediation when they'd already found in your favour?-- Well-----

Your evidence is that you were told that you were under an expectation to go?-- That's true.

MR MORRISON: Mrs Wallace - okay, you say yes, you did agree to that, but after being told it was an expectation of Queensland Health. Now, the purpose of the mediation would have been apparent to you, would it not? You each had to work with each other. You were both in the same area?-- That's true.

He'd had what he thought was a justifiable grievance, it had been aired and he'd lost, and he was still bitter, thought that he was right, and you both had to work together. Was that not the evident purpose of the mediation, to see if you could - somehow the differences between you could be patted down so you could work together? Ultimately it failed, but was that not the evident purpose?-- Ultimately it failed. I guess that was probably the purpose, but very early in the mediation session when Albert said well, he didn't believe any of the report and thought it was just lies-----

So it became pointless?-- -----he also told Tina Wallace that he was going to leave the employment of Queensland Health.

Well, as I say, the process of the mediation part became fruitless because of him, probably a pretty good pointer to the fact it would have been fruitless right at the start. Would you agree?-- No, I don't believe so.

One last thing I want to talk to you about is the question of your departure which you ascribe - that is from the NUM position - in paragraph 35 - can I ask you to look at this document, please? Do you recognise your signature?-- Yes.

This is your resignation letter. Is that correct?-- Yes.

I tender it.

COMMISSIONER: The letter of resignation of 19 July 2004 will be Exhibit 80.

ADMITTED AND MARKED "EXHIBIT 80"

MR MORRISON: Just so that you've got an opportunity if you wish it, can I draw your attention to the fact that in that letter you don't cite no support being shown by management. What you say is, "There are personal, health and family

reasons". That's true, isn't it?-- That's what I've stated, yes, but what else would you do? I mean, after what I'd been through, what would you expect me to do?

MR MORRISON: Thank you. I have nothing further, Commissioner.

COMMISSIONER: Thank you. Mr Diehm?

MR DIEHM: Thank you, Commissioner.

CROSS-EXAMINATION:

MR DIEHM: Ms White, I wanted to ask you some questions about the ASPIC Committee meeting of 19 April 2004. It's dealt with particularly in your statement at paragraphs 19 and 21. You talk there about what was discussed concerning wound dehiscence. If I can ask you to look at a document which I'll ask to be put on the screen-----

COMMISSIONER: Ms White, while that's being put on the screen, Mr Diehm of counsel is representing Dr Keating in these proceedings.

MR DIEHM: Thank you, Commissioner. I neglected to do that when I ought. The first of those two pages that I have handed to the assistant there, if we go down towards the bottom of the page you see an entry there, and if we can move just a little to the other side so that we can pick up "wound dehiscence" in the left-hand column, if we just stop there, and you can see the corresponding part in the middle section that starts with the word "concern". Did you pick up that that's the part that deals with wound dehiscence?-- Mmm hmm.

If I can just ask you to read to yourself what appears on that document at that page. Tell me when you get to the end?-- Can I just see the bottom of it?

It goes over the page, so I'll get the next page put on, if I may?-- I want to see the bottom of the first page.

That is the bottom of the first page, "sent to", and then it goes over to the next page, "DQDSU"?-- Yes.

"A definition of wound dehiscence was also requested."?-- Yes.

Does that minute fit with your recollection about what was discussed-----?-- Which meeting was this?

This is April 2004?-- Okay, yes.

That fits with your recollection of what was discussed at that meeting?-- Yes.

Now, in your statement you tell us, firstly in paragraph 19, after referring to Dr Patel and Dr Keating laughing at Di Jenkins for raising her concerns, you say that, "Dr Patel became angry and suggested that nurses, including those present, needed to have some education to understand what constitutes a wound dehiscence." We can see something about the topic in the sense that the last part of the minute talks about a definition of wound dehiscence being requested. Is that the flavour of what you're talking about occurred at that meeting?-- Mmm hmm.

And you also tell us in paragraph 21 that, "There was general discussion following which it was agreed Di Jenkins would research the definition of 'wound dehiscence', conduct a chart audit and prepare a report", and you were to supply her with the data. It seems that you and others were proposed to supply information for those purposes?-- That's correct, yes.

Again that was something that was clearly discussed at the meeting?-- Yes.

You've told us, and I just brushed over it at the start there, that when the topic was first raised by Di Jenkins, that Dr Patel and Dr Keating laughed at Di Jenkins for raising those concerns. That's something that you clearly remember, is it?-- Yes, and it's something that you wouldn't document in minutes.

No. But it's something you wouldn't forget happening either?-- No, and neither would the other Nurse Unit Managers that were present.

Because it was particularly offensive-----?-- Yes.

-----for them to do that, wasn't it? That's what you say?-- Yes.

Now-----?-- It was doubting our integrity.

I just want to try and get a clear picture of what's occurred at this meeting. I take it people are sitting around a table in a meeting room somewhere, are they?-- Yes.

And were Dr Patel and Dr Keating sitting near each other?-- I can't remember, I'm sorry.

You can't remember?-- No.

But you can clearly recall it was both of them that laughed at the suggestion?-- Mmm hmm.

Can I ask you to look at this page-----

D COMMISSIONER VIDER: Excuse me, just before that goes off, that's prompted me to ask something about the collection of data. I'm prompted by the fact that in here, if you are going to capture data by looking at the patient records - at the

charts, and pick something up from coding - and we've seen the record of a patient whereby there's been an amendment to the documentation as in the word "dehiscence" was crossed out and "infection" put in?-- Yes.

Which means the Discharge Summary would not contain the word "dehiscence" maybe. I'm wondering if you would be able to comment if you're aware that there were other situations where the documentation in the chart might not have been an accurate reflection for the coders to pick that up, and going just by, therefore, the coding number, you wouldn't necessarily pick up accurately the number of wound dehiscences?-- Well, that's true, but when the patient leaves theatre the chart goes to the ward, and the theatre staff don't have access to those charts once the patient has gone to the ward.

No, I understand that. I was just asking whether or not you were ever aware that that documentation that we saw with the patient's chart previously may have been repeated elsewhere, in which case you wouldn't pick it up. The coding wouldn't reflect wound dehiscence?-- No, it wouldn't.

Thank you.

MR DIEHM: Thank you, Deputy Commissioner. Ms White, if I could ask you to look at this document now - or this part of the same document. I'll have it put up on the screen. This is the front page of the minutes of the April 2004 meeting, and if I can ask you to focus your attention upon the statements in the "Present" and "Apologies" section for the meeting. You'll see that apologies were given for Dr Patel for that meeting?-- Meaning that my recollection of the particular meeting where they laughed at the issue of wound dehiscence was a meeting prior to this meeting.

Which meeting was the topic of wound dehiscence - which of the ASPIC meetings was the topic of wound dehiscence raised for the first time?-- I'm sorry, but I can't be sure. It's obvious from the documentation.

Well, I'm suggesting to you that there is a better explanation for the inconsistency between your evidence in the statement of what Dr Patel and Dr Keating said when the issue was raised and what the minutes show, and that is that what you say is wrong. It did not happen?-- Well, I think you need to look at the evidence of the other Nurse Unit Managers that were at an ASPIC meeting where wound dehiscence was brought up and we were laughed at by the Director of Medical Services and the Director of Surgery.

Ms Aylmer is one of the nursing staff who had concerns about wound dehiscence, isn't she?-- Yes, she was.

Her evidence to this Commission is that when she raised the topic of wound dehiscence from time to time and her concerns about increases in it, or increases in infection, that Dr Keating was, to her and for her in front of others, supportive of her concerns and initiatives. That's not your

experience, you say, of the way Dr Keating behaved?-- Not at that particular meeting.

Well, I put it to you that it is just a nonsense to say that when the topic was raised at the ASPIC Committee meeting, whenever, that Dr Keating laughed at the topic being raised?-- That may be what you believe, but I think if you ask the other Nurse Unit Managers, that they will verify that we were laughed at.

You see, if - and I can take you back to the document. The topic of wound dehiscence at the April 2004 meeting is the second item under the heading of "New business" - and again I can take you to the documents if you need to see them. When the topic of wound dehiscence was canvassed by the ASPIC Committee in May, June, August and October, it was shown as "Business arising" from previous minutes?-- Whether that initial discussion that we had about wound dehiscence with the nurse managers was not documented, I don't know. I can't say, I'm sorry. But if you ask the other Nurse Unit Managers they will tell you that I am speaking honestly.

Commissioner, I tender, together with the page that's there, the minutes for the meeting of the ASPIC committee in April 2004. Perhaps they can become part of the bundle of minutes for May to October that were tendered earlier this week.

COMMISSIONER: If you don't mind, I think I'll make it separate because it will just keep the record so much simpler if we know where this comes up. The minutes of the ASPIC Clinical Forum of 14 April 2004 will be Exhibit 81.

ADMITTED AND MARKED "EXHIBIT 81"

MR DIEHM: Ms White, further into your statement you say - it's in paragraph 22 - that at the June 2004 meeting it was suggested by Dr Patel that the ICD-10 code for identifying wound dehiscence should be used?-- I believe so, yes.

And you say that Dr Patel also commented that if you do a lot of operations you'll have an increased likelihood of wound dehiscence, or words to this effect?-- I do remember him saying that.

I'm sorry?-- I do remember him saying that.

I suggest to you that Dr Patel was not present at the June 2004 ASPIC Committee meeting, and if you have any doubt about it, by all means I'll take you to the exhibit?-- I'd have to look at the minutes.

All right. Perhaps, Commissioner, if the witness can see Exhibit 65, please.

COMMISSIONER: I don't think there's any point-----?-- I'd have to review my dates of when-----

You're accepting, as I understand it, that you might be quite erroneous about the dates that you've given for what happened at particular meetings?-- Because I did look up the dates of the ASPIC from the minutes. I did look up the meeting when I drafted my statement.

Let's make sure we've got this entirely right. When you made your statement, I assume this was done initially with the solicitors for the Queensland Nurses Union?-- Yes, I did review the minutes of the ASPIC meeting and I tried to put in my memory-----

Please, please. A lot of it was reconstruction, you were remembering events happening and then trying to work out-----?-- That's true.

-----retrospectively the date of the meeting where those things happened?-- Yes.

And your evidence is that you're confident these things happened, but it may be that you did-----?-- The dates may be wrong.

You may have the wrong meeting?-- Yes.

MR DIEHM: Thank you, Commissioner. The meeting, though, where Dr Keating laughed at the topic being raised by Di Jenkins about wound dehiscence was the first meeting where the topic was raised. Is that your evidence?-- Yes, I'm sure it was.

And he laughed in company with Dr Patel?-- Yes.

Can I ask you briefly about - it seems a long time ago now, Ms White, but you were asked some questions earlier today concerning the policy described as a draft policy in an email from February of this year that was put up on the screen and became an exhibit, but a policy concerning cancellation of elective surgery that was scheduled. It's already been gone over at some length. I just want to put this to you: prior to the implementation of that policy or draft policy, if that is what you want to call it, the system was that the Nurse Unit Manager had the sole say over the cancellation of elective surgery. Is that right?-- No.

I'm sorry, who was it that had the say over whether elective surgery was to be cancelled?-- When I'd come to - the Nurse Unit Manager - when I'd come to work and I would - there'd be a problem with beds or a problem with staff off on fatigue leave, I would consult with Dr Carter, the Director of Anaesthetics, and I'd also consult with the two consultants whose lists - the three consultants whose lists were scheduled. I wasn't the sole person that would make those sorts of decisions about cancelling these-----

In practical terms, that's what you did about the problem, but you were charged with the responsibility of doing that?-- I guess because the day had started, you had staff waiting to collect patients, I had staff in the operating theatres getting theatres ready. In general, if you don't know which lists you are going to do and which patients would have to be either delayed or rescheduled or some other alternative, someone has to take the initiative, you know, in the patient's interests, to decide what's going to happen, and often the surgeons may not be in the operating theatre at that time of the morning at 8 o'clock or quarter to 8, and usually the Director of Anaesthetics usually arrived at 10 to 8 or 8 o'clock, and he was usually my first port of call to say we had a problem, and then he would - we would consult with the surgeons, and often if it was, say, the gynae team or orthopaedic team that had been working into the night, often that would be the list that would be most likely to be rescheduled.

The new policy did prescribe, did it not, that what was required before a patient - an elective surgery patient would be cancelled - sorry, not that the patient would be cancelled, the surgery would be cancelled - what would be required would be there would be consultation, planning, co-ordination, as it were, between the Nurse Unit Manager, the Director of Surgery and the Director of Anaesthetics?-- That's true.

Now, you would say that that's effectively what you were doing before, anyway?-- Not so much, because you would also consult with the other two surgeons that had lists running that morning.

All right. Ms White, another miscellaneous question, if I may, concerning VMOs for general surgery? During the years 2003 and 2004 and, indeed, into early 2005, there were a number of VMOs who were general surgeons performing work at the Bundaberg Hospital, were there not, and if I could help you by making some suggestions: Dr Anderson, Dr Kingston and Dr De Lacy?-- Yes, I did mention them.

Can I ask you a question about the events described in paragraph 26 of your statement, and these are the events concerning the patient upon whom the wrong procedure was performed, and again this has been gone through at some length already today, and I'm not going to go through each of those again, but the long and the short of it is that after that problem arose, the matter was investigated by senior management, including Dr Keating, and that resulted in a number of nurses from the relevant area of the hospital getting together, having a discussion, analysing what had occurred, why it had gone wrong and what they needed to do to fix the problem so it didn't happen again in the future?-- That's true.

And if I were to suggest to you that Dr Patel was spoken to by Dr Keating about his involvement in the matter-----?-- I couldn't-----

----- you don't have any knowledge about that one way or the other?-- No.

One thing you might have knowledge about, though, is that after the event, the topic of what had occurred on that day was openly and, on a number of occasions, discussed at various meetings of clinical personnel with a view to making sure that everybody learned from mistakes that had been made on that day?-- I would assume that would happen, yes.

All right. Now, concerning the events described in paragraph 28 of your statement, and these are the events concerning the motor vehicle accident that Dr Patel was, in your words, trying to emulate a M*A*S*H surgeon with respect to, I want to ask whether you know of any of these matters: that the initial contact with the hospital concerning that accident came from the emergency services, i.e. the ambulance or State Emergency Services, other personnel of that kind who were involved in the immediate effects and attempts at rescue of the patient at the scene of the car accident; do you know anything about that?-- No, I wasn't informed, but I would assume that that's what would happen.

That the initial contact was with the hospital's Department of Emergency Medicine?-- That's the normal port of call.

That the Department, in turn, dispatched one of its personnel to the scene of the accident, complete with a supply of various drugs that might be needed for the patient at the scene of the accident?-- I have no knowledge of that.

That what was requested by the emergency services personnel was that the hospital send a surgeon out to the scene because of a concern that the person involved was trapped inside the vehicle, may be in a critical condition, and may need to be removed from the vehicle urgently, that that might require an amputation to be performed and that they would prefer it to be done by a surgeon rather than one of them attempting to achieve such a result. Do you know anything about that?-- No, I'm sorry, I don't.

The Department of Emergency Medicine involved Dr Keating and also contacted Dr Patel and that whilst the usual course that was followed under the policy that affected these sorts of situations was that a doctor would not be sent to the scene, that policy, in writing, allowed for the exercise of discretion where it was thought necessary; do you know anything about that?-- I guess that would be part of the disaster plan in an event that would happen, yes.

Because, indeed, that did happen when it came to the tilt train accident, didn't it - a doctor and a nurse were dispatched from the hospital out to the scene?-- I assume that would happen, but I've got no-----

You don't know of that happening?-- No, I did not have a report on the disaster or anything; same as I didn't have a

report on the disaster when Dr Patel went out for this particular episode. I didn't receive a report.

Okay. The situation with respect to what you complain about in paragraph 28 or what you express concern about is really one where you knew a little bit of what was going on, but certainly had no idea about the whole picture?-- No. I mean, our part was fairly small in it. I guess it was the entourage that was going out to the crash scene was probably the thing that was - that did concern me, because it is not necessary to send that amount of people.

Are you sure it was two Principal House Officers that were going to go with Dr Patel, and not just one?-- I'm sure there were two.

Are you sure there were two interns?-- Yes, I am.

How many interns were there at the hospital at that time?-- There should have been two for both the surgical team-----

If I were to suggest to you there was one intern in Surgery and one intern in the Department of Medicine, does that sound right to you?-- I'm not - I couldn't - you know - I'm sure that there was a considerable amount of people that came with Dr Patel, all dressed in scrubs, came out of the lift, with Dr Patel jumping up and down asking me to get - where the equipment was.

Okay, there were a lot of people?-- A lot of people.

You couldn't be certain whether there was, in fact, two of each of these people, like Noah's Ark, going out with him?-- There were six people and I felt that that was an extreme.

In paragraph 30 of your statement, you say at the conclusion of it that, "I did not approach him" - being a reference to Dr Patel - "or complain to management about his behaviour because I did not have any support from management; in particular, the Director of Nursing and the Director of Medical Services." You then in paragraph 31 go on to say, "It was extremely difficult for me as the Nurse Unit Manager to gain face to face access" - presumably it should be with either the Director of Nursing or the Director of Medical Services - "to voice my concern and those of the medical staff." Now, you have told us that prior to the arrival of Dr Keating at the hospital, the system had been changed, such that you no longer had a direct line of communication to the hierarchy with the Director of Medical Services, because that role was now fulfilled by the Elective Surgery Manager?-- Mmm.

It is true, though, is it not, that during the time of Dr Keating's tenure as Director of Medical Services, you had frequent communications with him?-- What would you call "frequent"?

Well, I can't put numbers on it for you, but that you would -

one thing I would put numbers on for you is that the TMG - that's the Theatre Management Group, is it-----?-- Yes.

-----if I am recalling the full name correctly, that was a committee that met once a month, was it not?-- Yes.

You were on that committee and Dr Keating was on that committee?-- Yes.

That was some contact you had with him every month?-- Yes, if the meeting was on or we were both at that meeting.

You would send E-mails to Dr Keating from time to time, would you not?-- No, not on a regular basis, no.

When you needed to, you would send an E-mail to Dr Keating, would you not?-- I think my E-mails to Dr Keating would have been quite rare.

Because you didn't often need to send him E-mails?-- I guess that there didn't appear to be the avenue to actually-----

What do you mean by that - "there didn't appear to be the avenue"?-- Well, I guess that he never came to my office to discuss anything with me - there was not any two-way communication between the two of us.

Did you ring him up from time to time?-- Rarely.

When you needed to?-- No, I probably went more so to the Director of Nursing rather than-----

You would go to the Director of Nursing because that was your line manager-----?-- Line manager.

But if you needed to go to Dr Keating, then you could ring him up, could you not?-- There was an avenue to do that, yes, but I guess I didn't use that avenue very much.

Not very much because you didn't need to do it very much?-- I guess that - not so much that I didn't need to, I guess I didn't feel comfortable, I suppose.

Why didn't you feel comfortable?-- I guess previous directors of medical services had more of an involvement in the operating theatre and Dr Keating really didn't - wasn't very much involved in the day-to-day - you know, in the day-to-day running of the operating theatre. Most of his attention was directed to the Elective Surgery Coordinator.

Yes. Right. Dr Keating wasn't responsible for the day-to-day operation of the surgical theatre, though, was he?-- No, that's true.

All right. Tell me, on the occasions when you did telephone Dr Keating, rare as that may have been, did he take your calls?-- Look, I'm sorry, I couldn't answer that. I mean-----

COMMISSIONER: Can you answer this: was there ever an occasion when you needed to call Dr Keating and you were unable to get through to him?-- There could have been. I can't remember.

You can't recall any occasion when you needed to speak to Dr Keating-----?-- If I didn't, I would have left a message and hoped that he replied - called me back.

It comes across in your statement as if you had a problem making contact with Dr Keating and from what you are now saying it sounds as if there rarely wasn't a problem with making contact with Dr Keating at all; is that right?-- Well, I guess it is the same thing; when you do want to call these people, you go through the barrage of questions from the clerical assistants as to what you want to meet with someone for.

Do you want to take that up?

WITNESS: That puts you off.

MR DIEHM: Yes. Did you experience that with attempts to contact Dr Keating?-- Yes, you are still asked a barrage of questions before.

Who asked a barrage of questions?-- The clerical staff.

The clerical staff. Can you remember specific instances of this happening?-- No, not off the top of my head, I can't.

Can you remember who the clerical staff were or was - if it was one individual - that would do this?-- There is a variety of people who work in that area.

Whatever questioning they may have had for you, you still got to speak to Dr Keating, did you not?-- Yes.

All right. How long did this barrage of questioning go on for?-- I'm not sure.

What sort of questions were you asked?-- Why you want to speak to someone - just typical questions.

Anything else?-- "How long will you be?", and, "How long do you expect to take?", and those sorts of questions.

That's the one question, isn't it, "How long will it take?", and, "What do you want to talk to him about?"?-- Mmm.

Is that it?-- There's probably other questions. I'm sorry, I can't remember off the top of my head.

You see, you are making statements here, I would suggest, that Dr Keating either advertently or inadvertently set up a wall, as it were, to stop communication with you; so it is rather important for this inquiry to hear some detail about what you

mean of those things?-- Well, I guess if you look at - if you set up not so much a wall - it is not referring to Dr Keating, but it is the system that, as a Nurse Unit Manager, in the past, as I explained, there was an open-door policy whereby you could call the Director of Medical Services, you could talk to them about a problem you may have had with a surgeon or you may have had a problem with equipment, and in the past I had always experienced good communication, and I'm just saying now that the Elective Surgery Coordinator was - seemed to be the contact for the Director of Medical Services. I didn't feel I had that avenue to discuss things with Dr Keating.

You used it when you thought you needed to?-- I probably avoided using it.

COMMISSIONER: It is not Dr Keating's fault at all; you chose not to use the system?-- I guess because - because of the way the system had evolved.

But Dr Keating didn't set up the system?-- No. I didn't say that in the first place.

I'm sorry if I'm sounding ill-tempered, but I said earlier today, you know, if there's problems with the system, we need to know about them. This Inquiry isn't going to make findings about whether someone's management practices were good or bad. You know, we can't descend into that sort of minute detail, but if the fact is that Dr Keating was working in accordance with an existing system, I don't see that there's any scope to criticise him, and we might as well move on to something else. You are not - your evidence is that you don't suggest Dr Keating did anything that was inconsistent with what you understood to be the established system?-- Mmm.

All right. Are you happy with that?

MR DIEHM: Yes.

COMMISSIONER: Thank you.

MR DIEHM: Ms White - I'm hoping that I'm going to finish, Commissioner - just concerning the patients that you have mentioned in paragraph 36 onwards of your statement under the general heading of your dealing with Dr Patel from August 2004, you did understand at those times that there was a policy and a process in place by which, if there was an adverse event in surgery, that it was open to you as a clinical nurse involved in the procedure to report the adverse event; is that right?-- No.

Were you unaware of any policy in existence at those times concerning the reporting of adverse events in surgery?-----

COMMISSIONER: Those times mean October onwards - October last year onwards.

MR DIEHM: August 2004 onwards.

COMMISSIONER: The last 10 or 11 months?-- The Adverse Event Form was in existence, you are talking about?

MR DIEHM: Well, let's start with that. Were you aware there was an adverse event form in existence in those times?-- Well, again, I don't know what you are driving at because-----

COMMISSIONER: Don't worry about what Mr Diehm is driving at. Mr Morrison only took you to these forms. You knew that a system was instituted?-- Yes. We had incident forms. We have had incident forms for a long time, but you will notice from the incident forms that we don't use the incident forms to document surgical techniques.

MR DIEHM: Yes. What I'm asking you about is something different from incident forms; Adverse Event Forms?-- Adverse event forms grew out of incident forms.

Grew out of them?-- They were developed.

Yes. So, they were a different form. They were a form designed to deal with, were they not, adverse events in surgery or other aspects of medical treatment?-- Or anything that happens in the hospital.

All right. You knew that those forms were in existence?-- Yes, I did.

And you knew that there was a policy supporting the reporting of those sorts of events by any member of staff, including the nurses, if they thought it was appropriate to do so?-- Yes.

But your evidence is that when these events occurred, for whatever reason, you didn't think it was appropriate for you to be reporting those events as adverse events?-- That's correct.

Thank you. Now, with respect to the information gathered - and I'm adverting to issues such as wound dehiscence here - you say when coders go through the records and record the information based on the coding system, they only look at the discharge summary. How familiar are you with the process of what coders do?-- Only basic information.

Sorry?-- Only basic information about the explanation of codes and how they work.

Sorry, I couldn't quite understand it?-- Just basic information about the codes.

About the codes?-- About the coder's job, no, I don't know to any great extent.

You don't know what the coders look for when they are going through these documents, do you?-- No, but I guess - I don't know that they go through the whole chart, as I said.

You don't know they do and you don't know they don't?-- Sorry, I really can't answer that.

Because my suggestion to you would be that they do, in fact, look through the whole record with respect to the patient, not just at the discharge summary, but you, I gather, don't know the answer to that?-- No.

Finally, you also mentioned in your evidence that you provided reports to the Director of Nursing on a monthly basis, I think, that included details about unplanned returns to theatre?-- Yes.

I suggest to you that you never gave such a report to Dr Keating?-- Those reports go to the Director of Nursing, and then I - they do go to the Finance Committee, which I assumed Dr Keating was on.

COMMISSIONER: You were not involved in handing them directly to Dr Keating?-- No.

MR DIEHM: Thank you, Commissioner.

MR MORRISON: Commissioner, can I ask a couple of questions as a matter of fairness, because it arose out of something I didn't get instructions on and it is fairness to the witness and not to myself that I'm talking about.

COMMISSIONER: Yes.

FURTHER CROSS-EXAMINATION:

MR MORRISON: Could you have a look at this document, Ms White? It is about the grievance process. On 6 May, did you receive this letter from Ms Mulligan attaching a copy of the investigation report for your information?-- Yes.

And saying in the last paragraph that she would discuss with you the options for mediation in relation to this matter in order to resolve any outstanding issues?-- Yes, that's correct.

And can I suggest to you that meeting occurred the next day on 7 May?-- Mmm.

And in that meeting, Ms Mulligan explained to you that she thought mediation would be a good idea because the two of you had to work together, but that she couldn't force it on you, it was up to you?-- No. She told me it was an expectation of Queensland Health that I attend mediation. That was part of the discussion.

And it is the fact, I think, at the end of that mediation process - at the end, notwithstanding Mr van Zanten's

attitude, you did agree on some things and signed off an agreement about some things?-- At mediation.

Yes?-- Yes, we did.

I'll tender that.

COMMISSIONER: Mr Morrison, I know it is not your client's fault, but I do wonder why someone who has been the subject of reasonably serious allegations, who has been the subject of an investigation, has been completely cleared, is then told that she's not allowed to tell anyone that she has been completely cleared because - it says that "ensures the integrity of the process for all those involved".

MR MORRISON: Commissioner, within your memory, I suspect, without identifying the person, you know of a certain counsel who used to be very proud of the fact he could reveal he left the partnership of a major firm in town and he couldn't reveal why. It is that sort of process. You can announce the result and not the contents. I think that's what that is about.

COMMISSIONER: Yes.

MR MORRISON: One last thing, Ms White: can I also suggest to you that when Tina Wallace was appointed as the mediator, she also said to you that it wasn't compulsory and you didn't have to do it; you agree with that?-- Yep.

Thank you.

COMMISSIONER: The letter of 6 May 2004, Ms Mulligan to Ms White, will be Exhibit 82.

ADMITTED AND MARKED "EXHIBIT 82"

COMMISSIONER: Many questions, Mr Farr?

MR FARR: Yes, Commissioner.

COMMISSIONER: Before we do that, Ms White, it has been quite a long day for all of us. We started at 9.30 and it is now close to 5 o'clock. We would normally finish at this time of day. Are you comfortable about continuing with your evidence?-- Yes, I am.

The risk is, as you can presumably guess, if you give barristers overnight to think about their questions, they will obviously think of a lot more, so if we finish tonight, we will probably finish sooner?-- Sounds good. Thank you.

COMMISSIONER: We will adjourn then for five minutes.

THE COMMISSION ADJOURNED AT 4.59 P.M.

THE COMMISSION RESUMED AT 5.06 P.M.

JENNIFER ANN WHITE, CONTINUING:

COMMISSIONER: Mr Farr?

MR FARR: Yes, thank you.

CROSS-EXAMINATION:

MR FARR: Ms White, can I take you back to the Adverse Event Reporting system? Do you recall that a system was introduced at the Bundaberg Base Hospital regarding the reporting of adverse events in February 2004?-- Yes.

And do you recall that accompanying the introduction of that system was a quite an intensive educational program for the staff of the hospital?-- I would like to look at the stats on how many theatre staff attended that particular inservice-----

Did you-----?-- -----because I'm not sure that everyone would have received it.

Right. Did you attend it?-- I don't think I did actually.

You knew about it?-- I can't remember.

You knew about it?-- I knew there was going to be a new form introduced.

Right?-- You know, changing, you know, incident forms to be more user friendly and, you know, to cover - so that people had a better understanding of documentation - documenting adverse events.

If you, for whatever reason - and it might have been quite a legitimate reason - but if you for some reason missed the educational sessions that were conducted, did you take any steps to find out what it was all about?-- Other than reading the information that came with the forms.

All right.

COMMISSIONER: Mr Farr, I'm sorry to interrupt you. It is getting late and I'm starting to get forgetful. I didn't ask Mr Ashton whether he had any questions.

MR ASHTON: I don't thank you, Commissioner

COMMISSIONER: I'm sure you would have let me know.

MR ASHTON: I'm sure I would have.

COMMISSIONER: I will also mention that Mr Farr, of counsel, is representing Queensland Health in these proceedings.

MR FARR: Sorry, I omitted that myself. I will ask you if you have seen this document, Ms White, if you wouldn't mind. Just show it to the witness to start off with, if you wouldn't mind. Have you seen that before?-- Yes, I have.

All right. Now, we can put that up on the screen so we can all see it, and just the first page, if you wouldn't mind. I might just scan it out a little, if we can. No, the other way. Now, this is the information pack - for want of a better term - that was produced and promulgated through the hospital regarding the introduction of this system in February 2004; would you agree with that?-- Yes.

This is the cover sheet of that pack?-- Mmm.

We can see in the top half of the document the "dos", if you like, and the ticks. If we then move down the page to the bottom half, the "don'ts", and we can see that the very first two don'ts are, "Do not use the Adverse Event Report as a gripe session" and "Don't blame individuals." No doubt those are sentiments that you agree with and I think you've, in fact, spoken of already?-- Yes.

All right. Could we then move onto the third page of that document. Just need to scan it out, thank you. I will give you the opportunity of reading that before I speak of it?-- Yes.

All right. Now, you concede there in the first paragraph, towards the end of the paragraph, it's highlighting that it's an approach that emphasises prevention, not punishment as its goal?-- Yes.

And that would have been your understanding, as I take it?-- Mmm. Yes.

As one looks down that explanation, we see in the third paragraph the comment, "We don't believe that people come to work to do a bad job, but given the right set of circumstances any of us can make a mistake." The last paragraph, of course, is using through understanding the real - this system to improve future performance. And, once again, all of those are sentiments that you would agree with, it would seem?-- Of course I do.

And these are the sentiments that were in existence from about February 2004, if not earlier, but certainly from then?-- Yes.

Now, the next page, we can see, is just a draft copy, if you like, of the form itself. We will just briefly put it on the screen so the people can see it. I think it humorously refers

to the patient as being Elvis Presley, but we can see the left-hand side of the page refers to the "Patient Adverse Event", and the right-hand side a "Staff Adverse Event", and no doubt your understanding of this was that this form was to cover a host of different situations?-- Yes, that's correct.

All right. Now, can we then go to the second last page? You will see at the top of that page "Categories of Adverse Events", and you will note that this list should not be viewed as a definitive list, there may be other events which require reporting that are not listed in this document. Again, you would have appreciated that fact?-- That's true.

Okay. If we can move down the page, however, we can see different categories of situations. Keep going a little bit further. You will see now towards the bottom of the page highlighted "Injury (including but not limited to)"; do you see that?-- Yes.

And then corresponding to that on the right-hand side, also highlighted for ease of reference, "Unintended Injury During Procedure"; do you see that there?-- Mmm.

And you would have understood that, no doubt, to include things such as during surgical procedures?-- Yes.

So, by using an example, if a bowel was nicked accidentally during the course of a surgery, that type of thing should fall within the parameters of this form?-- Yes, but I guess this form has only been around for a short - a short time and I think for nurses to come to terms that it is possible for them to actually document something that a surgeon has done, in real terms this is something that will take a long time to happen.

It's not a difficult concept though, you would agree with me, to fill in a form, for instance, if someone's bowel was accidentally cut during surgery?-- No, I guess it's probably the repercussions from someone completing that form. As I said, it will be a long time before nurses come to terms with being able to do that, that's my feeling.

I see. Do you mean to say by that that it's a long time for nurses to overcome this culture of us and them that you spoke of earlier?-- Yes, I think so.

All right. Do you accept that this system was certainly a step in the right direction to try and assist people to overcome that?-- Yes, it is a good step in the right direction.

D COMMISSIONER VIDER: Would you foresee a time when at the end of the case where something had happened that meets this criteria to be an adverse event, the nurse and the doctor involved with the case would be able to say, "This happened, this bowel - because this bowel has been nicked. We now need to report this in a particular fashion and come together and acknowledge that what you're reporting is the incident." Do

you think you would ever get to the stage-----?-- No, I don't. I really don't.

Do you think that you would need - I don't mean you personally - but do you think the culture of any work environment will ever get to the stage of acknowledging reporting the event has got to be separate from the personalities?-- That's true.

This is an incident that has occurred, it may have ramifications, it needs notification. With that understanding, as outlined in the preamble, actually as in no blame, et cetera?-- That's true.

That we need to work towards getting towards that sort of a working environment?-- It's something I would like to see happen, but I think it will take a long, long time for nurses and the doctors to get together on that issue, to be able to do that.

MR FARR: And don't for a second think that I'm suggesting that only nurses would need to complete such a form, this form was directed at all staff working in the hospital, wasn't it?-- Yes.

Whether it be nurses, doctors, or any other person for that matter?-- Yeah.

All right. I will tender that document.

COMMISSIONER: Thank you. Yes. Is that form the same one as that attached to the Raven statement, but this is a separate document of the package?

MR FARR: Yes.

COMMISSIONER: The bundle of pages headed "Adverse Event Reporting Instructions" will be Exhibit 83, and I think you suggested this dates from about February of last year?

MR FARR: Yes, it does. Thank you.

ADMITTED AND MARKED "EXHIBIT 83"

MR FARR: And just for completeness, can I ask you if you also agree with this: in about November of 2004, the system of Adverse Event Reporting had changed minimally, in that the person making the report was also asked to do the risk assessment at that stage?-- Yes.

And do you understand that to be in accordance with the Queensland Health policy that came in at that time?-- Yes.

Prior-----?-- But, again, I think we haven't - theatre staff haven't received, you know, too much education.

All right. Prior to November, the form would have been submitted and you agree the person to whom it was submitted would then do a calculation, which I won't bother you with?-- Yeah.

To assess the risk level?-- Yes.

But from November '04 onwards, that was then asked of the person making the report?-- Which probably that will make it harder for people to fill the forms out, because it involves more and more paperwork, which nurses do not - when you are working clinically, you really don't have a lot of time, so you've really got - if you can't do it when it happened, then you will lose it.

Right?-- And that's the important thing. I think the system has to be simplified and why would you - why can't someone else assess that risk? I think from a nursing point of view I think that should happen.

All right. Could the opposing point of view, however, be that the person best positioned to assess the nature of the risk is the person who witnesses the event?-- Yes, I guess that's probably true. But, again, it makes it an unwieldy system that you will find people will not fill in the forms.

There might be competing trains of thoughts perhaps in that regard; would you agree with that?-- Yes, I would.

Can I just briefly ask you just a couple of questions regarding the issue of wound dehiscence? We have heard the term "ICD-10" during the course of your evidence. Do you understand that that, in fact, stands for International Classification of Diseases?-- Yes.

Did you understand that?-- Yes.

And do you also understand that that is a classification system which is utilised for the classification of diseases worldwide?-- Yes, and that system gets updated quite frequently. I think we go to different numbers of codes.

That's right. It might be number 10 at the moment, I suspect?-- Yeah.

And I take it from your evidence that you, in fact, agree that that is a good source of definition for disease or issues medically?-- Yes.

Okay. Just in some small degree associated with that, you have spoken of an occasion when you witnessed an intern performing a closure operation, anastomosis?-- Yes.

Can I just ask you generally, is it part of the function in a surgical - in surgery that junior doctors or interns are sometimes asked to close? It's part of their training, if you like?-- That's true.

And please correct me if I am wrong, but my understanding is that as the intern or the junior doctor becomes more proficient at this type of thing, the level of supervision that is required would not be as great? By that I mean, the doctor rather than standing over him-----?-- You're talking from an intern to registrar level? At registrar level the supervision would be greatly reduced.

Sure?-- And perhaps, like, with Dr Patel in close proximity, but not necessarily scrubbing in.

I see?-- But to close anastomosis is a fairly technical procedure.

I know and understand what you say your criticisms are about this incident, but I'm just asking generally?-- Yeah.

And it's - again, correct me if I am wrong - but it's a discretion that the surgeon involved in the operation would have as to whether he would, A, allow the junior person to close or not?-- But I think an intern that has just finished, like, medical school and hasn't done a lot of suturing, to take on that technical task was very unusual. It was.

I'm not talking about that specific incident?-- Yes.

My question is: is it a discretionary matter for the surgeon in the circumstances of that particular surgery?-- Yes, it is. Yes, it is.

And you disagree with the discretion which was exercised on that particular occasion obviously?-- Based on the experience of the intern.

All right?-- I mean, if it was a PHO doing it, you know, it probably wouldn't have caught my attention.

All right. I will ask you this: on the topic of what you raise in paragraph 26 of your statement, the wrong operation being performed?-- Mmm.

It is obviously a very rare event, you have given evidence of that. Are you also aware of a policy from Queensland Health that is about to be rolled out - that is a term that has been used with me, so I will use it with you - on that topic? Have you any information about that yet?-- On the right site of surgery?

On steps that must be taken?-- Yes.

To ensure that the correct-----?-- Yes, we had inservice last Thursday morning.

Right. All right. And that is something that provides simply further checks and balances to ensure that that type of situation can't occur in the future?-- And, in general, checking in of the patient will include the surgeon.

Right?-- In the new policy.

Again, you would be of the view that is desirable?-- Yes, it is.

Now, we have heard some evidence from you regarding this Elective Surgery Program. Can I suggest to you that that program came into existence in 1996; does that sound right to you?-- Yeah. Yeah.

The effect of that program is that through the categorisation of patients awaiting elective surgery, the lists for surgery are determined?-- That's true.

We have heard some conversation in the course of your evidence today regarding the term "elective surgery". Do you know of any particular definition of that term yourself?-- Meaning that it's certainly not life threatening.

Can you tell me if you have heard this before: firstly, have you heard of the National Health Data Dictionary Version 12?-- Not specifically, no.

All right. Have you heard the term "elective care"?-- No.

Okay. Can I just read this to you and ask you if you would accept this term as being reasonable: "Elective care is defined as care that in the opinion of the treating clinician is necessary, and admission for which can be delayed for at least 24 hours", and further the definition of elective surgery is, "Elective care where the procedures required by patients are listed in the Surgery Operation Section of the Medicare Benefits Schedule Book, with the exclusion of specific procedures frequently done by non-surgical clinicians." Do those two definitions seem to accord with your understanding of the term?-- I guess they're new terms that have recently been developed and I'm not familiar with them.

All right?-- But it would appear that way.

Are you of the understanding that the term "elective surgery" has a common definition throughout Australia?-- Yes.

And are you of the understanding that at least one of the benefits of that is that the whole of Australia can compare data?-- That's true.

Knowing that they are comparing like with like?-- That's true.

Okay. Now, the preparation of the elective surgery lists, the lists themselves-----?-- Yes.

-----is, as I understand it, the result of a number of people getting together and determining what the list will be for a particular week or a particular day; do you understand that to

be the case?-- No. I guess it's the clerical support people who look at what lists - what surgeons are available when the patients are booked into their sessions from the big theatre booking forms.

I don't wish to be unfair to you. Is the way in which the lists are promulgated something about which you have very much knowledge?-- Over the years I have, yeah.

All right. Well, look, can I suggest this to you: that the lists are determined as a result of these people meeting at least weekly, sometimes daily: the Director of Anaesthetics, the Director of Surgery, the Nurse Unit Manager of Theatre, the Elective Surgery Coordinator and the Director of Medical Services?-- I think you will find that I've been at many of those meetings. It mainly includes the Elective Surgery Coordinator, Nurse Unit Manager of Theatre, and Director of Anaesthetics and Intensive Care, and at those meetings the lists that have been generated by the clerical staff are looked at under each speciality and under each day, and on checking those lists we have looked at the first sets of availability of the session to start with and the anaesthetist support for sessions, they have to try to plan, and then the content of those lists are also looked at, and from the Nurse Unit Manager's point of view, is to ensure you have got the correct equipment for the correct procedure at the correct time. Often if you are looking for equipment that is available from out of town, you obviously have to book that equipment for that procedure. But they don't generate the list any more. They basically just check the list. But, mind you, in real terms that I have seen that what is agreed to at that list doesn't happen the next week. There is quite a few changes made and often the Nurse Unit Manager was not informed of that.

I see?-- That's an ongoing problem.

That is what?-- That is an ongoing problem. That is a problem.

The preparation of the lists, as you have just indicated, is the result of having to look at a number of different things?-- Yes.

One of the matters that has to be looked at is the categorisation of the patients concerned?-- That's true.

The category one patients being those people who should have their procedure with a reasonably short period of time, it's serious. I think you said - six weeks I think you said in your evidence-in-chief?-- Yes.

In fact, is it the case that if the category 1 patients do not receive whatever the procedure is that they are awaiting within that limited period of time, that penalties can apply to the hospital concerned?-- Yes, I am aware of that.

Also, is it the case, of course, that one has to look at the people in the category 2 and in the category 3 areas to try and keep those lists moving as best one can?-- Yes.

And the effect of doing - looking at those things in conjunction with all of the matters that you have just been speaking of-----?-- Yes.

-----is the production ultimately of daily lists?-- Yes, that's correct.

All right. Would you agree with me that the most important consideration for all concerned is the welfare or the need for the category 1 patients to have their procedures performed?-- Yes, that's true.

And those meetings or those involved with the production of such lists prioritise that first and foremost?-- Yes.

It, I'd suggest to you, is not the case that surgery is performed with the priority of earning money out of it?-- Well, I guess that's where the hospital gets their funds from.

Yes. But have you ever been or seen at that meeting where that's been given the priority?-- No. Only when we haven't reached our elective surgery targets or, like, looking at them in March, that we're not going to meet our elective surgery targets and then money then has been discussed.

Money's - yes. But my question is-----?-- Funding has been discussed, I'm sorry.

I understand that, that there is this budgetary consideration?-- Yes.

Okay. But I'm suggesting to you that notwithstanding any budgetary considerations, it is always the case that the patients' welfare is first and foremost?-- Well-----

Do you agree with that, and if you don't please tell me?-- No, I guess in most instances that does happen but there has been occasions where we have had blitzes.

Where we have had?-- We have had concentrated efforts to do certain procedures in one week.

Yes?-- Which I described before.

Right?-- Whereby we either have to do extra work without any extra staff to meet the category 1 patients and put on extra sessions, our extra lists, but in general there is never any extra staff to do that.

Does that then mean that there are, for instance, people in category 1 who are just pushed aside who would otherwise be operated on?-- I guess their waiting time may be extended a week. I couldn't really say.

You don't know?-- No, at that particular time, but-----

If you don't know, please, I don't - not asking you to speculate on something you don't know, but I am asking you if you do know?-- No, I can't answer that honestly, no.

All right.

D COMMISSIONER VIDER: Can I just ask a question? In terms of some forward planning, then, in the operating theatre schedule, do you have a routine? Would you have X general surgical sessions per week on a regular basis?-- Yes, we do.

For example, would there be general surgery done on Mondays, all days Wednesdays-----?-- Yes, that's true.

-----Thursday afternoon, whatever, there's X number of orthopaedic sessions that are put aside, you will do urology, so that there's some routine?-- Yes, there is. There's an Operating Theatre Schedule.

Which translates through to some advance notice to patients as to when their likely admission is?-- Yes.

And when their surgery is?-- Yes.

So that is scheduled?-- Yes, it is.

And follows a routine?-- Yes, it does.

MR FARR: Elective surgery targets each year vary, don't they?-- Yes, they do.

They can go up and they can go down?-- Yes.

And that has occurred in the past?-- Not to my knowledge. Generally surgery targets are increasing.

Is that something that you actually are provided information about?-- Not generally, no.

All right?-- Which makes it hard, as I said in earlier evidence, that when we are told in March that we haven't met our elective surgery targets and that everyone needs to pull together so that we meet our elective surgery targets, that impacts on nursing staff by - there is a concentrated effort that no elective category 1 patient would be cancelled, and so that members that - the staff have to work longer hours to do emergencies into the evening and into the night, and that's where we are having problems with fatigue leave and staff burn-out and increases in sick leave.

And that is an area, as I understand it, that Dr Patel, for

instance, was attempting to address in the course of producing that staff survey and the suggestion of having some evening sessions?-- Yes, but it wasn't - that wasn't going to achieve anything because we were only shifting hours and we were shifting hours when it suited Dr Patel.

But looking at the correspondence that has now been placed into exhibits which we have all seen today, it would seem to be that the staff - for instance, surgery staff were in agreement with this trial?-- Initially the theatre staff were in agreement but there was some concerns because - because - when the staff realised that we weren't going to get - they agreed first because they thought we were going to get more staff but when it came to the realisation that we weren't going to get any more staff, it was just hours being shifted, they couldn't see the point in shifting hours to suit Dr Patel.

All right. The extra funds, if you like, that are earned by way of conducting certain elective procedures-----?-- Yes.

-----you spoke of being weighted, is the term, the term weighted?-- Weighting separation.

Weighting separation. I understand that's a complicated method which I don't intend to go into because I don't understand it at the moment?-- Yes.

But the effect of it is that it's designed to be compensation for the length of time that a surgery might be in operation for a particular proceeding?-- Yes.

Is that your understanding of it?-- Yes.

And for a fairly straightforward procedure that might only take half an hour, it would be a lesser weight of separation. If it's a three hour procedure then it would be a greater weight of separation?-- Yes, it does.

Your understanding-----?-- Yes, it changes, yes.

COMMISSIONER: As I understand, it's not just length of time. That's one factor, but there's also complexity of the operation?-- Yes, it is.

Which may add to the time, of course, but that's another factor in the complexity, and another factor is the state of the health of the patient?-- Of the patient, yes.

MR FARR: Thank you. All of which - it's all designed to look at the cost associated with, if you like, the procedure itself?-- That's true.

All right. Now, can I ask you this. Just bear with me for one moment. There have been some questions asked of you in relation to VMOs. Are you aware of how many VMOs have been working at the Bundaberg Hospital for the past three years, 2000 - this year, last year, and the year before?-- Yes. I

can't recall all their names, no. Please don't ask me-----

I wouldn't expect you to. You were asked some questions a little while ago about surgeons, but just tell me if you agree with this, that in 2005 there are nine VMOs at the Bundaberg Hospital, 2004 there were 10, and 2003 there was seven. Does that accord with you understanding of it?

COMMISSIONER: This is across all disciplines.

MR FARR: Across-----

COMMISSIONER: Not just surgery?-- Sorry, I really only know what VMOs are working in the surgical system, sorry.

MR FARR: All right. I do wish to ask you just not very much more. But one topic is this, and you - again you have spoken of it before, of course, during the course of today, but in paragraph 30 of your statement you say, "It is my observation that nurses tend not to criticise doctors because of the possibility of reprisal." You made that - you have that sentence in the context of speaking of Dr Patel's attitude towards other staff members, particularly junior staff members. Is the reprisal that you speak of there in relation to reprisals from Dr Patel or is that a general statement you are making? I just wasn't sure?-- I guess also it would be I was referring to Dr Patel, because - I mean, if you question Dr Patel - he really doesn't discuss things with you, he just - you know, he doesn't acknowledge your opinion.

Right?-- And would then - you know, he can get quite verbal in his opinion.

I see. All right. But that's-----?-- So that's why.

That's the way we should read that sentence. That's all I am asking, just a clarification.

D COMMISSIONER VIDER: We have heard witness - we heard from other Nurse Unit Manager witnesses who have indicated that Dr Patel reached a stage where he didn't talk to them. Did Dr Patel have open communication with you when you were the Nursing Unit Manager in the operating theatre?-- Not all the time, no. After I'd - I'd questioned him about - you know, use of some equipment and I found that he used to avoid talking to me. He would talk to other staff in the operating theatre rather than talk to me, and he would give information to the - to other staff in the particular operating theatre that he was working in rather than inform me when there was plenty of opportunity to inform me.

Given the working relationship between the manager of the operating theatre and the Director of Surgery, did you ever have an opportunity to say to Dr Patel, "We seem to have some communication difficulty. Can we discuss it?"?-- No, I never approached him. He just isn't the sort of person that you could confront or talk to him about that or-----

D COMMISSIONER EDWARDS: This lack of communication existed with other staff as well with Dr Patel?-- To some degree, yes.

MR FARR: That's all I have, thank you.

COMMISSIONER: Thank you, Mr Farr. Mr Allen, any re-examination?

MR ALLEN: Just one matter.

COMMISSIONER: Yes.

RE-EXAMINATION:

MR ALLEN: Ms White, it arises from some questions that Mr Farr had asked you fairly recently and you were taken to the information bundle regarding the system of adverse event reporting which was apparently introduced in February last year?-- Mmm, yes

And you were shown some of the contents of that and in particular do you recall being shown some listing of types of adverse events?-- Yes.

Which could be checked as describing the event?-- Yeah.

And a particular one which was highlighted was under, "Injury", "Unintended Injury During Procedure"?-- Yes, I do.

And you agreed that that would include, for example, an unintended injury during a surgical procedure?-- Yes.

And that would, for example, include by way of describing an incident of a surgeon who had accidentally caused a laceration of the bowel when that shouldn't have occurred?-- Yes.

Do you have any understanding as to who should be filling out the Adverse Event Form in an incident of that particular type, and as a concrete example the incident regarding patient P70 which is referred to in paragraph 36 of your statement and has been described in - well, no, excuse me, I will withdraw that, the incident involved in describing - in paragraph 40 of your statement regarding patient P38 where there was apparently an accidental three to four centimetre incision in a healthy bowel. Now, who according to this policy should be filling out an Adverse Event Form. Should it be the-----?-- It should be the surgeon.

The surgeon?-- Yes.

All right. So the responsibility wouldn't rest - for example, with the intern who'd actually noticed that when Dr Patel hadn't and drew it to his attention, it would still rest with

the surgeon?-- Well, you would think that in - if they are - these forms are going to make any impact and are going to be used correctly it should be the surgeon that has made the mistake.

It certainly wouldn't rest with a scrub nurse who may or may not have seen the - and noticed the accidental incision?-- I don't think it's a nurse's responsibility to complete it, no.

COMMISSIONER: Mr Allen, from the documents which are attached to the statement of Ms Raven, there is a sort of explanatory policy and procedure document, RTL4, Adverse Events Management.

MR ALLEN: If one goes to the third page of that-----

COMMISSIONER: That's what I was going to draw to your attention. It says that, "The staff member who was involved or discovered the adverse event completes the relevant section of the Adverse Event Report Form." So, that would seem to suggest that in the case we are just talking about, the person involved presumably is Dr Patel, was holding the scalpel, the person who discovered it was presumably the intern who pointed out to Dr Patel that he'd nicked the bowel. One would think that there was the option for others who observed the incident but weren't either directly involved or involved in discovering it might choose to fill in such a form, but there doesn't seem to be any obligation to do so under this policy, as it stands.

MR ALLEN: No, and the question would then arise is such a person obligated to try and find out whether the person who is required to fill out the form has in fact done so.

COMMISSIONER: Goes around in circles.

MR ALLEN: Yes.

COMMISSIONER: That gets back to Deputy Commissioner Vider's question, that the whole point should be to arrive at a situation where all of those present are concurring, not blame-storming, but simply making an actual factual record of what happened so it's there in the system. If someone needs to allocate blame later on, that's a different issue.

MR ALLEN: Yes.

COMMISSIONER: But at least in relation to your example you have spoken about in your statement, you didn't have any understanding there was any obligation upon you to fill out such a form?-- No.

MR ALLEN: And likewise in relation to patient P70 where you talk about a rough removal of a bowel and a lack of ligation of bleeders-----?-- Yes.

Are you aware for that - whether that would, in fact, even come within the description of an adverse event under this

current policy?-- I don't think so, because it's - it's just a surgeon's technique.

Well, certainly, then, you wouldn't have had any belief there was any obligation on your part to fill out such a form in relation to that procedure?-- No, no.

Thank you.

COMMISSIONER: Mr Allen. Mr Andrews, any re-examination?

MR ANDREWS: No, thank you, Commissioner.

COMMISSIONER: Thank you, Mr Andrews. Ms White, thank you very much for coming in to give your evidence today and, as I said earlier, I know it's been a very long day?-- Thank you.

And I think I should say something. I realise that it can be very embarrassing as a witness to have it drawn to your attention that there are factual inaccuracies in your statement?-- Mmm-hmm.

I think you can trust the fact that the three of us up here on the Bench have enough experience of human nature to know that all of us are capable of forgetting dates and times and places, and you shouldn't feel bad about that. What is important to this Inquiry is hearing your recollection of the facts, and Mr Morrison has done his job very ably for his client and Mr Diehm likewise for his client in drawing attention to some of the - some inaccuracies in your statement, and-----?-- Yes.

You know, don't think for a moment that we're going to assume that you are a liar just because you got a couple of things wrong. It really doesn't work like that?-- Right.

Thank you very much for coming in and giving your evidence and it has been a great assistance to us?-- Thank you.

You are now excused from further attendance?-- Thank you.

WITNESS EXCUSED

COMMISSIONER: Gentlemen, before we rise, there are just a few things I want to raise. The first concerns - well, there are three essentially housekeeping matters. One is that tomorrow will be the last day of the week we are spending here and given that this has been our first week in these facilities if anyone has any suggestions or comments or input as to how the facilities could work better, anything that we need here that we haven't got or any other resources that would be useful, please feel free to let us know either through Counsel Assisting or through the secretary.

I mentioned a couple of days ago the possibility of extending our Bundaberg sittings to a fourth week and I think it's now become pretty apparent to everybody that we are going to have to do that. Can I inquire whether anyone has a particular objection to doing that, if we continue into a fourth straight week? Mr Diehm, you look uncomfortable.

MR DIEHM: Commissioner, my only observation, perhaps, or suggestion that I might make is whether that week not happen consecutively or whether it might be more convenient to be held in Brisbane, and I am in your hands obviously with respect to that, but looking around the room it's quite apparent there are a lot of Inquiry staff, Commissioners and the lawyers, who probably outnumber many of the other people involved.

COMMISSIONER: Look, I take the force of that, but we have come here not for our own convenience but for the convenience of the people of Bundaberg who are expected to come here and give evidence, and in a sense I think we will be letting them down if we didn't stick to that initial plan. So, unless it's particularly inconvenient from your viewpoint or from the viewpoint of the majority of people who are involved, I feel, quite frankly, we owe it to the people of Bundaberg to carry through to that initial plan.

MR DIEHM: Very well, Commissioner.

COMMISSIONER: I accept what you say. The third thing I wanted to mention again, a housekeeping matter, is I understand a number of people are booked on a flight out of Bundaberg tomorrow afternoon at around about 5 o'clock. It might be 10 past or so. So everyone has to understand that tomorrow there's not going to be any late sitting. We all have to be able to make that flight.

If, Mr Morrison and Mr Devlin, you feel that that would justify starting early tomorrow, I am happy to do that.

MR DEVLIN: I have discussed it with my learned friend. We are of the view that we will usefully take up to about half past 3. Mr Morrison thinks he will take the morning.

COMMISSIONER: Yes.

MR DEVLIN: I think if there's a 2 o'clock start or thereabouts I will tailor what I have to ask to that hour and a half so there's plenty of time for people to get their flights and so on.

COMMISSIONER: I appreciate that very much, Mr Devlin. That really leads me to something else I wanted to ask and this is probably the most important thing. It concerns particularly Mrs Linda Mulligan and also to a lesser extent concerns Mr Leck and Dr Keating. It will be apparent to everybody that our Terms of Reference can really be divided into three categories. There are the issues relating to specifically to Dr Patel and they stand by themselves. There are issues

relating to what I refer to as systemic problems and problems of procedure within Queensland Health. The third category is that we're invited by the Governor-in-Council to advise if there are any individuals who should be the subject of either criminal complaint or referral to the Crime and Misconduct Commission on the basis they may have committed official misconduct or possibly disciplinary charges.

Now, the evidence, particularly today - I don't say this as criticism of anyone at all - but particularly today it's descended into a bit of mud-slinging on issues which plainly wouldn't fall within any of those categories. That's no-one's fault. It is just the way the evidence has come out. We are certainly not going to be publishing a report that expresses a finding as to whether or not Dr Keating and Dr Patel laughed at the reference to dehiscence at a particular meeting on a particular date. Our final report is not going to descend into questions about management style and how difficult or easy it was to get through on the telephone to Dr Keating's office or Mrs Mulligan's office. Those sort of managerial issues are undoubtedly very important to the people directly concerned, but we are concerned with things that are even more important, and that is dealing with these problems that have been identified in Queensland Health.

From the evidence received to date I think I can say with absolute confidence that there is nothing which would suggest that Mrs Mulligan, in particular, is within the scope of consideration for criminal charges or reference to the CMC for consideration of official misconduct charges or even disciplinary matters. There have been criticisms of her management style and, as I say, we just don't want to get into that sort of minutia.

Mrs Mulligan is represented here by extremely experienced counsel in the form of Mr Morrison QC, and he obviously has an important duty both to protect his client's reputation, because some of the things that have being said are obviously capable of being harmful to the reputation of Mrs Mulligan, to protect her future in her chosen career, and also to answer any evidence that might be thought to support some sort of criminal or disciplinary or official misconduct charge.

To the extent that it is of any assistance, Mr Morrison, I can say that we don't think any of the evidence received by us so far is calling for an answer in that latter category. That's not to cut you short in defending your client's reputation to your utmost.

MR MORRISON: Thank you, Mr Commissioner.

COMMISSIONER: But if we can avoid going into detail like some of those we have heard this afternoon about who said what at what meeting and how long it took to get through on the phone and how difficult it was to arrange a meeting, that sort of thing, you know, that's - as I said, I accept it's very important for those involved, and I accept that Ms White was totally earnest in her perception, whether it was a right

perception or a wrong perception, that she had difficulty in getting through. But we are not going to resolve those sorts of issues here and, frankly, the less said about them the better, as far as we're concerned.

I know that at the Fitzgerald Inquiry there was the precedent of issuing certificates or letters indicating that a person was no longer under suspicion or under consideration. Indeed, Sir Llew Edwards is the proud owner of one such letter.

MR DEVLIN: I was probably the proud writer.

COMMISSIONER: I really think it's too early in the day to start issuing those sort of letters, and if we were in a position to do that we certainly would, but we don't know what further evidence is going to be forthcoming and it would be - just as it would be unfair to Mrs Mulligan to make allegations against her which are not yet supported by any evidence - it would be equally unfair to exclude the possibility that there may be future evidence. But as matters stand at the moment, really she is not a person of particular concern to us.

I am afraid I can't extend that to Dr Keating and Mr Leck at this stage because there are specific issues which each of them will have to address, and I'm not saying that they won't have complete answers in relation to those issues, but for example, in Mr Leck's case the issue about the issuing of the payment voucher for the ticket back to American may be one issue that he will have to answer and depending on what answer we receive that may be taken further.

Similarly, I indicated yesterday that there are some issues we would like to hear from Dr Keating about if given an opportunity to explain. None of that's to suggest that we've formed any view that either of the men has a prima facie case to answer, but so far as Ms Mulligan is concerned, I think I have said enough to indicate that Mr Morrison shouldn't feel a need to go down every little rabbit Warren to exclude the possibility of something adverse remaining on the record.

MR MORRISON: Thank you for that indication, Mr Commissioner.

COMMISSIONER: Does that assist?

MR DIEHM: Commissioner, it does, though one point that I ought make is that particularly in the earlier stages of the evidence in this Inquiry, and including when Dr Keating was questioned by yourself at the Brisbane sittings, questions were directly put to him about issues, for instance, such as the difficulty that staff in that instance - in particular I'm thinking of Dr Miach - might have had in communicating with Dr Keating.

COMMISSIONER: Yes.

MR DIEHM: And in that sense the issue that arose today about the ability to communicate with Dr Keating when the accusation was being made, it seemed by Ms White, takes on a significance.

COMMISSIONER: I accept the force of that, but the reality of the situation is that based on the evidence as it then stood, I asked Dr Keating that question and he answered it.

MR DIEHM: Yes.

COMMISSIONER: That's where it stands.

MR DIEHM: Yes, and I'm not cavilling with anything you've said, Commissioner. I'm just saying there are reasons why these things are gone into beyond the immediate issue.

COMMISSIONER: Of course, and I emphasise again, none of this commentary is intended as criticism of anyone, it's just that we all still have a big job in front of us, and if we can chisel that job back to the things that really matter, things that are likely to result in adverse findings or recommendations, then hopefully the process would speed up just a little bit.

Mr Ashton, is there anything you want to say?

MR ASHTON: I have nothing to say.

COMMISSIONER: Thank you.

MR DIEHM: Can I inquire for my own personal convenience, with what's outlined in terms of the plans for tomorrow, should I safely assume that I will not be called upon to cross-examine Ms Hoffman tomorrow?

COMMISSIONER: The position so far as I'm concerned is this: Mr Morrison and Mr Devlin will both be given their opportunity to cross-examine so far as they like. After that I would expect Mr Mullins to be next. Mr Mullins doesn't-----

MR DIEHM: He may not be here, but I think his junior might be here tomorrow.

COMMISSIONER: But if we get to 3.30, I would be quite happy to give him the option of either continuing on tomorrow afternoon until we need to leave, or resuming on Tuesday when

we're all back here again.

MR DIEHM: Thank you, Commissioner.

COMMISSIONER: If Mr Mullins isn't here and someone else wishes to take up half an hour or an hour - Mr Allen or someone else - then that option will be made available as well.

MR DIEHM: Thank you.

MR ALLEN: Commissioner, can I return briefly to the second topic of housekeeping and that's the fourth week.

COMMISSIONER: Yes.

MR ALLEN: I'm just wondering whether it would be a situation again where there may be a four day week, and in that event could I indicate at this stage that my client and certain of its employees and members would have a distinct preference that if there is a day off, that it be the Friday because of certain things happening in Brisbane.

COMMISSIONER: Look, I suspect that all of us would find that convenient if we're going to have that fourth week in Bundaberg, that it be a Monday to Thursday week. So we can proceed on that assumption for the moment.

MR ALLEN: Thank you, Commissioner.

COMMISSIONER: We can proceed on that basis. It will be a Monday to Thursday week.

MR ALLEN: Thank you.

COMMISSIONER: All right, ladies and gentlemen. 9.30 tomorrow then.

THE COMMISSION ADJOURNED AT 6.01 P.M. UNTIL 9.30 A.M. THE FOLLOWING DAY