Transcript of Proceedings

MR A J MORRIS QC, Commissioner

SIR LLEW EDWARDS, Deputy Commissioner

MS MARGARET VIDER, Deputy Commissioner

MR D C ANDREWS SC, Counsel Assisting
MR E MORZONE, Counsel Assisting
MR D ATKINSON, Counsel Assisting

IN THE MATTER OF THE COMMISSIONS OF INQUIRY ACT 1950

BUNDABERG HOSPITAL COMMISSION OF INQUIRY

COMMISSIONS OF INQUIRY (No. 1) 2005

BRISBANE

..DATE 23/05/2005

..DAY 1

4th Floor, The Law Courts, George Street, Brisbane, Q. 4000 Telephone: (07) 3247 4360 Fax: (07) 3247 5532

MR D C ANDREWS, with him MR E MORZONE and MR D ATKINSON, counsel assisting the Commission

MR G MULLINS, with him MR J HARPER (instructed by Carter Capner) for the victims

MR D K BODDICE SC, with him MR C J FITZPATRICK and MR B FARR (instructed by Crown Law) for the Director-General

MR D H TAIT SC with him MS S J GALLAGHER (instructed by Hall Payne) for the AMAQ and its members

MR R DEVLIN with him MS K McMILLAN (instructed by Gilshenan & Luton) for the Medical Board of Queensland

MR G DIEHM (instructed by Flower & Hart) for Dr Keating

MR J ALLEN (instructed by Roberts & Kane) for the Queensland Nurses' Union

MR R PERRETT (instructed by Clayton Utz) for the Health Rights Commission

MS R KELLY for the Queensland Clinician Scientists' Association

MR R S ASHTON (instructed by Hunt & Hunt) for Mr Peter Leck

COMMISSIONER: I will begin proceedings by asking the Secretary to the Commission of Inquiry, Mr Groth, to read the order in Council constituting this Commission.

MR GROTH: Commissions of Inquiry Order NO. 1 (2005), appointment of commission under the provisions of the Commissions of Inquiry Act 1950, Her Excellency The Governor acting by and with the advice of the Executive Council hereby appoints Mr Anthony John Hunter Morris QC to make full and careful inquiry in an open and independent manner with respect to the following matters:

(1) The role and conduct of the Queensland Medical Board in relation to the assessment, registration and monitoring of overseas trained medical practitioners, with particular reference to Dr Jayant Patel or other overseas medically trained practitioners.

(2) The circumstances of:

a. the employment of Dr Patel by Queensland Health; and
b. the appointment of Dr Patel to the Bundaberg Base Hospital.

(3) Any substantive allegations, complaints or concerns

relating to the clinical practice and procedures conducted by Dr Patel or other medical practitioners at the Bundaberg Base Hospital.

(4) The appropriateness, adequacy and timeliness of action taken to deal with any of the allegations, complaints or concerns referred to in (3) above, both

a. within the Bundaberg Base Hospital; and
b. outside the Bundaberg Base Hospital.

(5) In relation to (1) to (4) above, whether there is sufficient evidence to justify

a. referral of any matter to the Commissioner of the Police Service for investigation or prosecution; or
b. referral of any matter to the Crime and Misconduct Commission for investigation or further action; or
c. the bringing of disciplinary or other proceedings or the taking of other action against or in respect of Dr Patel or any other person.

(6) The arrangements between the Federal and State Governments for the allocation of overseas-trained doctors to provide clinical services with particular reference to the declaration of Areas of Need and districts of workforce shortages.

And, as a result of any findings in respect of the above matters, to make recommendations in relation to

(1) Appropriate improvements to the functions, operations, practices and procedures of the Medical Board of Queensland, in particular in regard to the assessment, registration and monitoring of overseas-trained medical practitioners.

(2) Any necessary changes to the Queensland Health practices and procedures for

a. The recruitment and employment of medical practitioners (particularly overseas-trained medical practitioners)

b. The appointment of medical practitioners, (particularly overseas-trained medical practitioners) to regional and remote hospitals; and

c. The supervision of, and maintenance of the standards of professional practice of, medical practitioners, with particular reference to:
(1) overseas-trained medical practitioners; and
(2) medical practitioners (particularly

overseas-trained medical practitioners) appointed to regional and remote hospitals;

(3) Mechanisms for receiving, processing, investigating and resolving complaints about clinical practice and procedures at Queensland Health hospitals, particularly where such services result in adverse outcomes both:

a. within the hospital concerned; and
b. within Queensland Health generally; and
c. through other organs and instrumentalities of the Queensland Government, including State Coroner, the Health Rights Commission, the Medical Board of Queensland, the Queensland Police Service and the Crime and Misconduct Commission; and
d. otherwise.

(4) Having regard to any unacceptable situations or incidents revealed in evidence, whether at the Bundaberg Base Hospital or at other Queensland Health hospitals, any systems of accountability necessary or appropriate to prevent the recurrence of such situations or incidents;

(5) In reference to (6) above, measures which could assist in ensuring the availability of medical practitioners to provide clinical services across the State;

(6) Any other action which should be taken properly to respond to the findings of the inquiry.
And directs that, in conducting such inquiry:

1. without limiting in any manner the generality of the above, the Commissioner may have regard to and take account of the functions of:

(a) the State Coroner;
(b) the Health Rights Commission;
(c) the Medical Board of Queensland;
(d) the Queensland Police Service;
(e) the Crime and Misconduct Commission; and
(f) any Queensland Health investigation under section 55 of the Health Services Act 1991.

2. The Commissioner shall liaise and cooperate with the parallel Queensland Health Systems Review and may refer to such review any matter which in the opinion of the Commission:

a. Has implications for the broader public health system; or
b. Can more conveniently or effectively be considered and dealt with by such Review.
And directs that the Commission make full and faithful report and recommendations

concerning the aforesaid subject matter of inquiry and transmit the same to the Honourable Premier and the Minister for Trade by 30 September 2005.

Applicable Act

3. The provisions of the Commissions of Inquiry Act 1950 shall be applicable for the purposes of this inquiry except for section 19C - Authority to use listening devices.

Deputy Commissioners

Under section 27 of the Commissions of Inquiry Act 1950, Her Excellency the Governor acting by and with the advice of the Executive Council approves the appointment of Sir Llewellyn Edwards AC and Ms Margaret Vider as Deputies to the abovementioned Commission.

Conduct of Inquiry

The Commissioner may hold hearings in such manner and in such locations as may be necessary and convenient. The Commissioner may:

a. Hold hearings constituted by the Commissioner, whether sitting alone or with one or both of its deputies; or
b. Authorise his Deputies or either of them to hold hearings or exercise powers pursuant to section 28 of the Commissions of Inquiry Act 1950.

Ministerial Directions

The Honourable the Premier and Minister for Trade is to give the necessary direction herein accordingly.

COMMISSIONER: In accordance with the provisions of the recording of Evidence Act of 1962, I direct that the evidence to be given in this inquiry and any ruling, direction, address or other matter in the inquiry be recorded by officers of the State Reporting Bureau, either in shorthand or by using a mechanical device, as they think fit from time to time.

The order in Council will be marked as exhibit 1.

ADMITTED AND MARKED "EXHIBIT 1"

COMMISSIONER: There is also an instrument appointing the two Deputy Commissioners, Sir Llewellyn Edwards and Ms Vider, and I will ask that that be marked as exhibit 2.

ADMITTED AND MARKED "EXHIBIT 2"

COMMISSIONER: Mr Andrews?

MR ANDREWS: May it please the Commission, I appear to assist the Commission with Mr Morzone of counsel and Mr Atkinson of counsel.

COMMISSIONER: Thank you, Mr Andrews. Are there any applications for leave to appear?

MR MULLINS: I seek leave to appear with Mr J Harper of counsel on behalf of Beryl Crosby, Ian Flemming and Members of the Bundaberg Hospital Patients Support Group for the duration of the Commission's public sittings. A written outline of that application has been prepared. Can I hand up a copy?

COMMISSIONER: Thank you, yes. Do you have copies for the two Deputies? Is it convenient to refer to your clients collectively as the Bundaberg Hospital Patients Support Group?

MR MULLINS: Thank you, Commissioner.

COMMISSIONER: We will give you leave to appear throughout the course of the proceedings. In saying that, may I mention two things: one is that I understand your instructing solicitors have applied to the Commission for its support in relation to obtaining legal funding to represent the Patients Support Group. We are in the course of referring that to the Attorney-General's Department and I can inform your clients that that will be referred with that support. The other thing I want to say is that whilst you have leave to appear throughout the proceedings in relation to any issue of interest to your clients, you are not expected to be here the entire time if it is not convenient and we will attempt to inform you of matters and co-ordinate proceedings in a way that doesn't inconvenience you if it is necessary for you to absent yourself or for your instructing solicitors to be absent at any stage.

I have particularly in mind the proceedings in Bundaberg because I realise it will be an expensive and logistically difficult exercise for everyone interested in proceedings to be present in Bundaberg throughout that stage of the proceedings. Thank you for your appearance and you have the leave I mentioned.

MR MULLINS: Thank you, Commissioner.

COMMISSIONER: Mr Boddice?

MR BODDICE: If the Commission pleases, I seek leave to appear with my learned friends Mr Farr of counsel and Mr Fitzpatrick of counsel for Queensland Health. The basis for seeking leave is as follows: Queensland Health is the organisation responsible for the operation of public hospitals throughout

Queensland. Queensland Health is the organisation responsible for the employment of all medical or allied health staff in the public health system. As such it is responsible then to respond to complaints made to or by medical or allied health professionals. (3), Queensland Health was the effective employer of Dr Patel and was responsible for the provision of medical advice and treatment by its employees, including Dr Patel at Bundaberg Base Hospital; (4) Queensland Health's practices and procedures are the central focus of the terms of reference dealing with the appropriateness, adequacy and timeliness of action taken to deal with any allegations, complaints or concerns; (5) Queensland Health is a responsible entity for the determination of Areas of Need, it utilises the services of overseas trained doctors in such areas, and (6) Queensland Health is the focus of most of the areas of recommendation in the order in Council.

In our respectful submission, the applicable principles for the granting of leave is really a determination of whether the particular entity seeking an interest or organisation seeking an interest has a peculiar and material interest to protect or advance, and in our submission there is little doubt that Queensland Health does have such an interest in the present case. It is specifically named in the Commission of Inquiry Order No. 1 (2005) at terms of reference (2) and is by inference the relevant organisation in respect of the matters the subject of terms of reference (3) and (4). It is specifically named in areas of recommendation (2), (3) and (4) and is by inference the responsible entity to be considered in respect of the area of recommendation (5).

One matter that I should raise, of course, Queensland Health is not a legal entity in itself but in our submission that is not a bar to its being granted leave. (1) it is certainly, from the point of view of the Governor in Council framing the order there is no doubt Queensland Health is a sufficient entity or organisation to be identified by that term within the order in Council, and, secondly, in the Commission of Inquiry into matters set out in the order in Council dated 26 May 1987 known as the Fitzgerald Inquiry, leave to appear was granted to the Queensland Police Department represented by Mr Callanan QC, as he then was, and Messrs Needham and Philp of counsel. The Queensland Police Department, of course, was not a legal entity. And it was not specifically named in the terms of reference, although the terms of reference referred to any members of the police force. Significantly, for present purposes, as part of the granting of that leave the Commissioner also ruled that the same counsel may apply for leave to appear on behalf of further branches of the Queensland Government or the government generally if circumstances in which that became appropriate arose. If leave is granted it is proposed that Queensland Health would be represented throughout the duration of the inquiry. In our submission, it has a relevant interest in all terms of reference, and in all of the areas of recommendation.

COMMISSIONER: Thank you, Mr Boddice, for those very helpful submissions. I personally have no difficulty with the

proposition which you advance as to why Queensland Health has an interest in this matter or the criteria which should be taken into account in granting or refusing leave.

My difficulty at the moment is in understanding precisely who or what it is that you will be representing. I take it from what you have said so far that you are not proposing to represent all of the staff of Queensland Health?

MR BODDICE: Yes, except to the extent of it causes a conflict or they seek separate representation.

COMMISSIONER: Then how do we know which of the staff you are representing and which you are not?

MR BODDICE: Because, as I understand the system that applies, staff who seek representation make application to the Attorney's Department, a division of it, and a decision is made as to whether to grant indemnity or not. If they are granted indemnity, I represent those people. If it is of concern to the Commission I can indicate at each time whether I represented that person or not.

COMMISSIONER: I think the difficulty arises at an earlier stage, though, whether - counsel, consisting of investigative staff, going out and interviewing people, how do we know in advance whether it is a client of yours or not? For example, our first witness today is going to be Ms Hoffman. At the stage when we were interviewing Ms Hoffman, how were we to know whether you were going to be appearing for her or not? I assume you are not, by the way?

MR BODDICE: Not that I am aware, no. I don't understand she has sought leave - I don't understand she has sought representation.

COMMISSIONER: You will see the difficulty, don't you? Who do your instructions come from? Is it the Director-General?

MR BODDICE: They come from the Director-General, and I suppose ultimately-----

COMMISSIONER: Or the Minister?

MR BODDICE: And the Minister as well.

COMMISSIONER: Well, isn't there a potential conflict there? Isn't it a situation where ultimately this inquiry will have to determine if there are problems within the department, whether it is a situation where the Minister was informed of the problem and did nothing about them, or whether it is a situation where the department withheld relevant information from the Minister?

MR BODDICE: No, because in my submission I am there representing the department, and as has been stated in public and I state publicly now, Queensland Health intends to cooperate fully, and all documents that have been asked for

have been provided and will be continued to be provided.

COMMISSIONER: We will come back to that in a moment. Do you have instructions to represent the Minister?

MR BODDICE: I expect that I will do.

COMMISSIONER: I can't give leave on the basis of your expectation. Will you get those instructions and inform the inquiry whether you are representing the Minister? Do you represent the Director-General.

MR BODDICE: At the moment I seek leave to represent Queensland Health.

COMMISSIONER: I am not going to give leave on that basis. Do you have instructions to represent the Director-General?

MR BODDICE: I expect when the Director-General is called to give evidence, I will have instructions to represent him while he is giving evidence.

COMMISSIONER: Only while he is giving evidence, not in cross-examining other witnesses?

MR BODDICE: I expect, as is consistent with my instructions, I am here to represent Queensland Health, which is the entity.

COMMISSIONER: It is not an entity, that's the problem. Queensland Health is a branch of the Government of Queensland. To say you are representing Queensland Health is like saying you are representing the Stones Corner Branch of the Commonwealth Bank. It is not a separate and distinct entity, it is part of the Crown right of the State of Queensland.

MR BODDICE: I understand that, but it is the organisation responsible for the running of the hospitals and it is that organisation I am seeking leave to represent.

COMMISSIONER: And that's where I have difficulty in understanding where you draw the line. If you speak about it as an organisation, that presumably means all of its staff, and you will be protecting the interests of all of its staff. If it is something less than that, I would like to know what it is, whether it is only the Director-General, whether it is the Director-General and its deputies. You refer to the Fitzgerald Inquiry. My recollection was Mr Callanan was given leave to appear for the Commissioner and Deputy Commissioners of the Queensland Police Service, or natural persons, rather than the Police Service as an entity. That may be mistaken.

MR BODDICE: That's not correct, with respect. In fact, they were separately represented by other counsel, as were, of course, the union-----

COMMISSIONER: Yes.

MR BODDICE: -----separately represented by other counsel.

COMMISSIONER: In this case we have got - as I understand, the Queensland Nurses' Union will be seeking leave to appear. They obviously will represent a great number of people who are members of the staff of the department that you are purporting to speak for, the AMA Queensland will be seeking leave to appear. They obviously represent quite a number of the people that you are purporting to speak for. I just can't see practically how you can say, "I appear for the department", without identifying in what sense you appear for the department.

MR BODDICE: That must be the difficulty that confronted the Fitzgerald Inquiry.

COMMISSIONER: Well, perhaps the decision was wrong or perhaps the circumstances were so different that it didn't matter, but in this case, given the structure of Queensland Health, the zones and regions, and so on, before giving leave I would like to know quite specifically whose interests you are representing. If it were, for example, the council or the committee operating Bundaberg Hospital, they might have quite different views about the matters arising here from the Director-General or other staff in Charlotte Street.

MR BODDICE: Yes.

COMMISSIONER: Again, I can't see how you can possibly get around the conflict of interest that arises from representing on the one hand the interests of the bureaucrats in Charlotte Street, and on the other hand representing the interests of people who are operating the hospital on the ground in Bundaberg.

MR BODDICE: That, with respect, assumes there is a conflict in those interests.

COMMISSIONER: I thought you just agreed that there was. Those parties would have quite different views as to the likely outcome of the appropriate recommendations and findings of this inquiry.

MR BODDICE: I don't think that necessarily follows at all, with respect.

COMMISSIONER: Well, do you have instructions? Have you spoken to the people from Bundaberg? Do you know what they are hoping to get out of this inquiry?

MR BODDICE: I have instructions to act for Queensland Health.

COMMISSIONER: Who gave you those instructions?

MR BODDICE: Pardon?

COMMISSIONER: Who gave you those instructions?

MR BODDICE: Those instructions came, I am instructed, through

the Crown Solicitor.

COMMISSIONER: Yes, and who gave the Crown Solicitor his instructions?

MR BODDICE: I expect it would have been the Director-General.

COMMISSIONER: Well, I am inclined at the moment to give you leave to represent the Director-General, if you wish to have such leave.

MR BODDICE: Well, they aren't my instructions at the moment.

COMMISSIONER: I will adjourn your application until you have got instructions identifying quite specifically who it is that's going to be represented here. Not just some nebulous, amorphous body that's referred to as Queensland Health, but some quite specific description of who it is who is going to be actually represented, who is going to be the source of your instructions, and whose viewpoint is going to be expressed to this inquiry through you and your learned juniors speaking on behalf of those who give you those instructions.

MR BODDICE: I will get those instructions.

COMMISSIONER: Thank you, Mr Boddice. Who do we have next? Mr Tait?

MR TAIT: Good morning, your Honour. I seek leave to appear for the Australian Medical Association (Queensland) and its members.

COMMISSIONER: Yes.

MR TAIT: Would you like to hear any detailed submissions?

COMMISSIONER: Mr Tait, not in relation to the question of whether or not leave should be granted, but let me say at this stage I detect a similar problem to that which I have with Mr Boddice, when you say "and its members".

MR TAIT: Yes.

COMMISSIONER: Obviously, some of those members will have different interest to others.

MR TAIT: Absolutely.

COMMISSIONER: I would feel more comfortable at this stage confining leave to the organisation AMAQ, and if at some stage there are particular members that need representation, you can identify who it is that you are representing.

MR TAIT: That would be the appropriate course if any AMAQ members seek support from the association, and no doubt there will be some who may be peripherally involved only, then they can identify themselves to the association and I will seek leave on an ad hoc basis for them. But for the moment I will

make my application only for the association.

COMMISSIONER: Well, Mr Tait, to save time, rather than seeking leave on each occasion I am happy to say that you have leave to represent the AMAQ, and any individual members of the AMAQ whose name is notified to the inquiry. You have that leave now. It is just a matter of informing us in due course who specifically it is you will be representing.

MR TAIT: Thank you, very much.

COMMISSIONER: Thank you, Mr Tait. And, Mr Tait, what I said earlier about your presence throughout the proceedings applies to the AMAQ. It may be that there are - you want to be here in relation to all issues. It may be that, to save funds or for reasons of personal convenience, or whatever, you don't feel the need to be here the whole time. That's entirely a matter for you. And if you are going to be absent, if you let counsel assisting know, we will try to structure things in a way that suits your convenience.

MR TAIT: Thank you very much. I am fortunately assisted by Ms Gallagher of counsel who will be my junior and we will endeavour to have one or other of us here the whole time.

COMMISSIONER: Thank you. And thank you, Ms Gallagher. Who is next?

MR DEVLIN: Yes, good morning, Commissioners. I seek your authority to appear for the following parties: the Medical Board of Queensland and its board members, past and present, the Executive Officer of the Office of Health Practitioner Registration Board, Mr James O'Dempsey and the employees of the Office of Health Practitioner Registration Board, past and present. I have reduced to writing a submission which I supplied to counsel assisting on Friday. I expected it would be delivered to you. I understand that hasn't happened so I tender - seek leave to tender those written submissions. I have three copies.

COMMISSIONER: Mr Devlin, I would hate to curb your enthusiasm, but I can tell you now I am sure we will be sympathetic to your application and I am grateful that you have gone to the trouble of identifying with such particularity the parties that you are presenting. Yes, we will grant you leave to represent the parties that you have identified and I will make the same indication to you as I have made to other gentlemen at the Bar table, that you should feel free to come and go as you please. We will attempt to encompass within a particular phase of the proceedings anything specifically relating to the Medical Board of Queensland so as to meet your convenience, if that's at all possible. Thank you.

MR DEVLIN: I indicate I appear with Ms McMillan as my junior and our intention was to maintain a presence here throughout.

COMMISSIONER: Thank you very much. And thank you,

Ms McMillan. Mr Diehm?

MR DIEHM: Yes, good morning, Commissioners. I seek leave to appear on behalf of Dr Darren Keating. Dr Keating was and is the Director of Medical Services, Bundaberg Base Hospital, though he is presently on leave. I have also prepared a written outline of submissions which I can hand up to the Commission, if that's convenient.

COMMISSIONER: Well, again, without wanting at all to curb your enthusiasm, I think we will be disposed to grant such leave. Yes, we do. And I again make the same indication to you, particularly in the case of Dr Keating, given that he is unlikely to have an interest in all of the matters that are raised in the Terms of Reference, although we, of course, welcome the presence whenever you choose to be here. May I enquire whether Dr Keating is in the position of wanting any assistance from the Commission of Inquiry as regards his funding, or has that already been dealt with?

MR DIEHM: At this point in time, he has no need to apply for assistance but if that situation changes, I am sure my instructing solicitors will take that up.

COMMISSIONER: Thank you, Mr Diehm. Good morning.

MR ALLEN: Good morning, Commissioner, Deputy Commissioners. I seek leave to appear on behalf of the Queensland Nurses' Union. My instructing solicitors have filed with the Secretary a preliminary submission and I read that. I do have copies for the Commissioners if you see fit at this stage.

COMMISSIONER: Again, I won't trouble you with that. Am I to assume that your position is a bit like that of Mr Tait; that you will represent the union as an organisation but you will also potentially be representing individual nurses who may be giving evidence or otherwise involved in the proceedings?

MR ALLEN: That is so. For example, the first witness in these proceedings is a member of the QNU, and I will be representing her interests when she gives evidence, and also in examination of other witnesses who may touch upon matters of relevance flowing from her evidence. So at this stage I seek leave to appear on behalf of the union itself and indicate that I will also be representing the interests of certain members of that union who may be called to give evidence.

COMMISSIONER: Well, I will grant leave on the same basis as Mr Tait's leave, that is to say you have leave to represent both the union and any individual members of the union whose names are notified to the Commission of Inquiry.

MR ALLEN: Thank you, Commissioner.

COMMISSIONER: Yet, again, I indicate that we will attempt to meet your convenience if you are unable to be present throughout the entire proceedings.

MR ALLEN: Thank you. I should indicate that my instructing solicitors have communicated with the Honourable Premier in relation to the issue of funding of the representation of the QNU and its members before these proceedings. Given the comments made in relation to other parties, I expect my instructing solicitors may direct correspondence on that subject to the Commission itself.

COMMISSIONER: Thank you. We will look forward to receiving that.

MR ALLEN: Thank you, Commissioner.

COMMISSIONER: Mr Perrett.

MR PERRETT: Good morning Commissioners. My name is Perrett, solicitor with Clayton Utz. I seek leave to appear before this Commission for the Health Rights Commission. Mr Commissioner, I do have submissions which I could hand up in support of that application if required.

COMMISSIONER: Just so we understand the situation at the moment is the application only on behalf of the Commission as a legal entity or are you also seeking to represent individual officers or staff of the Commission?

MR PERRETT: Mr Commissioner, pursuant to section 7 of the Health Rights Commission Act, the Commission is said to comprise the Commissioner and officers of the Commission, so in representing the Commission, we also seek to represent the Commissioner and its officers.

COMMISSIONER: Well, I'll grant you leave on that basis, thank you.

MR PERRETT: Thank you.

COMMISSIONER: And yet again, the comments I made earlier apply to you and your client as well.

MR PERRETT: Thank you. Anyone else? I'm sorry, I missed you sitting there.

MS FEENEY: May it please the Commission, I act for Mr Peter Leck who is the district manager of Bundaberg Health Service District.

COMMISSIONER: Yes.

MS FEENEY: I have briefed Mr Ron Ashton of counsel who is unfortunately in another Court this morning. We seek leave to appear for Mr Leck. We have not yet prepared a written submission but we've been in consultation with Mr Stella in relation to the parameters of that submission.

COMMISSIONER: Leave is granted. I won't give any direction about providing a submission except to say that we'd appreciate receiving it sooner rather than later.

MS FEENEY: We'll certainly attend to that.

COMMISSIONER: Can I also add for your benefit, but also for the benefit of everyone else in the legal profession represented here, that given that this isn't a Court, I don't feel strongly about the separation of between the Bar and solicitors, and if any party is represented by a barrister but he or she isn't able to be present, I'm quite happy for a solicitor to fill in whenever it's convenient.

MS FEENEY: Thank you Commissioner.

COMMISSIONER: Of course, we'll be delighted to see Mr Ashton when he does get here, but in the meantime we'll appreciate your assistance as well.

MS FEENEY: Thank you, Commissioner.

COMMISSIONER: Thank you.

MS KELLY: Commissioners, I seek leave to appear on behalf of the Queensland Clinician Scientists' Association. It's too soon for us to have prepared a detailed submission the basis upon which I seek leave to appear, but I do have a written outline sketching who we are and the basis upon which we seek leave to be heard.

COMMISSIONER: I'm sorry, I don't know your name?

MS KELLY: Kelly of counsel.

COMMISSIONER: Yes, I think we better have a look at that submission if you don't mind?

MS KELLY: I've brought only two copies with me.

COMMISSIONER: That's all right, Ms Vider and I can probably share. Ms Kelly, having read - I admit very briefly - through the submission provided, it is obvious to me that your organisation has an interest in the outcome of this inquiry and has some useful contributions to make. I'm just concerned to put the members of your organisation to the expense of representation throughout the proceedings. Are you expecting that any of your members will be giving evidence?

MS KELLY: I expect that at least two will be, but at this point busy practitioners are unable to get proofs of evidence.

COMMISSIONER: Of course. And no doubt your client will wish to make submissions at the end of proceedings?

MS KELLY: That's so.

COMMISSIONER: Would you also be expecting to want to cross-examine other witnesses, particularly from areas not directly affecting your client's interests?

MS KELLY: It's possible in relation to the various factual evidence upon which my client's members may wish to give evidence, but there will be other persons to be cross-examined in relation to that, I'm speaking of Queensland senior members of Queensland Health. I don't imagine that that would traverse the whole range of issues with which the inquiry is concerned, but certainly with respect to certain discrete items of fact there might be cross-examination, yes.

COMMISSIONER: My inclination of - I'll articulate this and see if my deputies agree - is to grant you leave at this stage and to grant it on an unrestricted basis, that is, that you can be present and participate at any stage of the proceedings

as you see fit, but you will understand that we're trying to operate to a reasonably short timeframe and we won't be encouraging you to increase the duration of any cross-examination if the matters have already been adequately covered by your people, but we welcome your presence and thank you and your members for supporting the inquiry by being here today.

MS KELLY: Thank you.

COMMISSIONER: Thank you. Anyone else? Perhaps Mr Andrews, you can assist me with this: there was a suggestion that the Australian Doctors Trained Overseas Association Inc would be seeking leave to appear or be represented. Do you know where that stands?

MR ANDREWS: I anticipated that myself, Commissioner. I don't know where it stands.

COMMISSIONER: All right. Well, I'll indicate now that that organisation and any other organisation that hasn't made its application today can apply for leave if they so choose at a convenient time during the Commission's public sittings. The appropriate course will be to contact the Secretary in the first instance and work out with him a time where it's not going to disrupt other matters which are going on.

Similarly, Mr Andrews, there was an indication, I think, Mr Ian Prentice, the solicitor, indicated that he might be representing the Liberal Party's health spokesman and possibly the Parliamentary Liberal Party. Has anything further come of that?

MR ANDREWS: No, I anticipate that Mr Prentice may seek leave to appear at some stage.

COMMISSIONER: Yes. It may be that I've misunderstood that and it's simply that he's preparing submission rather than actually seeking leave to appear, but no doubt we'll hear in due course. And I don't know, I suppose, whether Dr Patel wishes to be present or heard?

MR ANDREWS: I haven't heard that Dr Patel wishes to be heard.

COMMISSIONER: All right. Mr Boddice, are you any closer?

MR BODDICE: I'm awaiting those instructions, Commissioner.

COMMISSIONER: And Mr Boddice, so that my position is not misunderstood, I did say that I wasn't going to give leave to Queensland Health under that name. I'm prepared to reconsider that when you've got full instructions, but I think you'll see it clearly, as anyone else does, the difficulty of representing a body which is not a legal entity without clearly defining whose interests are being represented, but anyway, we'll wait and see what instructions you get.

MR BODDICE: It's actually interesting, Commissioner, I

actually have the transcript of the leave inquiry before the Fitzgerald Inquiry before Mr Callaghan and the Commission initially sought leave on behalf of the Queensland Government but was granted leave on behalf oft he police department. Irrespective, the union was employed so something which wasn't a legal entity was granted leave to appear for that inquiry even though there was separate representation for the Commissioner and the Deputy Commissioners and for the police officers, but I will raise the matter when I get those instructions.

COMMISSIONER: Thank you. While I notice that I see Mr Ashton in the back of the room and I realise that a number of the people and Mr Perrett and so on don't have positions at the Bar table, when we have a mid morning break, I'd appreciate it if people would work out the seating at the Bar table so that everyone who's got a speaking role has a chair at the Bar table, and if that mean instructing solicitors or even juniors have to sit further back in the room, so be it. I think it's very important, for example, to ask Mr Perrett to stand in the corner and conduct his submissions from there. That may involve asking some members of the press and media to move into the seating over here, and I'm sure there are probably those who are delighted to see the press and media in the dock. However, if we can all cooperate in a logistical sense, everything operates conveniently.

Before we proceed to evidence, there are a few preliminary comments that I wish to make. I want to welcome everyone here, and without in any way limiting the welcome to everyone who's present, I particularly want to welcome the representatives of the press and media who are here.

My view, and I know it's a view shared by many people involved in running Royal Commissions, Commissions of Inquiry and the like, is that appropriate press and media coverage is essential to the success of such an inquiry. In this case, I don't think anyone here would dispute that the very fact that this inquiry has been established owes a great deal to the press and media, and without singling out any particular individuals, I think it's fair even at this stage to pay tribute to people like journalists from The Courier Mail, including Mr Hedley Thomas; Mr Malcolm Cole; Mr Jeff Sommerfeld; journalists from the Gold Coast Bulletin, Ms Ann Wason Moore; journalists from television and radio, as well as, I know particularly Mr Patrick Condren from Channel 7 and Spencer Jolly from Channel 9 have been following this matter; Sean Parnell from The Australian and one that may not be known to many people in this room, Ms Susan Goldsmith from a newspaper called The Oregonian who has also been quite instrumental in bringing to light relevant evidence concerning Dr Patel.

In saying that, I don't want anyone to be under the misapprehension that this inquiry is going to be media-driven or that we're going to accept at face value everything we read in the press and newspapers, but we acknowledge the importance of the press and media as our channel of communication with

the people of Queensland.

We want the people of Queensland not only to know that this inquiry is happening, not only to know what is going on at this inquiry, but also to understand completely this inquiry is quite independent of the Premier of the State Government, of the Health Department and the Director General of Health, of any particular individuals within any of those organisations. People should feel free at all times to speak with us, even if it's on a confidential basis or an off-the-record basis, to speak with our counsel assisting or our investigators knowing that you can trust us to be totally independent of the Government of the State and all agencies of the Government.

Apart from that role of the press and media, may I add that the press and media have a very important role at the end of this Commission of Inquiry when recommendations are made. I notice from the press over the weekend that the Premier has declined the precedent of one of his predecessors of committing himself the recommendations of this inquiry lock, stock and barrel. I have not asked the Premier for any such commitment and I would not ask the Premier for any such commitment.

In my view, it is a mistake for any elected holder of office to commit himself or herself to decisions or recommendations made by unelected people, and we must keep in mind that we're not elected, we will make recommendations at the end of this proceeding but it will be a matter for the Government of the day to consider those recommendations and implement them in accordance with their own judgment of what is right and wrong. But again, the press and media have an important role to play in reviewing our recommendations, letting the people of Queensland know what they are, commenting on them. If we've got something wrong, then we'll be big enough to read in The Courier Mail or see on the television commentators saying that we've got something wrong, but if they're found to be useful and helpful recommendations, then ensuring that the people of Queensland are aware of them and ensuring that there is appropriate debate within the Queensland community as regards implementing them.

We have, I think, set a precedent at least in Queensland by inviting television cameras and radio recording into this room. In doing that, I've been extremely careful to bear in mind that there's one class of people who are involved in this investigation and this inquiry by bad luck rather than as part of their career or their line of professional or business activity, and that is, of course, the patients and members of patients' families.

In any medical or health context, patient confidentiality is extremely important, and I would ask the press and media here to respect that issue of confidentiality not only for patients but also for members of patients' families. They are not to be filmed, their evidence is not to be recorded in this room or in the room at Bundaberg without their permission, they're

not to be named in the press or media without their permission.

As regards other witnesses, if anyone has a particular reason for wishing not to be filmed or recorded, then they are invited to make application, but in relation to patients and patients' families, the situation is that a prohibition stands unless an alternative direction is given, based on the particular witness' consent.

Again, before the evidence gets underway, I just want to express my thanks, and if I may say so, the thanks of my two Deputy Commissioners, for the support that we've had in getting this inquiry up and running so quickly. And again, it would be without making any attempt to be exhaustive, I would identify his Honour Judge Erwin, the Chief Magistrate, who's made these facilities available to us, which we are very appreciative; people in the Attorney-General's department who've been responsible for pulling together our team; our legal and investigative team and providing us with the material resources necessary to conduct the inquiry and I particularly identify in that context the Attorney-General, Mr Welford; Ulla Zeller, who's from the Legal & Corporate Services Section of the Attorney-General's Department; and also Robert Campbell, the Acting Crown Solicitor who's made available for us, he will forgive me for saying the very best staff to supplement the legal team that we have from the private bar.

Also staff in the public affairs office in the Attorney-General's Department who have, for example, created our exceptional web site and assisted us in other respects in making the existence of this inquiry and its Terms of Reference known to people of Queensland and also I should mention Uschi Schreiber from the Premier's Department who has been similarly helpful with our material and administrative needs.

In that context, there's something that I have been asked to mention and I'm very pleased to do so. In a report in The Courier Mail on Saturday morning, the Deputy Premier, Mr Mackenroth, was identified as having had reservations about the composition of this Commission of Inquiry. I received a telephone call this morning from Mr Mackenroth and I have a fax from him which he has asked me to publicise.

It is in these terms:

> "I write concerning The Inside Mail article, `Sickness In The System' by Hedley Thomas on Saturday, 21 May at page 25. The article stated that I reportedly expressed reservations about the appointment of Tony Morris to head the Health Commission of Inquiry. This is not correct. In fact, when the Premier decided to launch a Commission of Inquiry, we discussed potential candidates to lead this important task. We both agreed that Tony Morris would be ideal and agreed to utilise his experience and expertise if he was available. The Premier and I

> subsequently jointly met with Tony Morris regarding his availability. Therefore, any inference that I did not support his appointment is pure fantasy. Yours Sincerely, Terry Mackenroth."

And I'll ask the Secretary to mark that as an Exhibit. I can personally attest to at least some of the facts set out in that letter because my first meeting in relation to this inquiry was at the Parliament House office of the Premier. Mr Mackenroth was present on that occasion and at that time and ever since his support for this inquiry has been at least as strong as that of the Premier and everyone else in the Cabinet.

I've mentioned earlier the team that's been drawn together for this inquiry and it is, I can frankly say, humbling that such an extraordinarily capable team has been put together, particularly at such short notice. I was delighted when David Andrews, Errol Morzone and Damien Atkinson each agreed to take roles as counsel assisting. David Groth, our Secretary, has been a tower of strength. In fact, when the Attorney General's department asked me last week if there was anything else we needed to get the inquiry up and running, I indicated that if they had a cloning machine, two or three more David Groths would be all I could ask for.

Also our legal staff, Tony Stella, John Stubbings, Jarrod Cowley-Grimmond and Angus Scott and our two investigators who have already been doing work both here in Brisbane and in Bundaberg and have achieved an extraordinary amount in a very limited period of time, and whilst speaking in this way, I should add how wonderful it has been over the past two or three weeks to work with the two Deputies, Sir Llew Edwards and Ms Vider who bring to this inquiry something that most Commissioners never have, and that is a deep experience, a deep personal experience of the very matters which are being investigated, Sir Llew in his case not only as a fully qualified GP and a medical practitioner of many years standing but also someone who has held the Office of Minister for Health and is intimately familiar with the operation of the bureaucracy at that level; similarly in relation Ms Vider, a dedicated lifelong member of the nursing profession who is, at least from the indications I've received from all sources, highly respected and regarded by everyone in the medical profession, and I am really very grateful to have been provided with the assistance of two such outstanding deputies.

The evidence obviously is about to start and I'll shortly be inviting Mr Andrews to call his first witness. I'd like not only people here but everyone in Queensland to understand that we can't chase down every rabbit warren. It would be impossible for this inquiry to examine everyone who feels that they have a grudge or a complaint or a dissatisfaction with medical treatment received by themselves or by family members somewhere in Queensland. That just isn't possible.

Ultimately, at the end of this inquiry, we'll be making recommendations and, that is, those recommendations may well

include systems for dealing with such complaints in the future, but at this stage to embark on an attempt to examine every complaint throughout the State would blow out the cost of this inquiry to tens of millions of dollars, it would expand the duration of the inquiry from five months to probably a number of years and, candidly, no-one wants to see that happen. What we want to see is a short sharp lean investigation that gets to the facts, comes up with appropriate recommendations and puts in place systems and structures that ensure that the problems of the past don't happen again.

Most importantly, we want to look to the future. Obviously, part of our fact-finding process is to find out what has gone wrong at Bundaberg and what may have gone wrong in other parts of the State, but looking at the history isn't going to achieve much unless at the end of the inquiry we put up recommendations which will ensure that these problems don't happen again.

Whilst I and my two Deputy Commissioners naturally have an open mind as regards any suggestion which anyone wishes to bring forward to this inquiry, I think it's fair to say that we've already started focussing our own minds on areas that we think will need attention: areas like providing regional public hospitals with more autonomous administration; systems for ensuring that medical personnel, and by that I mean not only doctors but nurses and our allied health care practitioners have a greater say in the administration of public hospitals and particularly regional hospitals; improvements which have been made to complaints handling systems in the Queensland Public Health sector; possible changes to the management and administrative structures within the Queensland Health sector, which we'll be looking at in conjunction with the Forster Review, which is being conducted independently; improved procedures for the recruitment and also the retention of medical staff in Queensland Public Hospitals and also the use of visiting medical officers, that is, qualified experts from outside the public system to provide the depth in the public service which have been suggested to have been lacking from some overseas-trained staff.

We may also need to examine the protection that is provided to whistleblowers in this State. We have started looking at precedents in other States, situations where there is specific protection to people in the capacity of whistleblowers who make reports to Parliamentarians or who make reports to the press and media, and that also raises, of course, the question of whether or not there should be some recognition of a journalistic privilege which allows journalists to assure their sources that they will remain confidential at all times.

Those are some of the areas that we expect to be looking at with a view to offering, at the end of the inquiry, recommendations which don't merely identify what has gone wrong in the past but provide a blueprint for what may be done to prevent those problems happening in the future.

Finally, can I make one particular plea as our evidence gathering has gone over the past three or four weeks, one thing that we have been repeatedly told, I personally have heard this, I know that Sir Llew and Ms Vider have heard this and I know that our counsel assisting and legal team have again and again be told that Queensland has some terrific foreign-trained doctors, that some of the best doctors in the State are foreign-trained.

Some of them have different coloured skin, some of them come from what might be regarded as non-traditional backgrounds for the medical practice in this State, but they are still extremely talented doctors. It would be a tragedy if the concerns which have arisen in relation to a handful of doctors and a handful of hospitals took away people's confidence in medical practitioners who have chosen to come to this country and live in and give this county the benefit of their skill and training and ability and we sincerely hope that everyone, and particularly the press and the media, get out to the community the message that this isn't the witch-hunt about every doctor who has been trained outside Australia.

Perhaps it would help if I share an anecdote, and this was said to me very recently by one of the most senior and most experienced surgeons in the State, a man who did his training in Australia, although he did his post graduate training in Edinburgh, and he mentioned that he has a Registrar who's of Asian origin and in fact a second or third generation Australian and a patient recently said to this surgeon, "Well, I don't want that foreign-trained doctor coming near me.", and the surgeon said, "Well, I'm the foreign-trained doctor, I was trained in Edinburgh, so if you don't want a foreign-trained doctor operating on you, you better have the Registrar who was trained exclusively in Australia."

That's a sign of the sort of impact which will occur if we allow these proceedings to turn into some sort of exercise in defaming all members of the medical profession who have not been trained outside Australia and I sincerely hope that all of us will work together to ensure that that sort of thing doesn't come across.

Mr Andrews, it's almost 11 o'clock. Would it suit you to have the morning break before the first witness comes into the box?

MR ANDREWS: Yes, Commissioner, thank you.

COMMISSIONER: We will stand adjourned for 15 minutes.

THE COMMISSION ADJOURNED AT 11.00 A.M.

THE COMMISSION RESUMED AT 11.28 A.M.

COMMISSIONER: Mr Boddice.

MR BODDICE: I renew our application. My instructions are these - our instructions are to seek leave to represent Queensland Health and its employees past and present who do not seek to be separately represented. The instructions come from the Director-General, as the accountable officer of Queensland Health, and I understand, Mr Chairman, your concerns in terms of how the Commission identifies whether the person is represented by our side or separately represented.

COMMISSIONER: Yes.

MR BODDICE: And in our submission, the method by which that is properly to be dealt with is this, that if leave is given to Queensland Health on the basis that we will undertake on an ongoing basis to inform counsel assisting of the names of any employees who have sought separate representation.

COMMISSIONER: Look, I take the force of what you're suggesting but it strikes me as a little bit impractical. Wouldn't it be more satisfactory to proceed the way, for example, Mr Tait's client is proceeding: having leave now to represent the Director-General and you can notify the inquiry of any other member of the staff of Queensland Health from whom you have specific instructions at any time.

MR BODDICE: The difficulty-----

COMMISSIONER: Because presumably - how many staff are there, 60,000?

MR BODDICE: There's a lot.

COMMISSIONER: Presumably you haven't got statements from all of them, or instructions.

MR BODDICE: No.

COMMISSIONER: It does seem to me a little bit, I won't use the word foolish but impractical to say that you're representing 60,000 people. I don't know that anyone can do that.

MR BODDICE: I'm seeking leave to represent Queensland Health. What I have indicated is that that leave will extend, like Mr Tait, to when employees come along who have not sought to be separately represented, I'll be seeking leave to represent them, but at the moment I seek leave to represent Queensland Health. I obtained those instructions from the accountable officer: the Director-General.

COMMISSIONER: Yes.

MR BODDICE: But I seek leave to represent Queensland Health, which does have practices, policies and systems, and in our submission that may be the explanation for why in the Fitzgerald Inquiry the Queensland Police Department was given leave to be represented separately to the Commissioners and the Deputy Commissioners and the employee, because whilst it may not be a legal entity, it does have practices, policies, systems and procedures which is the very issue the subject of investigation of this Commission of Inquiry.

COMMISSIONER: Does your application still embrace the Minister as one of the people you're representing?

MR BODDICE: I haven't been able to obtain instructions on that because there is a Cabinet meeting on at the moment so I haven't been able to speak and obtain those instructions.

COMMISSIONER: Mr Boddice, for the time being I am prepared to give you leave to represent the Director-General and any other employee of Queensland Health whose name you notify to the Secretary of the Commission of Inquiry. I'm not prepared to give leave generally to represent an entity called Queensland Health when you can't even tell me whether or not that includes the Minister for Health. I'm just not prepared to do that.

MR BODDICE: As you please.

COMMISSIONER: If you wish to stay on the basis of the limited leave I have given to represent the Director-General, you are of course welcome to do so. If you don't have instructions to stay and represent the Director-General, that's a matter for you.

MR BODDICE: Well, at the moment my instructions don't extend. My instructions are to seek leave to represent Queensland Health.

COMMISSIONER: So be it. Mr Andrews.

MR ANDREWS: Before I call Toni Hoffman, Commissioner, you raised the question before the break as to whether there would be an appearance for Dr Flegg and Mr Quinn.

COMMISSIONER: Yes, yes.

MR ANDREWS: I'm instructed that Mr Prentice is not proposing to seek leave at this stage to appear for them but may review that during the course of the proceedings.

COMMISSIONER: I see Mr Prentice in the back of the room. Mr Prentice, you will of course always be welcomed here but at the moment I understand that your clients simply want to make a submission to the inquiry and don't want to participate in the proceedings throughout the course of the inquiry's hearing. Is that a fair statement?

MR PRENTICE: Yes, that's correct, Commissioner.

COMMISSIONER: Thank you, Mr Andrews.

MR ANDREWS: Commissioner, I call Toni Hoffman.

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

COMMISSIONER: Thank you. Whilst Ms Hoffman is coming, do you know if she has any objection to her evidence being televised?

MR ANDREWS: I'm instructed she has no objection.

COMMISSIONER: Thank you.

MR BODDICE: Commissioner, I can indicate that I'm seeking to have it conveyed, what your ruling is, to those who are instructing me. If you have no objection, and the other Commissioners have no objections, perhaps it is more convenient if I simply stay here, but I promise I won't say a word.

COMMISSIONER: Of course, Mr Boddice. Mr Boddice, if you feel it appropriate at any stage to say something, even if it is as amicus curie, you are welcome to do so and despite our discussions earlier, I certainly welcome you personally and your two learned juniors' contribution that I am sure you will be able to make to this inquiry.

MR BODDICE: Thank you, Commissioner.

TONI ELLEN HOFFMAN, SWORN AND EXAMINED:

MR ANDREWS: Ms Hoffman, would you tell the Commission your full name, please?-- Toni Ellen Hoffman.

And what's your occupation?-- I'm the nurse unit manager in the Intensive Care/Coronary Care Unit at Bundaberg Base Hospital.

For how long have you held that position?-- Since June 2000.

Ms Hoffman, what's your experience in intensive care units? How long have you worked in such units?-- I first did my intensive care course in 1981 in London at Kings College Hospital and then I worked in the Harley Street Clinic in London.

Kings College Hospital, you obtained, what, an intensive care certificate there?-- Yes.

For how long did you work in the intensive care unit at that hospital?-- Probably about 10 months.

And then at Harley Street. Is that Harley Street in London?-- Harley Street Clinic.

For how long did you work there?-- I think probably about another 10 months or so.

And is that an intensive care clinic?-- Yes, it is, yes.

What academic qualifications do you hold?-- I have my general training with midwifery endorsement.

Well, to begin with, you're a registered nurse?-- Yes, yes.

And you have been since?-- '79, 1979.

And you did a midwifery course, did you say?-- Yes.

When was that?-- Actually, I might have just - what did I tell you I did my ICU? I think I might have muddled that up. I had my-----

You told us you obtained your intensive care certificate through Kings College Hospital in London in 1981?-- Yeah, it was 1982.

I see.

COMMISSIONER: Mr Andrews, feel free to lead through non-controversial evidence if that will speed things up.

MR ANDREWS: Thank you, Commissioner. Have you obtained further academic qualifications within the last 10 years, for instance, a Bachelor of Nursing from Monash University in

1997?-- Yes.

Have you obtained a Graduate Certificate in Management from the Queensland University of Technology in 2003?-- Yes.

Have you obtained a Masters in Bioethics from Monash University in 2003?-- Yes.

Did you obtain those degrees externally, or those qualifications externally?-- Yes.

And did you - were you at the time continuously working in intensive care?-- When I did my Bachelor of Nursing, I think I was actually the after-hours manager at Nambour Hospital. I didn't work in intensive care then.

Right. From 1982, is it fair to say that you've worked for about 20 years or more in intensive care units?-- Yes.

Have you worked in Saudi Arabia in intensive care?-- Yes.

Can you tell us about your experience there?-- I worked in a - it was two eight-bedded ICUs in a tertiary hospital in Riyadh.

Now, a tertiary hospital, it's not an expression we've heard. What does that mean?-- It means a hospital with the highest-----

Highest complexity of cases?-- Yeah.

And greatest level of facilities for attending to patients?-- Yes, that's right.

Now, for instance, the Bundaberg Base Hospital, what level is it? Is it a tertiary hospital or primary?-- It's - I'm not sure what the hospital actually itself would be classed at but the intensive care there is classed as a level 1 intensive care unit.

Now, in Saudi Arabia, for how long were you working in intensive care?-- Five and a half years.

I see. And what kind of intensity did you work under?-- It was a very busy hospital. It was for the National Guard, which is the Saudi Arabian National Guard and their dependants. We cared for every type of patient from the neonate to the elderly. A lot of neurosurgery, because they have a lot of motor vehicle accidents there, a lot of trauma, any major surgery. The only thing that they didn't do there was any open heart surgery.

And were you there during the Gulf War?-- Yes, I was, during - during-----

Were you attending to casualties?-- Yes, I was, yes.

Did you commence as Nurse Unit Manager of the Intensive Care

Unit at Bundaberg Hospital in June 2000?-- Yes.

And you've worked continuously there since?-- Yes.

For some short spells you've acted in another capacity?-- Yes, as the Assistant Director of Nursing and for a very short term as the Director of Nursing.

Ms Hoffman, can you assist the Commission by describing the standards of practice in intensive care in Australia with standards elsewhere?-- Australian intensive care units have got a very - a very good name. They're world leaders in intensive care. A lot of the research in intensive care has actually come out of Australia, and I think even some of the first intensivists were actually trained in Australia. We use a different model of caring for patients here to what they do in - perhaps in the States, where the intensivist - we have, like, what's called a closed unit and the intensivists actually care for the patients once they come into the unit, which is slightly different to the American model.

Does it mean that with the Australian model, more responsibility and discretion as to what's the appropriate care will be left to those within the intensive care unit than in the American model?-- Yes.

Where, perhaps, the surgeon might continue to direct what kind of care will be administered even when the patient is within an intensive care unit?-- Yes.

Now, at the Bundaberg Hospital, as Nurse Unit Manager, what are your responsibilities? Would that include staffing, making sure the parents are - the patients are catered for and monitoring the nursing standards?-- Yes, mmm-hmm.

Are you also responsible for the recruitment and retention of the appropriately qualified and experienced nursing staff on the unit?-- Yes, I am.

How many staff are there in the - I beg your pardon. Employed to work at the intensive care unit at Bundaberg?-- We have a full-time equivalent staff of around 15.4. Some of them work part-time, so there's actually about 20 staff.

And is it the position that there are only a few of those rostered on to any full shift?-- We have three - three staff on per shift. We work two shifts a day.

COMMISSIONER: Mr Andrews, you are probably coming to this but can I ask at this stage what doctors are involved in intensive care: is there an intensivist?-- No, we don't have an intensivist.

Right?-- We have a director of anaesthesia in ICU and three anaesthetists.

All right. Who is the director at the present time?-- Dr Martin Carter.

I'm sorry, I-----?-- Sorry, Dr Martin Carter.

Yes. And who are the other three anaesthetists?-- Dr Dieter Behrens, Dr Reedy and Dr Zia.

Thank you for that. I wonder if I can ask the cameramen - I think you have probably got your full share of photographs by now and the clicking does tend to distract us a bit, do you think you can leave it off now? Thanks. Thank you.

D COMMISSIONER EDWARDS: Ms Hoffman, are they all full-time positions?-- Yes, they are.

Thank you.

D COMMISSIONER VIDER: Mr Andrews, could I just ask a question. Your workforce in the intensive care unit, is that all registered nurses?-- Yes.

So you have got no other category of nurses in the intensive care?-- No.

Is it easy to get registered nurses for an intensive care unit in Bundaberg? Do you have difficulty staffing the unit?-- We don't have as much difficulty as other areas to get full-time staff but for agency staff or short-term staff, we have more difficulty.

Thank you?-- More of a stable area to-----

Yes.

MR ANDREWS: Ms Hoffman, how many beds do you have in your intensive care unit at Bundaberg?-- There's actually eight beds in the unit but five are only funded, at this point in time.

I see. Is there a limit to the number of acutely ill patients whose needs can be met by the unit?-- Yes, there is, yes.

And is the number limited simply by the number of beds or the equipment and staff available to attend to the patients?-- It's limited by the complexity of the illness of the patient, the acuity plus what staff are available at that particular time. If we have one ventilated patient, that usually takes up one and a half staff members for the shift. If we have two, it takes the whole three staff.

Do you have at Bundaberg three ventilators in the intensive care unit?-- Yes, we do.

Is it best practice that only two should ever be operating at one time with the third in reserve?-- Yes.

And is it a risky adventure to be obliged to use all three ventilators at once?-- Yes, it is. And it would mean also that we would need to supplement the staffing with extra

staff.

Is it the position that when there are ventilated patients, there should be one nurse available to monitor each patient?-- Yes.

Who is ventilated?-- Yes.

Then should there be a third nurse available to do, well, more mobile duties?-- Yes.

D COMMISSIONER VIDER: Mr Andrews, could I ask a question, please?

MR ANDREWS: Certainly.

D COMMISSIONER VIDER: Ms Hoffman, in the intensive care units, the position description of the Nurse Unit Manager, is there an expectation that that person would be able to - in consultation with the senior medical officer for the intensive care unit, by whatever title that person goes under, would you be able to have discussions regarding the nature of the incoming patients from elective surgery lists and work out the clinical load and expectation that you would be able to manage?-- Yes.

Does that always happen?-- No.

Thank you.

MR ANDREWS: Ms Hoffman, does the College of Intensive Care Physicians publish a classification system which differentiates between level 3, level 2 and level 1 intensive care units?-- Yes, it does, yes.

Would you look at this document, please. Do you need your spectacles?-- Yes.

I wonder if you'd be kind enough to look at perhaps page 4 of the document, or starting there, where level 1 intensive care units are described and explain to us what are the features of Bundaberg which mean that it's classified as a level 1 unit rather than level 2. You may, if you prefer, turn to the level 2 classifications and show us why Bundaberg doesn't fit within it?-- Okay.

You will see them on page 3?-- All right. For a level 2 unit, you should have four staffed and equipped beds-----

Yes?-- Which we do, we do have that. It states further on that we should normally have more than 200 mechanically ventilated patients per annum. We usually only have around 100.

All right. So at 2.1.2 you identify the first disparity between level - between Bundaberg and a level 2 unit?-- Yep, yes. The staffing requirements suggest that the medical director should practise predominantly in intensive care

medicine. We don't have that. And 2.2.2 also states that there should be another specialist who is a Fellow of the Joint Faculty of Intensive Care Medicine. We don't have that.

COMMISSIONER: Sorry to interrupt there, bust just so that I understand those requirements, I think I've read somewhere that the College of Anaesthetists and the College of Physicians have a joint accreditation faculty. Is that what's being talked about here, the Joint Faculty of Intensive Care?-- Yes.

Right. So you don't, am I right in thinking, and you have never had a medical practitioner at Bundaberg who has that qualification from the joint faculty as a specialist intensivist?-- No, that's right.

D COMMISSIONER EDWARDS: Because you can't get them? You can't get them or there's no position for that?-- No, there would be a position for that, I think, Sir Llew but, yeah, I don't think they like to come further north of Nambour. Just going down the list, we do have one-to-one ratio of nursing - nursing staff to patients. The majority of the staff do have a post-registration qualification in ICU. The 2.2.9, we don't have access to a dedicated nurse educator. There's only generic nurse educators at the hospital. Support staff, we don't have - we do have some engineers who do fix our equipment but they're not what the big hospitals would have classed as by medical engineers. We have only two hours of clerical staff per day.

MR ANDREWS: Which item are you looking at?-- 2.2.10.

Thank you. Two hours of clerical staff a day, I understand, yes?-- Yeah. And the scientific staff works - work straight days, or whatever, shifts like that, and are on-call for the rest of the time. So we have to call in staff for pathology, radiology, that type of thing. 2.3, operational requirements, we do have defined management admission and discharge policies. Looking down at those things, we do have - we do have them up until we talk - up until they talk about 24-hour access to pharmacy, pathology, theaters-----

Is that 2.3.6?-- Yes.

What about it can be distinguished from Bundaberg?-- We only have on-call pharmacy, pathology, theatres and radiology after hours.

D COMMISSIONER VIDER: Does that give you appropriate cover?-- For - not always, no. No.

Thank you?-- The other things talk about design and that sort of thing. I mean, we have - we have - it's a new - it's a new unit so the design of it is fine.

COMMISSIONER: You have passed over 2.3.7, which refers to an active research program. Is there such a program in Bundaberg?-- We do research, yeah, and we do participate in

research programs. Then, of course, 2.6 at the end, we don't train any - any medical staff there in intensive care medicine.

MR ANDREWS: I see 2.6. Well, 2.6, to me reads, as a non-medical person, tells me that, "Level 2 units may apply for maximum accreditation as C12 training units", and continues. Is that what you were talking about?-- Yes.

Can you translate for me why your unit is not a level 2 unit? Is it because you have no training?-- Because we don't have all of these things that we should have that I've just read out plus we don't have an intensivist or someone to train intensivists there.

Thank you. Can you compare, for instance, the ability of the intensive care units at the Brisbane metropolitan hospitals with your own? Are they - for instance, the Royal Brisbane Hospital, the Mater Misericordiae and the Princess Alexandra Hospitals, are they level 3 intensive care units?-- Yes, they are.

Prince Charles?-- Prince Charles would be a level 3, yes.

And are there occasions where patients are transferred from Bundaberg to those hospitals by helicopter when the facilities of the intensive care unit at Bundaberg are inadequate?-- Yes. Helicopter or fixed wing aircraft.

Now, is there, with respect to intensive care units at level 1, a guideline as to how long patients should remain there and requiring ventilation before being referred to a better hospital?-- It actually refers to short-term ventilation.

Do you-----?-- Can I just - it just says, "The patients most likely to benefit from level 1 care include patients with myocaridal ischaemia", which is patients that have had heart attacks, "post-surgical patients requiring special observations and care, unstable medical patients requiring special observations and care beyond the scope of a conventional ward and patients requiring short-term ventilation", and we've determined that to be 24 to 48 hours of ventilation.

Well, if it's 48 to 72, do you regard that as something that ought - a patient who ought really to be transferred?-- Theoretically, but we wouldn't usually do that because it's very disturbing for the patients and their relatives, so we would try and keep them.

I see.

COMMISSIONER: I'm sorry, Mr Andrews, I'm trying to restrain myself from interrupting so often but just so I understand this transfer system, your usual place of transfer would be one of the major hospitals in Brisbane?-- Yes.

Is there a level 2 hospital nearby to Bundaberg?-- Hervey Bay is regarded as level 2.

All right. And are there situations where you'd transfer a patient to Hervey Bay rather than sending them to Brisbane or would you simply send them straight to Brisbane?-- We have transferred them to Hervey Bay in the past when we've been so full that we couldn't cope any longer and they've not had any patients, so we have transferred them to Hervey Bay. It's difficult because you have to transfer them by road.

Yes?-- The plane won't - the RFDS won't come in and take them, obviously because it's such a short flight.

Yes, I understand. Those sort of transfers are really just because you've got too many patients in ICU at Bundaberg?-- Yes, yes.

Not because you're transferring them to get a higher quality or a higher standard of intensive care supervision?-- They don't have any intensivist either.

So if it were a transfer to Hervey Bay, it would simply be an overflow situation, whereas a transfer to Brisbane would be because you need a higher standard of-----?-- Yes.

-----supervision?-- Yes.

Okay.

D COMMISSIONER VIDER: Could I ask a couple of questions, Mr Andrews. In relation to the number of patients, and you talk about the unit being full, is the unit full because you have got a busy emergency centre where patients come directly to the intensive care unit which would be regarded as unplanned admissions or do you have a backlog of elective surgery patients in the unit?-- We don't usually have a backlog of intensive - of patients requiring surgery. There had been cases in the last two years where we have required beds for patients that require surgery, but usually it's because, you know, we've gone over our quota and we have got one or two or three ventilated patients and we have had to supplement our staff with overtime and calling people in on their days off, and you can only sustain that for a few days.

And my second question is, in regarding clinical audits, given the discipline you've put around the unit, your own unit, in terms of how long you would regard keeping a ventilated patient, 24 to 48 hours, do you do case reviews and some sort of clinical auditing for the exceptions when you have gone outside that rule and do you have case conferences whereby you can discuss those?-- No, we don't. We probably would have an informal discussion but not formal, no.

Thank you.

MR ANDREWS: Ms Hoffman, the most senior doctor in intensive care would be?-- Dr Martin Carter.

And he is, what, a specialist anaesthetist?-- Yes.

Now, in 2003 you took a holiday earlier in the year and when you returned Dr Patel was on staff?-- Yes.

Can you tell us your first impressions, in the weeks after your return, as to whether there was anything different occurring at the hospital?-- Dr Patel was wanting to do very complex and large-scale surgeries which really didn't fit within our scope of practice.

Now, had very complex and large-scale surgeries been done prior to Dr Patel's arrival?-- Not like - not since I had been there. They may have been done years ago, but not-----

And you had been there 2000?-- Yeah. But not in the recent past.

Have you prepared a statement, Ms Hoffman, with the assistance of solicitors engaged by the Nurses' Union?-- Yes.

And have you ensured that the matters expressed in the statement are accurate to the best of your knowledge?-- To the best of my knowledge, yes.

And where you express opinions in this statement, are they opinions honestly held by you?-- Yes.

In part, is the statement based upon your recollection of things you saw in clinical notes?-- Yes.

Do you no longer have access to those notes, those clinical notes?-- The patients' notes?

Yes?-- I have no access to them now.

Did you, in compiling that statement, do your best to keep confidential the names of patients that you from time to time referred to within the statement?-- Yes, we did.

Did you do that by coding those statements with codes such as P1 and P2?-- Yes.

COMMISSIONER: Is there a key available to that code for use of the Commission staff?

MR ANDREWS: There is indeed. Ms Hoffman, within the statement, from time to time you annex exhibits including e-mails. Now, is it the case that some of those e-mails do still retain the names of patients?-- Yes.

They have not yet been blanked out?-- No.

Would you look, please, at this bundle and tell me if you can

identify it as - to begin with, the confidential patient key in a couple of pages, that is in two pages?-- Yes.

That's the key prepared by you?-- By the solicitors.

All right, in consultation with you?-- Yes.

And do you - and the statement that follows it, is it yours?-- Yes, it is.

I tender that document.

COMMISSIONER: Mr Allen, do you wish to be heard about that.

MR ALLEN: If the Commission pleases, my instructing solicitor, Mr Rebetzke, who in fact prepared that statement over the best part of a week with Ms Hoffman, has filed, in accordance with the Practice Direction, an electronic copy of the statement, the attachments, and the confidential patient key. I can, if the Commission wishes, provide some hardcopies of those documents.

COMMISSIONER: I think Mr Andrews has got hardcopies available, haven't you?

MR ANDREWS: Yes, I have.

COMMISSIONER: All right. This is what I am proposing to do at the moment. Subject to anything that anyone wants to say, we'll have Ms Hoffman's statement marked as an exhibit. That will be marked Exhibit 4.

ADMITTED AND MARKED "EXHIBIT 4"

COMMISSIONER: The patient key we will have marked as Exhibit 5. I want to make them separate exhibits because what I propose is this: the statement without the patient key will be an exhibit available generally, including on the Commission of Inquiry website. The patient key will be a confidential exhibit subject to this restriction: anyone who wishes to do so from the press or media can look at the key to work out who it is talking about, but the restrictions earlier indicated about mentioning names of either living or deceased patients will apply.

So that everyone understands that very clearly, the press can, for example, link up names in the statement to people who have already provided them with interviews, but it won't be put on the website and those names won't be generally available.

Is that a satisfactory approach from your viewpoint, Ms Hoffman?-- Mmm

Mr Allen?

MR ALLEN: The press would need to be mindful that, as indicated by my learned friend Mr Andrews, the attachments to the statement of Ms Hoffman which form part of Exhibit 4 in some instances do identify patients by name.

COMMISSIONER: Yes.

MR ALLEN: So there would have to be some type of discretion involved if any of those attachments were referred to in a public way.

COMMISSIONER: I will make an order in the same terms as the order I previously made concerning the Hervey Bay documents; that is that no-one is to be mentioned in the press or media. If that person is relevant only in the capacity of either a patient or a member of a patient's family, and that includes, of course, deceased patients. So those names aren't to be mentioned in the press or media but I am not going to stop journalists from knowing who the names are so they can join the dots themselves and carry through the story.

MR ALLEN: Thank you, Commissioner.

COMMISSIONER: Is that acceptable, Mr Allen?

MR ALLEN: It is.

COMMISSIONER: And the statement itself will go on the website. For the time being the attachments won't because we might have to doctor those ourselves to take out names so that people's names aren't seen on the website. Mr Secretary, can we make sure that's attended to? Thank you. So the witness's statement will be Exhibit 4 and the patient key will be Exhibit 5.

ADMITTED AND MARKED "EXHIBIT 5"

MR DEVLIN: Could the document referred to by the witness earlier, the official document about classification of intensive care exhibits, also be tendered into the record?

COMMISSIONER: Yes, thank you, Mr Devlin. Very useful suggestion. We will mark that as Exhibit 6.

ADMITTED AND MARKED "EXHIBIT 6"

COMMISSIONER: What's the formal description, Mr Andrews?

MR ANDREWS: It is the Minimum Standards for Intensive Care

Units of the Joint Faculty of Intensive Care Medicine.

COMMISSIONER: That's the Australian joint faculty, I assume?

MR ANDREWS: Yes, it - well, indeed, Australian and New Zealand. The document refers to the Australian and New Zealand College of Anaesthetists and the Royal Australasian College of Physicians.

COMMISSIONER: Okay, that document will be Exhibit 6. Thank you, Mr Devlin, for reminding me of that.

MR ANDREWS: Before continuing, it may be convenient if I hand up to the Commissioners copies of this document so that Ms Hoffman's evidence can be followed. And, as I recall it, the only parties who seem to not have received one yet would probably be Queensland Health and Mr Leck. Queensland Health?

COMMISSIONER: Mr Perrett, do you have a copy?

MR PERRETT: No, I don't.

COMMISSIONER: Perhaps at lunchtime steps can be taken to make sure everyone who hasn't got a copy, all of the parties who have been given leave to appear, including the people seeking leave to appear for Queensland Health, have a copy.

MR FARR: Thank you, Commissioner.

MR ANDREWS: Ms Hoffman, would you look at your statement, please? At paragraph 8 you refer to concerns about the number of patients suffering postoperative complications. Can you please tell us what postoperative complications you refer to in that period after your return from holiday?-- We - I can't remember exactly what we had sent - what I had seen by that time, but we - we were seeing a lot of patients come in to intensive care that normally wouldn't require intensive care postoperatively that had had some intraoperative occurrence.

I see?-- And they seemed to be quite common. But that wasn't the first. Apart from that, there was some other things that sort of alerted us to the - that there was something sort of not quite right.

Ms Hoffman, if you can tell the Commission about your own recollections, rather than the recollections of you and others, it would be helpful. You have mentioned what "we" saw and what occurred to "us". It is more your own recollections I am most interested in?-- Uh-huh.

Do you understand?-- Yeah. I was very worried about the way that Dr Patel would describe critically ill patients and he would describe patients that were requiring extremely high doses of drugs to keep their blood pressure up and very high amounts of oxygen as being stable.

Is that an unorthodox description of people in that condition?-- Yes, it is. Normally a doctor would write

something like "critically ill, blood pleasure maintained by" whatever drugs were used, you know, whatever ventilation was required, that sort of thing, but Dr Patel would write that they were stable and they were actually what I would regard as being not stable. And it was after probably - a very large operation that was done on a patient, the first patient that comes to mind that I had concerns about, and that's the patient that I describe in paragraph-----

9?-- 9.

P34, patient on the 19th of May?-- Yes.

2003?-- Yes.

COMMISSIONER: We see from the key that's a male patient, at least a male name. Do you know approximately what age?-- I think - I think he was in his 40s.

Right?-- He was quite a young man but he had a lot of comorbidities. He had renal failure and required dialysis, and from my recollection he had cancer of the oesophagus, and he - I believe he was actually refused surgery in Brisbane because they thought that it wouldn't be in his best interest to have the surgery. And that he wouldn't do well afterwards.

Sorry, am I to understand that this patient came to a Brisbane hospital and was told that his condition was tragically so bad that an operation would be of no use to him?-- That's - that is - that's my understanding and my recollection of the-----

Then Dr Patel performed, what is it, an oesophagectomy?-- Dr Patel decided that he would go ahead with the consultation - with one of the other doctors as well, he would go ahead and do the operation in Bundaberg, and we actually had - we did have a plan - a contingency plan for caring for this patient because we had to get extra staff in to do the dialysis and we were expecting him to have a bit of a stormy course.

My vague understanding is that the oesophagectomy is a very, very serious operation, is it?-- Yes, it is a very serious operation.

Had that sort of operation been done at Bundaberg previously?-- Probably. And there was one other that I have noted that was done prior to this that year, and I don't know which surgeon did that, I didn't make a note of that.

Right?-- There was another surgeon there from - I think he was from the States as well, and he did do an operation. I think that one was successful, but this patient, when he came into us from theatre, he was very unstable, and I remember he hadn't had a recordable blood pressure for the last 45 minutes that he was in theatre, and the anaesthetist actually complained - anaesthetist actually stated as she brought the patient in, "This is a very expensive way to die." And the patient - the patient was quite well known to the staff because he was a renal patient, so the renal nurses were

coming down to do the dialysis, and they knew the family very well. So we were telling the patient's family that the patient was unstable, and Dr Patel was telling them that he was stable, and it caused a degree of friction between the nursing staff and Dr Patel at that time.

You mention that he had been a renal patient at the hospital. There is a renal specialist, isn't there, at the hospital?-- Yes, Dr Miach, yes.

Had this patient been a patient of Dr Miach's?-- Yes.

What was Dr Miach's attitude to this surgery?-- From what I can recall, Dr Miach was in agreement to the surgery and he was handling the dialysis part of it.

Right?-- Because I think that they had come to the conclusion that maybe this patient had a little chance if he was operated on, whereas if he wasn't operated on at all he wouldn't have had any chance of survival. So I think at that point Dr Miach was in agreement to that surgery.

D COMMISSIONER EDWARDS: By Dr Patel?-- Sorry?

By Dr Patel?-- By Dr Patel. This was very early days and. Dr Patel was telling - he would tell us, you know, that he had had 15 years' experience in all these different things. So at that point in time that's what everybody thought he did have.

COMMISSIONER: Just going back to the comment it was the anaesthetist who said, as I understand your evidence, it was an expensive way to die?-- Mmm.

When the patient came to you in intensive care, do I understand that he was really only being kept alive because he was being pumped full of adrenalin and oxygen?-- Yes, that's right.

And the anaesthetist was, you understood, saying that he wasn't going to remain viable?-- Mmm.

There have been suggestions of what rather sensationally has been called body snatching, of people who are virtually dead in the operating theatre but moved out of the operating theatre so they wouldn't have to be reported to the Coroner's Office. Is that, in your opinion, what was going on here, that the body was moved out of the operating theatre to avoid it being reported as a death in surgery?-- No.

No?-- No. The surgery was over and he was due to come - I think that's a misunderstanding of, actually, a situation that happened not very long ago. Much, much, much later.

Right?-- Yeah, but that's not in relation to this case, no.

Okay, fine.

MR ANDREWS: Ms Hoffman, oesophagectomy, do you mean to say

that this was only the second occasion within three - your three years that an operation of this complexity had been carried out?-- That I recall, yes.

And is one of the reasons that an oesophagectomy might be counselled against, when dealing with a person who has cancer of the oesophagus, that the quality of life that the patient will enjoy after the surgery is so compromised that the patient is better off not undergoing the surgery?-- Often that's the case, yes.

So, indeed, if a - if at one hospital there is a refusal to perform the surgery, it is consistent with the advice that the patient would be better off without it, rather than that the hospital refusing the surgery was too busy or disinclined; it is for the patient's welfare that such refusals are made?-- Yes. There is a lot of literature that actually refers to what sort of hospitals should be doing oesophagectomies and what's important in the recovery. There is a very high mortality rate with an oesophagectomy, even if it is done at a tertiary hospital, and what the literature actually states is that a hospital should be doing at least - or a surgeon should be doing at least 30 per year to be competent in that area, and the post operative care needs to be - is pivotal, is a pivotal point in that patient's recovery. So, therefore, it should be done in a tertiary hospital where they can continue to have very intensive physiotherapy 24 hours a day and have the care of an intensivist and a specialist gastroenterologist for their recovery.

Your own experience with oesophagectomies, did you have any prior to May of 2003?-- Yes, I did.

Can you tell us about that? Had you treated oesophagectomy patients in other hospitals?-- I had cared for patients that had had oesophagectomies in other hospitals, yes.

On how many occasions?-- I don't know on how many occasions. Probably - probably around a dozen over the years.

COMMISSIONER: Were they hospitals with Level 3 ICU facilities?-- Yes, yes. And hospitals that - and the surgery was carried out by a specialist gastroenterologist.

I see, rather than general surgeon?-- Yeah.

D COMMISSIONER EDWARDS: Ms Hoffman, it would be fair to say that oesophagectomy is very major surgery?-- Yes.

Secondly, it would be only undertaken by people who were well experienced, is that correct?-- Yes.

And, thirdly, the intensive care requirements for a patient post successful oesophagus operation would be enormous?-- Yes.

And would involve a team effort?-- Yes.

And, therefore, Dr Patel would have been involved in that, too?-- Yes.

I guess my point is: can you give us a view, even at this stage of your evidence, that very major concerns, therefore, were along two lines: the surgical competence?-- Yes.

And, secondly, involvement in intensive care?-- Yes, both of those issues.

Would you care to make any general comments about your views now as to his competency in both areas?-- Well, it is in hindsight now.

That's probably a better way to do it.

COMMISSIONER: Yes. But these problems didn't become apparent to you all at once, is what you are saying; it was over a series of incidents?-- Yes, it was over a series of incidents. It was also just his whole persona and his whole bravado about things and things didn't match up. You know, he would say he had trained in the States and he had - you know, he would say one day he had 15 years as a trauma surgeon. The next day would be 25 years as a cardiothoracic surgeon. Every day there was a different qualification and every - and he was very - he was very loud, and he was very old fashioned in his views in terms of the types of drugs and treatment that nowadays we use in intensive care. He was, around about, I would say, sort of 20 years behind. Like, we've sort of gone full circle in the types of drugs and things that we do in intensive care and he was way back there, but he would consistently refer to us as the third world, and that he was here doing us a favour, that he didn't need the money and we were very - we were very backward in our - the way that we cared for patients and things like that. So it was - there was a whole sort of picture evolving about Dr Patel.

You mentioned earlier there was a Head of Anaesthetics in ICU. It was Dr Martin Carter, is it? I can't read my own handwriting. Was he there at this time in May 2003?-- I don't - I can't - I don't think he was there at that particular time. I think that he may have been on holiday and - I am not sure. I can't remember exactly. And I think Dr - or - no, I think he was on holiday because Dr McCready did the surgery and Dr McCready is his wife. So I actually think - not the surgery, the anaesthetic. So I think he actually may have been away at that point in time and another doctor was in charge.

And then who would have been the responsible doctor in ICU? Would it have been Dr McCready, as the anaesthetist at the operation, or a different anaesthetist?-- It would have been a different anaesthetist. It was either Dr Younis at that time or Dr Joyner also at some point was Acting Director as well.

Was Dr Joyner full-time or visiting?-- No, he is the visiting GP who comes and does some anaesthetics at the hospital.

Okay, thank you.

MR ANDREWS: Indeed, in your statement you express the opinion that Dr Younis was left in charge, as the Director of Anaesthetics and Intensive Care was away at the time?-- Mmm.

Had you been concerned prior to this surgery that there shouldn't have been an oesophagectomy, to whom would you have reported?-- To my line manager, who was the Director of Nursing.

In Queensland Health is there a concept of line managers, and when any employee has a complaint to make, do they make it to their particular line manager?-- Yes.

And the Director of Nursing at that particular time was Glennis Goodman?-- Yes.

But before this oesophagectomy was Dr Patel an untried, untested phenomenon?-- Pretty much, I would say, mmm.

After you saw this procedure and its results, did you have concerns?-- Yes, I did have concerns.

To whom did you speak?-- I spoke to many people. I spoke to-----

Did you speak to your line manager?-- Yes, I spoke to my line manager.

Was that Glennis Goodman, the Director of Nursing?-- Yes.

Did you and Glennis then go and speak to someone else?-- Yes. Glennis and I - Glennis made an appointment for me to go and see Dr Keating and her and I went and saw Dr Keating.

How commonly do you go with your line manager to speak to the Director of Medical Services; that is, how commonly up until that stage would you have done such a thing?-- I can't remember if I had been before or not but not - it is quite uncommon.

And what were your - what were the concerns you reported to Darren Keating?-- My concerns, I think, at that time were just - was partly to do, I think, with my concerns of the overall behaviour of the surgeon and also about - I think we did talk about the oesophagectomies. It was soon after that that I went back to see him with Jon Joyner about the oesophagectomies in particular.

And who was Jon Joyner?-- Jon Joyner was the GP anaesthetist who was - I think he was acting, actually, in charge - I am not sure if he was actually in charge or not at that time but he - he was raising the concerns about oesophagectomies being done at the hospital.

And these two visits to Darren Keating, can you place them in

time? Were they soon or long after this oesophagectomy on patient P34?-- They were after that patient and before the next oesophagectomy was being done.

Right. Now, you see, you made two visits to Dr Keating. You have said that you raised concerns about the surgeon, that is Dr Patel's behaviour, and concerns about oesophagectomies. What about Dr Patel's behaviour did you bring to Dr Keating's attention?-- The things that I had already described, about his way of thinking. Usually when you work in intensive care, the doctors and nurses are fairly much on the same sort of wavelength but it appeared to me that Dr Patel was - he thought so differently to myself and the other staff members as well that it was almost like - I remember saying to Dr Keating it is like we're from a - we're coming from two different planets.

COMMISSIONER: Just so that we understand what you're saying, my imagination is that I see you as, generally, very much a team effort between the medical practitioners, the nurses and the other staff involved, and I guess it wouldn't be uncommon for a doctor to ask your opinion as a very experienced ICU nurse what should be done in a particular situation, not necessarily delegating to you but at least consulting with you in getting your input; is that a fair guess on my part?-- That is, and it all very much depends on the personality of the doctor. I mean, a lot of doctors wouldn't talk to a nurse at all, whereas a lot of doctors would value the opinion of a nurse.

Yes?-- So it very much depends on the doctor, the personality of the people involved and a lot of, you know, sort of other factors, I guess, as well, but-----

So how did Patel's conduct sort of stand him apart from other doctors that you've worked with in ICU?-- Apart from all of those other things, he would threaten us, he would say things to us like, you know, "The executive will do whatever I want them to do because I'm making them so much money." "I'll resign if they don't let me keep my patients here." He didn't want his patients to be transferred out, he wanted them to stay in the Intensive Care Unit and he would then, like, threaten to resign, he would go and - he would tell us - this is what he would tell us, that he was going up to executive and resigning and then there'd be no surgeon, and in Queensland Health, surgery's the only thing that brings in revenue, so the executive is under a lot of pressure to, you know, to put through as much surgery as they can so they come in on budget and meet their surgery targets.

D COMMISSIONER EDWARDS: This is where the patient's care is refunded by Medicare to the hospital or the doctor; is that what you're saying? That this is a form of gaining extra income? What do you mean by that?-- I just mean that surgery is the only - the only revenue that the hospital gets, apart from whatever their budget is per year, is for surgery, so they must meet their elective summary targets, so that's why it's very, you know, it's very important for them to have a surgeon who's putting through a lot of patients because they will meet their surgery target and they'll-----

And Dr Patel was doing that?-- Yeah, Mmm. Dr Patel was, you know, he was - and he would say that, that was part of his threat, and he would, he would - yeah, he was, he would threaten the staff, he would tell the staff when I wasn't there that, you know, I wasn't supportive of them and try and create disharmony within the unit and he was also, he would also argue with some of the anaesthetists and it was very unpleasant at that time working in the unit. He was very loudly spoken and he would make a lot of disparaging comments very loudly so that you could hear them about the IC - you know, about the ICU and Australia itself being the third world and, you know, how backward it was for him to come here and all that sort of thing.

COMMISSIONER: While we interrupt Mr Andrews again.

D COMMISSIONER EDWARDS: Yes, sorry.

COMMISSIONER: Can I also follow up on something you said earlier about his being 20 years out-of-date with medication and that sort of thing?-- Mmm.

Are you able to give any specific examples? For example, antibiotics that he was recommending that had been replaced more recently with more effective ones or-----?-- Yeah, not so much antibiotics, it was more like the drugs that we call the inotropics, the drugs that keep your blood pressure up, over the years we used to use Dopamine and Dobutamine and now we use Adrenaline and Noradrenaline and that's all done through research, it isn't just we decide to use it, and a lot of research has gone into the best sort of inotrope given in the best situation when the patient's got an infection, you use a certain type of inotrope, but Dopamine and Dobutamine went out of fashion, went out a good nearly 10, 15 years ago and he would come in, our doctors the - the doctors in the ICU would put the patient on adrenaline and Noradrenaline, he would come in and tell them to take it off and put them on Dopamine and Dobutamine, and it caused a lot of - the nurses didn't know who to take notice of.

So anyway, these are the points you raised with Dr Keating when you went to see him?-- Yes, I think, yeah.

And I see in your statement, I think it might have been the second meeting with Mr Keating that Dr Joyner also went along?-- Yeah, Dr Joyner and I went along together to talk about the concerns about the ability the oesophagectomies.

Is that because Dr Joyner shared your concerns?-- Yeah, he shared my concerns and Dr Patel wanted to do another Oesophagectomy.

Yes?-- And we thought it was unwise to do another one and so we went along to try and see if we could stop it.

And what was the reaction from Dr Keating when you said these things to him?-- I can't - I can't remember, like, the exact conversation, I just remember that we were told that Dr Patel was a very experienced surgeon, very used to doing these sorts of surgery and that no, it was important that we keep him in the hospital so it was important that we worked with him and did what he wanted, basically.

One could perhaps understand the medical superintendent reacting that way when it was a complaint merely from one person, but what was the reaction then when you had Dr Joyner come along and really echo the same concerns that you had?-- I don't think there was any difference. I don't recall there being any difference.

Yes. Did you raise your concern about Dr Patel describing patients as stable when clearly they weren't stable?-- Yes.

What was Dr Keating's reaction to that?-- I can't remember if he - I can't remember.

Yes, Mr Andrews?

D COMMISSIONER VIDER: Mr Andrews, could I ask a question?

MR ANDREWS: Of course.

D COMMISSIONER VIDER: Just continuing that line of questioning, Ms Hoffman, P34, that patient, the outcome for that patient was-----?-- He died five days later.

-----I'm presuming the patient died. You - then you had said in this statement that Dr Patel would describe a patient as stable when all the clinical indicators were by everybody else's assessment the patient was not stable?-- Yes.

And that Dr Patel would then communicate to the family presumably?-- Yes.

That he'd considered the patient to be stable?-- Yes.

Can you just use patient 34, if you could recollect then what happened with that family when the patient died; how were they dealt with by Dr Patel?-- Dr Patel was very angry with the nursing staff because we were telling the family that he was unstable and he was telling them that he was stable, but it's at some point during the patient's stay it became obvious that, you know, the patient was going to die, so I think the family were aware of that at that time and I can't remember any - I can't remember exactly any interaction between Dr Patel and that particular family at that particular time.

D COMMISSIONER VIDER: Thank you.

COMMISSIONER: So the effective result of all of this, Dr Patel performing an operation, that the patient had been told in a tertiary hospital in Brisbane shouldn't be performed, was what, to shorten the patient's life and to make the last few days of his life fairly uncomfortable; that's all that was achieved?-- Mmm.

And of course, the hospital got more money?-- Yes, Mmm.

Thank you Mr Andrews.

MR ANDREWS: About two and a half weeks after patient P34 came into Intensive Care, there was another oesophagectomy; wasn't there?-- Mmm.

Do you recall in the days prior to that oesophagectomy Dr Patel announcing that it would occur?-- Yes.

And was there something unusual about his announcement?-- Yes. He came into the unit and he stated in front of the staff that - to warn all the staff that we'd be working on the

weekend, that he would be - can I refer to my patient statement about that - what was - can I refer to that?

Of course you may?-- It's attachment number 1, I think.

MR ANDREWS: It's being put up on the screen now?-- Okay. Dr Patel came into the unit.

Is that a letter written by another staff member?-- Yes, another staff member who was present.

Do you have your own recollection of the events?-- Yes, I do.

And why would Kay - would that particular staff member write to you? Were you her line manager?-- I was her line manager, yes, and he just, I think she was incensed that he would - what he was saying is that he didn't trust the staff that were on, he said in our hearing - he didn't say it exactly to us, he would come in and he would make statements that were loud enough to be heard but he may not actually address you, you know, directly, so he came and said in our hearing that we should warn the staff that we were working Thursday and Friday that he would be in the unit for the whole two days whilst my oesophagectomy is in here until he leaves the unit and then everybody ignored him and he went out of the unit. So - okay.

Was it such an unusual thing to occur, that it warranted a report to a line manager?-- Yes, it was, because for the start, what he was saying was, he wasn't going to let this, the intensive - well, the anaesthetist care for his patient that he was going to be there directing the care for his patient because he didn't trust anybody and that he didn't trust the nursing staff either.

All right. Now, the oesophagectomy took place on Friday the 6th of June?-- Yes.

And that patient, P18, was admitted to Intensive Care?-- Yes.

COMMISSIONER: P18 is we see again a person with a male name; do you have any recollection as to his age?-- I don't but he was an older - he was slightly older man, I think, probably, I'd say in about his 70s.

Okay.

MR ANDREWS: Now, when he was first admitted to Intensive Care, was there any plan as to whether he would remain in the Bundaberg ICU? Was that the original intention or was it always anticipated that he would be transferred elsewhere?-- Well, a normal oesophagectomy does only require usually intensive care therapy for two to three days and then they would go to a high dependency unit or to the ward. So I don't know what the plan was, I don't know if Dr Patel had come to an agreement with either the anaesthetist or anybody else about keeping his patient in there, but I know that he did not, you know, like, he wanted that patient to stay in the ICU at Bundaberg.

And indeed, the patient stayed there for 14 days?-- Yes.

Before being transferred to Royal Brisbane Hospital?-- Yes.

And was the patient transferred to Royal Brisbane Hospital because he'd stabilised and improved or because he needed care that could not be delivered in the ICU at Bundaberg?-- He - the patient had a very very stormy post-operative period where he actually went to theatre, returned to theatre two or three times for wound dehiscence, which is where the wound falls apart.

This is June 2003; how many times in your career had you encountered wound dehiscence?-- Probably about once.

And so this was the second occasion that you saw it?-- Yes.

COMMISSIONER: Are we talking about the results of infection or what brings about-----?-- Normally that is one of the reasons why a wound does come apart from an infection, but it was noted and once again, this is a bit in hindsight too, I'm getting ahead of myself, a lot of - Dr Patel had a lot of wound dehiscence, that was a lot of the things that we noticed very early on as well, and but it didn't seem to be associated with a - necessarily with an infection, and so this was something that was looked at quite widely within the hospital with various other people involved.

No doubt we'll be hearing from other medical practitioners later on, but did you have your own views or theories about the causes relating to the suturing or to something else?-- Well, I didn't know why, I had not, you know, I've only had seen it once before, but this particular patient suffered three in one episode, so he had to return to theatre, I think, three times for repair of a wound dehiscence. Dr Patel did blame it at one point on inferior suture material and there was an issue that he was letting his junior staff sew up the wound at some point. I'm not quite sure if it was with a surgery of this type of this nature or not, but the wound dehiscence was a major cause of alarm and concern throughout the hospital.

MR ANDREWS: So the wound of patient P18 came apart on three separate occasions?-- Yes.

Having been sewn up three times?-- Yes.

It opened up three times?-- Yes.

Now, the suggestion of Dr Patel that it was an inferior suture material, were you aware that there were any different suture materials being suddenly introduced to the Bundaberg Hospital?-- No, I wasn't aware of that.

COMMISSIONER: Did any other surgeon or doctor in the hospital report problems with inferior suture material?-- No. Neither did we have any other wound dehiscence from any other surgeon

either.

MR ANDREWS: Now, the complications that ensued for patient P18 that required a transfer to a Brisbane Hospital, did they result in any conversations between Dr Patel and ICU staff? How did Dr Patel react to the notion that the patient might be transferred?-- At one point we had obtained a bed in Brisbane for the patient, he'd been there quite some period of time, much longer than the 24/48 hour rule, and we had obtained a bed for the patient in Brisbane and Dr Patel came to the unit and he got very angry with the staff and he said he was going up to see Dr Keating and Mr Leck and that this patient would not be transferred to Brisbane, and apparently, from my recollection at that point he had a meeting with Dr Keating, and I'm not sure whether Mr Leck was there or not, and they decided to keep the patient for another 24 hours and re-assess him.

Was it explained to you why that was done?-- I think it was just to appease Dr Patel.

No, but was it explained to you why it was done?-- No.

And can you think of any explanation that would be consistent with a proper attention to care for this patient for leaving the patient in the Bundaberg ICU?-- No.

D COMMISSIONER VIDER: Mr Andrews, could I make a request? This patient was ventilated?-- Yes.

For the whole time in the Intensive Care Unit?-- Yes.

Had a tracheotomy been performed?-- No, not to my recollection, no.

For the duration of that ventilation?-- Yes.

Thank you?-- Can I talk about what happened next or not?

MR ANDREWS: You may?-- The next day we tried to get a bed again in Brisbane but there was no beds to be had, so we had to wait another five days, I think, about another five days.

Is that a common enough occurrence?-- Yes.

Even in Brisbane?-- Yes.

D COMMISSIONER EDWARDS: Even for seriously ill patients?-- Yes, it is and - yeah, and they have to look at what - they have to prioritise as well, so.

COMMISSIONER: But when you say shortage of beds, particularly shortage of ICU beds?-- Yes, shortage of ICU beds. I remember we tried around the State in any tertiary hospital to try and get a bed for this patient and this is I think when Royal Brisbane and PA said to us, "Why are you doing these big operations there when you can't care for these patients?", and when we tried to get a bed, when we talked to Prince Charles,

they said, "They didn't have the ability to care for someone who'd had an oesophagectomy so why are you doing it in Bundaberg?"

MR ANDREWS: Now, Prince Charles, it would have had a Level 3 Intensive Care Unit?-- Yes.

And yet do you mean that even Level 3 Intensive Care units which would have an intensive on staff might not have the facilities to care for a patient after an oesophagectomy?-- Yes.

If they didn't have the experience of that type of surgery, yes?-- So the patient stayed an extra, I think it was probably five days, I think there's another - there's an e-mail or something about that but he did stay another, for about five days in the ICU at Bundaberg which compromised his care.

After this surgery and the complications for patient P18, did you make any complaint?-- Can I refer to my - just to my e-mails?

I think TH2 and TH3 may refresh your memory?-- Yes.

While you're looking that up, can you tell us what happened to patient P18?-- I just have to refer to another note.

Certainly?-- He actually went, after he went to Brisbane, he - which was on the 20/6, he actually lived until the 8/1/04, so he had probably-----

Six months?-- -----about six months, yeah.

Now, do you see before you a monitor?-- Yep.

Showing your Exhibit TH2; is that a copy of an e-mail you wrote to Glennis Goodman?-- Mmm-hmm.

Glennis being your line manager at the time?-- Yep.

And the portions in yellow, do they reflect the expressions of people from the Princess Alexandra Hospital and the Royal Brisbane Hospital?-- Yes.

That is the-----

COMMISSIONER: The Prince Charles.

MR ANDREWS: -----and TPH3, is that the Prince Charles Hospital?-- Prince Charles Hospital.

Now, were you making a suggestion to your line manager that there should be an examination of whether it's appropriate to do oesophagectomies, having regard to the ICU at Bundaberg Hospital?-- Yes. I'd had informal discussions with Glennis on her - when she would come and do her morning rounds about the patient.

Did you and Glennis - I beg your pardon - did you the next day write to Dr Keating by e-mail and copy it to Glennis, your line manager?-- Yes, I did.

COMMISSIONER: Just while we have that in front of us, for my benefit, and in the third line it talks about the patient having again gone into "AF"?-- Yes.

What do you mean by "AF"?-- Atrial fibrillation.

Right?-- So he'd actually become more unstable and he also developed what to me was like a chylothorax, which was another example of why I was perturbed about Dr Patel because Dr Patel didn't recognise a chylothorax, it's when you have an intercostal catheter, a catheter put into your chest and it drains off lymph fluid and it looks like feeding and when once you've seen it, you always remember it.

Yes?-- But Dr Patel didn't recognise it at all and that's another reason why I was - alarm bells were ringing in my head about Dr Patel.

In your e-mail, you say "developed what looks like a chylothorax"?-- Yep.

And has some question mark "feeding coming out of the bottom of his wound"; is that your way of saying you're not certain of what it was that was coming out of it?-- I think it was feeding coming out of the bottom of the wound but out of the chest tube it was what was chylothorax, yep.

MR ANDREWS: So there were two separate discharges from the body, weren't there?-- Yes.

One from a wound that was consistent with feeding and one from a tube from the thorax which was consistent with chylothorax. And what did Dr Patel - did Dr Patel name the discharge from the thorax, did he give it a-----?-- Initially he didn't say it was chylothorax and it was after - it was, I think it was a couple of days after when I had actually said it was that one of the residents wrote that in there and then I think it became a chylothorax.

Yes. Would you look please at TH3? Is that the e-mail that you sent to Dr Keating on the 19th of June?-- Yes, it is.

And do you have some way of checking to ensure that in fact Dr Keating received that document?-- Yes, you just go into "Properties" and it tells you it's been opened and when.

I see.

COMMISSIONER: This is, although it's - we refer to it as an e-mail, it's actually on Intranet within the hospital, is it?-- Yes.

And therefore there'd be an indicator on your terminal showing

that Dr Keating had picked up his mail?-- Yep, and opened it.

From the Intranet system?-- Yep.

Okay. I assume Queensland Health's going to get around to producing copies of these eventually.

MR FARR: If they've not yet been produced, then they will be.

COMMISSIONER: Thank you?-- And in this e-mail too, this is, I think it, for me, it's quite a strongly worded e-mail and I start to talk about that "We have to discuss the issues regarding the transfer of patients and the designated level of the unit and also the behaviour of the surgeon" because at this point he had started to sexually harass the nursing staff and that's what I'm referring to when I talk about certain very disturbing scenarios have occurred.

MR ANDREWS: All right. Now, from Dr Keating's point of view, you've pointed out that a patient's returned twice for wound dehiscence?-- Yes.

Now, that would be an unusual thing to be reading about in a patient, wouldn't it?-- Yes.

Did you have a follow-up discussion with Dr Keating after you sent this message?-- I don't recall so, no.

Does that mean you didn't have a follow-up discussion or you don't remember whether or not you did have one?-- I don't believe I had one.

Did Dr Keating come to see you about this?-- No.

COMMISSIONER: Mr Andrews, I notice the time. Just before we rise for lunch, I was going to ask everyone at the Bar table about sitting times. My experience in long-running cases, including Commissions of Inquiry, is that ultimately things work much more efficiently if people have a day off at the end of the week to catch up and to prepare for the next week and so on, so I was going to suggest that we extend the sitting hours during the week starting, say, at 9.30 and having only an hour for lunch rather than the usual hour and a half and then have Fridays off so that particularly you people at the Bar table, all of you can keep abreast of what's happening and prepare your work.

I just ask people around the room to think about that and perhaps let me know after lunch what you would prefer to do, whether you want to sit normal Court hours for five days a week or whether you want to sit extended hours for four days a week.

MR ANDREWS: Thank you.

COMMISSIONER: Thank you, we'll now adjourn until 2.30. Thank you.

THE COMMISSION ADJOURNED AT 1.00 P.M. TILL 2.30 P.M.

THE COMMISSION RESUMED AT 2.34 P.M.

COMMISSIONER: Sorry, ladies and gentlemen, about the slight delay. I had things I had to deal with. Have we managed to reach any consensus yet as to whether counsel and solicitors would prefer to work a four-day week extended hours or five-day week? Mr Tait, I know you would like a four-day week regular hours.

MR TAIT: Commissioner, I'm prepared to accept that, four days and longer hours.

COMMISSIONER: Anyone else? Anyone else have a different view?

MR DEVLIN: I think it is appropriate.

MR ALLEN: Likewise.

MR DIEHM: I'm comfortable with it too.

COMMISSIONER: As of tomorrow we will start at 9.30 and take only an hour for lunch in accordance with that and then we won't sit on Friday.

MR ALLEN: That, of course, is subject to the recognition of the toll it may take on certain witnesses.

COMMISSIONER: Indeed. I will certainly be cognisant of that. I should also mention something that has been said before but it is worth saying again. Obviously a lot of the witnesses in these proceedings are people from the medical and allied health care professions. The last thing I want to hear it suggested is that we have taken someone away from the operating theatre or from their clinical responsibilities and we will try to be as flexible as possible to have witnesses give evidence outside ordinary Court hours or at other times that suits their convenience if that becomes necessary.

MR ALLEN: Commissioner, this may be an opportune time then to raise one matter. The Queensland Nurses Union continues to assist this Commission in its inquiry by way of provision of intelligence and also statements from its members. The QNU is also assisting the Crime and Misconduct Commission in relation to its investigation of a complaint of official misconduct on the part of Commonwealth Health officials.

COMMISSIONER: Yes.

MR ALLEN: We know that the CMC has announced public hearings from the 6th of June this year. My instructing solicitors have written to both the Commission and the CMC raising the union's concerns that its members may suffer unnecessary inconvenience or distress if required to give evidence before both inquiries. Given that the Terms of Reference of this inquiry would appear to encompass the matters the subject of

the CMC investigation, it would be likely that QNU members, if required to give evidence before both inquiries, would necessarily be repeating evidence that has already been given in the case of Ms Hoffman or which will be given in the future before this Commission. At least one of the union's members has had accepted by WorkCover a claim for psychiatric injury suffered as a result of the circumstances surrounding Dr Patel's practice and Queensland Health's response to complaints by nursing staff.

We recognise that this Commission cannot tell Mr Needham what to do but the QNU does hope that all avenues have been explored between the Commission and the CMC to avoid the need for its members to basically repeat their evidence before both inquiries.

COMMISSIONER: Mr Allen, I'm very grateful to you for raising those concerns. In response to what you've said, may I make a few points. Firstly, what you say is very true, that we can't tell the CMC what to do and nor can they tell us what to do. It was not my decision nor that of Mr Needham that we would have two inquiries running at the same time in relation to similar issues but being put in that situation, Mr Needham and I have met on a number of occasions to attempt to minimise not only the trauma for witnesses likely to give evidence at one or both inquiries but also the delay and expense and inconvenience for everyone concerned.

We have arrived at arrangements which are designed to minimise, I can't say eliminate but minimise, the sorts of concerns which you've articulated. For example, if one of your members gives evidence at the CMC inquiry, we will be quite happy to take that evidence as an exhibit in these proceedings without requiring the witness to go into the witness box and repeat what's been said elsewhere. If one of the parties in these proceedings or one of the organisations or individuals who has been given leave to appear wishes to cross-examine that witness, then the cross-examination can proceed on the basis of the evidence that's already in the transcript and you can be assured that I will be very astute to prevent cross-examination from going over ground that has already been thoroughly, thoroughly canvassed.

The other thing I should make clear is that where the evidence of a witness is non-controversial in the sense that there is no dispute as to whether what the witness says is true and false and no conflicting evidence from any other witness, we are very comfortable about taking evidence in the form of written statements without requiring the witness to come to the hearing and give evidence orally. Obviously if there is some conflict between the testimony of one witness and another, then the parties represented will have to be given an opportunity to proceed with cross-examination, but hopefully that can be minimised.

I should also mention that your instructing solicitors communicated with the Commission of Inquiry a couple of weeks ago raising the concern that if we had adhered to our original

dates, there would actually be two inquiries going on at the same time and we have rescheduled the Bundaberg sittings to make sure that, so far as possible, there is no overlap.

The other thing that's important for everyone to be aware is that senior counsel assisting this inquiry, Mr Andrews, has also been seconded to the Crime and Misconduct Commission to be, in effect, the senior counsel conducting their inquiry. So that, any information produced from that inquiry will be available to this inquiry as well.

Mr Allen, I know that that is not a complete answer to the concerns you've raised but I can assure you we have done our best to minimise those sorts of concerns and inconveniences. If there is any particular matter that comes to your attention, please feel free to raise it. For example, if there's a witness giving evidence in a fortnight's time at the hearing in the CMC and that witness feels emotionally exhausted and unable to give evidence to this inquiry for some period of time, then we will try and schedule the witness at a time when it gives him or her an opportunity to recover from the ordeal and come along to give evidence on a later occasion. Those are the sorts of things we will try to do anyway. I can't guarantee that everybody will be happy but it is the best we can do.

MR ALLEN: Thank you indeed, Commissioner.

MR DEVLIN: May I raise another issue of housekeeping, and that is the availability of transcript. Is there a formula of availability for those now with authority to appear?

COMMISSIONER: The direction I have given - there is a set of standing orders or directions for the conduct of proceedings and that includes a direction that every party with leave to appear is entitled to a free copy of the transcript.

MR DEVLIN: Is modes of delivery determined yet?

COMMISSIONER: I understand that in each case it will be electronic delivery and I suspect, Mr Devlin, although I don't know off the top of my head, that if you provide an e-mail address to the staff of the Commission, that will probably ensure that it gets to you quickest. The other thing is that we're doing our best to put transcripts on the Commission website as quickly as possible and it is hoped that each day's transcript will be on the website about an hour after the evidence finishes. So if we stop at 4.30, it should be available at about 5.30.

MR DEVLIN: Thank you.

COMMISSIONER: Anything else before we proceed? Mr Farr, any more developments from your end of the Bar table.

MR FARR: No, not at the moment, Mr Commissioner. There is a meeting taking place as we speak.

COMMISSIONER: Excellent, thank you. Mr Andrews.

MR ANDREWS: I should alert you, Commissioner, to two matters. One is that I'm instructed that tomorrow morning at 9.30 - oh, 10 o'clock there's to be an evacuation of this building as a fire drill.

COMMISSIONER: Right.

MR ANDREWS: But those who make it into this courtroom by 9.30 won't be obliged to leave. Indeed, they may not be able to leave until the evacuation is complete.

COMMISSIONER: Well, that's another incentive, if we wanted one, to sit extended hours.

MR ANDREWS: Yes. The second housekeeping matter is that the evidence of Ms Hoffman, I'd alerted counsel for Ms Hoffman and several of the parties who'd announced their intention to seek the liberty to appear that it was my intention to call her evidence-in-chief and it was anticipated that cross-examination of Ms Hoffman might be completed in Bundaberg.

COMMISSIONER: Yes. Thank you, Mr Andrews. I should have mentioned that earlier. It relates to the point that Mr Allen made about the two inquiries going on simultaneously. We are of the view that it would be unfair to Ms Hoffman to expose her to cross-examination in this inquiry before giving her evidence at the CMC inquiry. So the proposal is that she give her evidence-in-chief here and then she should be stood down and made available for cross-examination probably in the Bundaberg sittings in about a month's time. Does that cause anyone any inconvenience?

MR FARR: No.

COMMISSIONER: Also, if I hadn't made this clear, Mr Farr, until the situation is resolved regarding the people whom you represent, I'm more than happy to treat you as one of the parties represented here even though we will ultimately have to get some clarification as to who it is that you're representing.

MR FARR: Certainly. Thank you.

COMMISSIONER: Mr Andrews, since you have raised those matters, can I raise with you one other matter. Mr Allen did mention that some intelligence has been provided by the union to the Commission of Inquiry and one piece of intelligence at a very, very early stage was what appeared at the time to be quite compelling evidence regarding destruction of documents at Bundaberg. Are you able to inform the inquiry how that matter presently stands?

MR ANDREWS: Those allegations have been investigated and there seems to date to be no substance by way of prima facie evidence.

COMMISSIONER: So you're not expecting to be calling any evidence on that issue?

MR ANDREWS: I am not.

COMMISSIONER: All right. And perhaps it should be made clear we are grateful that those representing the nursing union brought that concern to our attention even though it seems to have come to nothing ultimately. Thank you, Mr Allen.

MR ALLEN: Thank you.

MR ANDREWS: I ask that Ms Hoffman return to the witness box.

TONI ELLEN HOFFMAN, CONTINUING EXAMINATION-IN-CHIEF:

MR ANDREWS: Ms Hoffman, I was asking you about your Exhibit TH3 before the luncheon adjournment. Within it you referred in two places to issues relating to the behaviour of the surgeon. I've identified them in the document with a pink highlighter and I'd ask you to look at the monitor to see where you refer to those - to behaviour on two occasions. Are they - do they both relate to sexual harassment or are there two different behaviours that you're reporting?-- I'm referring to the behaviour of the sexual - the sexual harassment plus the way that Dr Patel was yelling and screaming, and that sort of thing, in the unit.

I see. And which is the behaviour that was confusing the nursing staff. I assume the yelling and screaming?-- No, that was the - when the anaesthetist would give orders and then Dr Patel would counteract them. That was the confusing part.

Now, your intranet correspondence was to Darren Keating?-- Yeah.

Dr Keating?-- Yeah.

And to Glennis Goodman, your line manager?-- Mmm-hmm.

But you noted that you didn't want to make an issue of it. You just wanted it to be noted. Is that a-----?-- What I didn't want to make an issue of was that I was concerned that the patient's care had been compromised by not sending him to Brisbane on Tuesday, because I'm - what I'm saying is it's easy to be wise in hindsight. I mean, that patient may or may not have got better in that time, so I didn't - that's what I don't wish to make an issue out of. I would just like that to be noted, the fact that when we have - when we had a bed available, that we should have used it.

Now, the sexual harassment complaint, was it something brought

to your attention?-- Yes.

Because you were someone else's line manager?-- Yes.

And-----

COMMISSIONER: Is there any need to mention the name of the person?

MR ANDREWS: Not for my purposes, no.

COMMISSIONER: Does anyone have a different view? I don't see any point in that name coming into evidence. No.

MR ANDREWS: You received a verbal complaint from a registered nurse that Dr Patel had asked for her telephone number over the top of a patient they were both attending to?-- Mmm-hmm.

She'd given the telephone number and he'd continually telephoned her, harassed her and he'd come into her unit, hang around her and make her uncomfortable?-- Yes.

Now, when given such a complaint, was there a procedure to whom should you have reported that?-- We went to the human resources manager.

Ms Cathy Fritz?-- Cathy Fritz.

And you passed the complaint on to her-----?-- Yes.

-----to deal with?-- Yes.

Should you have reported it to anyone else?-- I reported it to my line manager, Glennis Goodman.

Was that in accordance with procedures?-- Yes.

Now, as we're passing along chronologically, on the 3rd of July 2003 you received an e-mail from the Infection Control Co-ordinator, Gail Aylmer, A-Y-L-M-E-R, is that how her name is pronounced?-- Aylmer, yes.

Aylmer. Now, it discussed wound dehiscences. Had you encountered - were there other staff who were encountering wound dehiscences?-- Yes. Yes, there were. To my knowledge there was - there were a group of us that were concerned about it. The nun from the surgical ward, the nun from theatre-----

Well, Ms Aylmer's e-mail seems to have been sent to numerous persons; by the names, they all look to have been female. Were they all nurses?-- Yes.

COMMISSIONER: That's a very chauvinist assumption, Mr Andrews.

MR ANDREWS: I can't argue with that, Commissioner.

COMMISSIONER: Well, we know they're not orthopaedic surgeons,

anyway.

MR ANDREWS: Ms Hoffman, the e-mail from Ms Aylmer spoke of these occurrences occurring over the previous six to eight weeks. Was there anything that had occurred at the hospital that was unusual in the last six to eight weeks?-- Not that - not that we could pinpoint.

How long had Dr Patel been at the hospital by the 3rd of July? Would it be about-----?-- Nearly six - six months I think.

Had he not arrived some time in May?-- No.

I see. Six months. Good?-- But it may have been - I'm not quite sure exactly when he started but it was - I think it was around February. January, February.

I see. Thank you.

COMMISSIONER: Before you move on, Mr Andrews, we canvassed earlier whether the name of the registered nurse who made the complaint of sexual harassment should be mentioned in the evidence. I see that her name does appear in the statement which is now Exhibit 4. I don't know whether there's any need to make a formal order but I would urge members of the press and the media not to give the particular registered nurse any unnecessary publicity. There is no suggestion that she has done anything wrong and it would seem inappropriate to publicise the fact that she was - attracted uninvited attention from Dr Patel or anyone else.

MR ALLEN: To put the matter beyond doubt, I would ask for an order for non-publication of that name, Commissioner.

COMMISSIONER: Does anyone wish to resist that, Mr Andrews?

MR ANDREWS: No, Commissioner.

COMMISSIONER: Well, I will make a non-publication order in relation to the name of the registered nurse mentioned in paragraph 27 of Exhibit 4.

MR ALLEN: Thank you, Commissioner.

COMMISSIONER: Thank you, Mr Allen. Again, members of the press and media may have access to that document uncensored but they may not use that name in reports either printed or in the electronic media. Thank you.

MR ANDREWS: You were asked to gather - you and others were asked to gather data about wound dehiscences. Do you recall if any survey was completed?-- I believe that we attempted to - we attempted to but I didn't actually - I don't recall the meeting, actually, so I don't know-----

Well, it was at the meeting that you were asked, no doubt, to gather data as your statement explains?-- Yes.

My question is whether after that meeting data was gathered so that conclusions were ultimately able to be reached?-- As I said, we did try and attempt to collect data but we had some difficulty attempting - we had difficulty collecting the data, for various reasons. We had - there was a - one of the forums that we attended was a surgical forum, a monthly surgical forum, and wound dehiscence was a part of that ongoing investigations that we talked about at this forum.

Wound dehiscence is an event which indicates that there are significant problems, is it not?-- Yes.

It ought not to be occurring at all?-- Yes.

You next speak of patient P39 admitted-----

COMMISSIONER: Before we move to patient P39, do you till have on the monitor in front of you the copy of attachment 5, I think it is, TH5 to your affidavit, or TH3.

MR ANDREWS: TH3, Commissioner.

COMMISSIONER: Just for my benefit, I'm sure the Deputy Commissioners could tell me this but in the fourth line you refer to a jejunostomy. Can you tell me what that is?-- It's just a tube that goes into the jejunum off the bowel for feeding.

Great?-- And it is just a routine procedure that's performed when someone can't be fed orally.

Okay?-- To maintain their nutrition whilst they recover.

Then the next sentence you refer to the details of the ventilation, 55 per cent Fio2 and 5 PEEP. Can you just explain in simple terms what that means?-- Air is 21 per cent. So 55 per cent, that just stands for fractionated oxygen-----

So in effect-----?-- A lot, it's quite a lot.

Heavily oxygenated air?-- The 5 PEEP, that's not that - that's okay. That's not that dramatic.

What does that mean?-- PEEP is positive end-expiratory pressure. We have a PEEP of 2.5 centimetres, so 5 PEEP isn't really that significant.

Then again in the sentence you refer to the patient becoming more haemodynamically unstable. I assume that just means that his blood pressure fluctuated?-- Was going up and down and then he was requiring those drugs I was talking about earlier, the inotropic drugs, to support his blood pressure. So he had actually really deteriorated quite a bit to be requiring that sort of support.

Was Dr Patel still describing him as stable at this stage?-- I can't recall but I'm sure if we had a look at the notes, probably, yes. Mmm.

How would you in your judgment describe the patient at that level?-- He was deteriorating.

D COMMISSIONER VIDER: Mr Andrews, can I ask a question, please?

MR ANDREWS: Of course.

D COMMISSIONER VIDER: I'm referring to the statement in TH5, which was the one from the infection control co-ordinator. I'm just interested in your comment that - where you are asked to come to the seminar room on Monday the 7th of July, having gathered some data. Am I correct in hearing you say that you had difficulty collecting the data?-- Yes.

Could you be a bit more specific, please?-- Yes. We had been made aware that Dr Patel had asked his junior surgeons not to use certain words in the chart, the patients' charts, and in discharge summaries, and the way that wound dehiscence is picked up in the hospital, as you would well know, is through coding. And so, if the charts weren't correct, it wasn't being picked up. So we had difficulty knowing what was wound dehiscence and what wasn't. And Dr Patel was also arguing with us about what was a wound dehiscence and what wasn't, about the - I can't think of the right word. The interpretation of the word "dehiscence". He would say, like, wound dehiscence is just - no, he would say a wound dehiscence had to be completely right down to the viscera, right down to the lowest level, whereas someone else might describe a low wound dehiscence a first level or to the second level or to the muscle or the fat, or whatever. But we were having a lot of trouble getting correct data and this is when also we were first thinking - we were first - first became aware that there was charting irregularities in patients' charts.

Did you have access to the medical record after the patient had left the intensive care unit had you so wanted it?-- Yes, I did, yes.

Thank you.

COMMISSIONER: Thank you very much for those questions. It does raise this whole area about the way in which matters were charted. You say there were instructions from Dr Patel to junior doctors as to the terminology they would use, more importantly the terminology they were not to use. Can you give us an example of the types of wording that were prohibited?-- I think they were told not to use the word "dehiscence", and I think they were told not to use the word "infection", and there is a lot of words that I think that they were told not to use.

Don't answer this question if you don't feel qualified to do so, but would you see this as a matter of falsification of the medical charts or simply using sort of euphemistic language, less robust language to describe symptoms accurately?-- I think there was falsification of the records which later on becomes very apparent.

Thank you.

D COMMISSIONER VIDER: Ms Hoffman, could I ask one more question following on from that? It would then follow in the case histories of some of these patients they actually returned to the operating theatre?-- Yes.

Because of the wound dehiscence?-- Yes.

Well, then, were the operating theatre records somewhat liberal in their description of the procedure that was carried on in the operating theatre as well?-- I - I can't answer that question because I can't - we would have to go back and have a look at those charts.

Thank you.

D COMMISSIONER EDWARDS: In this email you mentioned the behaviour of the surgeon?-- Uh-huh.

Do you mean his aggressiveness, or what?-- Just his - you know, his bullying behaviour, the way he would come down and say, you know, "You do what I say or I will go to Darren Keating", or "I will go to Peter Leck. They will do what I want because I am making them all this money." And the fact that the sexual harassment aspect, the yelling and the screaming, and the, you know, denigrating of the ICU staff, the calling of the ICU "third world", and the hospital "third world", and-----

This was a continuous-----?-- Yeah, it was.

-----constant?-- Constant, yeah, yeah. And also, from the first - probably after about the first issue when we first

went up to make the complaint, Dr Patel refused to ever speak to me again. So I was trying to run the intensive care unit with the Director of Surgery who wouldn't speak to me. So that was quite difficult.

COMMISSIONER: And extremely childish, one would have thought.

D COMMISSIONER EDWARDS: And improper.

COMMISSIONER: Again, I am sure the Deputy Commissioners understand these things. I am going to have to ask you some questions that you probably think are very, very simplistic, but within an ordinary ICU operation, is it a common thing for the surgeon who has treated - who has operated on the patient to be telling ICU staff how to manage the patient's recovery, or is that normally handled by the physicians or anaesthetists who are involved in running ICU?-- It all depends on your ICU but it is usually by the people looking after the ICU, the anaesthetists or the intensivists. The surgeons come in as a - as a-----

Consultant?-- Consultant, yeah. They come in as a consultant to look after their particular area of the surgery, or whatever, but the rest of the things are organised - like, the fluids and the ventilation, and the drugs and everything like that are looked after by the anaesthetist or the intensivist. The surgeon would just look after the wound aspect of it.

Did Dr Patel's behaviour in the ICU lead to any disagreements between him and the other doctors involved in ICU, particularly the anaesthetists?-- Yes, yes, they did.

One particular doctor or are there a number of them that he fell out with?-- There were a number that - there were a number - well, there were a couple that he fell out with, but they were very afraid of him. One of the best doctors there, Dr Behrens, he was - because the doctors, a lot of them have this issue with their visa status and he - I went to Dr Behrens to ask him, you know, later on when I was going to make this complaint, would he support me or not, and he just said, well, Dr Patel had ingratiated himself so much with the executive that it would - Dr Behrens would lose his job and. Dr Patel would end up staying there. So they would - there was always this argument, but they were - they were intimidated by him and frightened because they believed that he had this power, because this is what he used to perpetuate down in the unit, down in the ICU and in the theatre, he would perpetuate this type of behaviour. This is how he would talk to people.

I see?-- And they did argue. There were many - like, there were quite a few stand-up fights in the intensive care unit, but one of the hardest things was that the director of the intensive care unit wouldn't stand up to Dr Patel, which was quite unusual because he is not someone who is not afraid to stand up to other people but he didn't - because he had the opportunity right at the beginning to say, you know, "This is how this intensive care runs.", and that's it, but he sort of

- he didn't ever do that.

Although, in fairness to him, you say he was away when the first problem arose?-- The first problem, yes.

D COMMISSIONER EDWARDS: Could I ask are there written instructions, protocols laid down for the conduct, medically and otherwise, within the intensive care unit as to who is in charge relative to a patient's care?-- There is an admission and discharge policy.

By the Health Department?-- No, it is an internal, yeah.

Thank you?-- It does talk about how - it doesn't actually go into such detail as to specify who looks after what but it does talk about that, you know, if a patient comes in and requires ventilation, then they, you know, are cared for by the anaesthetist. So it does say that, yeah.

Thank you.

COMMISSIONER: Mr Andrews, in due course we might see if we can get a copy of those policies. That could be very, very useful.

MR ANDREWS: Yes.

COMMISSIONER: Do you want to continue?

MR ANDREWS: Yes. Dr Behrens you mentioned in the context of visa problems. Was Dr Behrens an overseas-trained doctor?-- Yeah. He was from Namibia. Namibia, mmm.

And I see you spoke highly of his skills?-- Yes, yes.

COMMISSIONER: Is he still practising in Australia?-- Yes, yeah.

MR ANDREWS: You said that there were stand-up fights between some of them. Who were some of the practitioners - medical practitioners who stood up to Dr Patel?-- Well, Dr Behrens was one. They would often argue. Dr Miach was another one. He wasn't an anaesthetist. He is a nephrologist, though, and he would argue with Dr Patel.

COMMISSIONER: Sorry, what was that term?-- Nephrologist.

Renal specialist?-- Yeah, renal specialist, yeah.

D COMMISSIONER VIDER: Ms Hoffman, could I just ask, these altercations go on in the intensive care unit in front of patients?-- Yes, they would.

Was any request made that the discussion continue elsewhere in another environment?-- Yes, there was.

And that was not accepted?-- No.

Thank you.

D COMMISSIONER EDWARDS: The hospital administration would have been aware of such feelings and difficulties?-- Well, they were aware of what we told them. And I can't really, I guess, comment on what else they were aware of and what they weren't. I know - I only know definitely what we had told them.

Would it surprise you that they didn't know?-- Well, yes, it would surprise me if they didn't know.

COMMISSIONER: I think, Mr Andrews, before I interrupted you, you were about to move on to patient P39.

MR ANDREWS: I was.

COMMISSIONER: Again, we see that's a male name. Do you recall anything about patient P39; what sort of age he was and what his-----?-- What page are you talking about?

MR ANDREWS: You might see some detail about him at TH36 - TH6, rather, and he is discussed at page 12 of your statement?-- Okay. Okay. He was a patient who came into the intensive care unit. He had a motor vehicle accident and he suffered major chest injuries, multiple fractured ribs and spleen - injuries to his spleen. He had been managed in the unit on non-invasive ventilation for a few days and then he had complications, including natural fibrillation and fainting episodes. He had a CT of his chest and he was supposed to go to theatre for drainage of the blood in his chest, and come back with either a catheter in his chest and perhaps requiring ventilation. This is where Dr Patel and Martin Carter, the anaesthetist, had come to an agreement by which Dr Patel will operate only if Martin Carter agrees not to transfer the patient. So they actually - they actually get together and decide that that's what they are going to do, that Dr Carter will promise not to transfer the patient out if Dr Patel operates. And the patient had already been in ICU for 12 days, was in quite poor health. He was going to require a lengthy period of ventilation. He was a fairly - he wasn't elderly but he was a fairly - he was an older man. And for anybody who had those sort of chest injuries, it is routine that they require ventilation for quite some period of time.

D COMMISSIONER VIDER: Is it your understanding that that arrangement between Dr Patel and the anaesthetist was unconditional?-- Yes - well-----

That the patient would remain in the ICU unit at Bundaberg?-- Yeah, that was the agreement they came to. If he said he wouldn't transfer the patient out, Dr Patel would operate. Otherwise Dr Patel wouldn't operate and the patient would, I guess, have been transferred out before.

That's no conditions, unconditional regarding what happened in the postoperative recovery days?-- Yeah, that's my understanding, but I don't know what - hypothetically what

would have happened if he deteriorated a lot.

COMMISSIONER: Your exhibit TH6, attachment TH6 is an email you sent to Glennis Goodman with a copy to Dr Keating. Did anything ever come back from Dr Keating saying, "No, that's not true. There was no such deal done between Dr Patel and Dr Carter."?-- No, not to me, no.

I take the force of the question asked by Deputy Commissioner Vider. It would seem to be an extraordinary arrangement that the doctor responsible for ICU agrees he won't send a patient to Brisbane, no matter what?-- Well, not only that, I mean, that has had the ability to affect all sorts of things, including the staffing. I mean, it was done without my consultation or my knowledge until it was being done. So to me it was a very serious event.

How long was this particular patient in your ICU unit?-- He was in - he had already been in there 12 days. I just have to refer to another note. Yes, I actually haven't got it written up how long he was actually in there for or what actually was his outcome. I can't remember.

Do you recall whether he was eventually transferred or whether he remained at Bundaberg? If you don't know, Mr Andrews-----?-- No, I don't recall.

-----might have those records turned up and see what happened to him?-- I don't recall, but in my email I bring up the issues, you know, that really he should go somewhere where there is a back-up of cardiothoracic team should there be complications, and then I write that I discussed my concerns with Martin. And once again I asked that could we have some guidelines about what type of surgery should be done here in relation to follow-up care and the services we can provide.

And that produced no response at all from Dr Keating?-- No.

MR ANDREWS: Now, aside from sending the email to Dr Keating and Glennis Goodman, you did speak with Dr Carter about this, didn't you?-- Yes.

And what was Dr Carter's response?-- I can't actually - I can't recall.

You sent another email the next day, an informal one to Carolyn Kennedy. Was she then the Assistant Director of Nursing?-- Yes, she was.

Can you translate that email for us?-- Glennis Goodman had resigned at this point in time and Carolyn Kennedy - we call her "CK". I said that, "I am going to have to go the same way as Glennis because I can't stand this unit any longer. They're going ahead with that operation even though we had tried to stop it. We already had another vent and four other patients." Gavin said rue the day I ever wrote e-mails like this. "I can't do any of the stuff I am supposed to do when I can't get my admin days up. Martin doesn't communicate with

me, he just makes deals with Patel. Do you know anywhere I could go? Even Mount Perry is looking better than this place any longer."

What's the surgery that was planned again?-- That was relating to P39.

There should be a non-publication order in respect of P39's name, or at least a reminder.

COMMISSIONER: Yes, yes. Press, you will recall I have already directed no publication of the names of these patients without their consent, or, in the case of deceased patients, the consent of family members.

MR ANDREWS: Now, you have some observations about a Dr Qureshi. Was Dr Qureshi an overseas-trained doctor working at the Bundaberg Hospital?-- Yes, he was. He was a - I think he was a Pakistani doctor and he - I was Acting Director of Nursing at this time and was on call for the weekend as the Director of Nursing. And - hang on, no, I am going ahead of myself here.

You heard something from nurse manager Jan Marks that Dr Qureshi had assaulted a patient?-- Yes, yes, but that email actually refers to him - his behaviour with the nursing staff.

Yes. Did you also receive complaints from members of the nursing staff from the intensive care unit?-- Yes, about Dr Qureshi's behaviour, yes.

And you describe them at paragraph 39 of your statement?-- Yes.

Now, at paragraph 38 you speak of the complaint relating to a patient. You reported it to Dr Keating?-- Yes, I did.

And Dr Keating took the action you describe?-- Yes.

Making sure that Dr Qureshi would be chaperoned when examining female patients?-- Yes.

Do you know if any other action was taken by Dr Keating?-- No, I am not - I don't know, no.

Now-----

COMMISSIONER: Just again, so I understand that, the initial complaint about this doctor was relating to, as it is described in your statement, the inappropriate way he examined a female patient?-- Yes.

But there were also complaints from two separate nursing staff regarding inappropriate behaviour on his part?-- Mmm.

I can understand how chaperoning might assist in relation to patients, but was anything offered at all to protect your

nursing staff from inappropriate contact? Did Dr Keating offer anything by way of protection of your nursing staff?-- No, not that I am aware of, no.

MR ANDREWS: Now, tell me, is there a hierarchy in the hospitals? For instance, between you and Dr Qureshi?-- Uh-huh.

Does he rank as more important than the position you held at that stage, that is Assistant Director of Nursing?-- I think doctors always think that.

All right. Well, I see that Dr Keating instructed you to telephone Dr Qureshi?-- Yes.

Why didn't Dr Keating deal with this-----?-- Himself?

-----significant matter himself?-- Mmm. Well, that's a good question, but I did it anyhow.

So you called Dr Qureshi, asked him to telephone Dr Keating?-- Yes, yeah.

And was it you who notified the other areas of the hospital that Dr Qureshi would need a chaperone?-- Yes.

D COMMISSIONER EDWARDS: In writing?-- No, I called them all up, actually, because it was - it was a weekend and I was at home, and it couldn't wait to be in writing, it had to be done urgently, so I called them all up.

D COMMISSIONER VIDER: It was you who told Dr Qureshi that he had to see female patients only when chaperoned?-- No, I told Dr Qureshi to ring Dr Keating and I think Dr Keating told Dr Qureshi that.

But you are not sure?-- No, I am not sure.

That Dr Qureshi was actually instructed that he must see female patients only when chaperoned?-- No, I don't know what was said between those two doctors, but Dr Keating, when he spoke to me later did say, you know, that he must be seen by a chaperone and that's when I let everybody know he must have a chaperone.

COMMISSIONER: Have you ever come across that before in your experience, of a doctor being chaperoned to see patients?-- All male doctors used to be chaperoned with female patients in certain procedures. Like, that was common when I was - you know, when I was younger. But nowadays - I mean, in intensive care there is always a nurse by the bedside anyhow. So I am not quite sure whether that's a requirement now or not, that all doctors - all male doctors are chaperoned by females. I don't think so.

If you think of an area of practice like gynaecology and obstetrics?-- I would say there would always be pretty much a female nurse with someone in that situation.

Yes?-- Mmm. But in the situations Dr Qureshi was involved with this particular patient, one was in the renal unit so - and another one was - another occasion was the lady had had a seizure, a fit, and woke up and Dr Qureshi was stroking her hair and kissing - kissing her.

What was Dr Qureshi's actual function? Was he a surgical doctor?-- No, he was a medical - junior medical doctor.

Right.

MR ANDREWS: Aside from that aberrant behaviour, were there any other concerns about Dr Qureshi with respect to his skills?-- Yes. There were a lot of concerns with respect to his skills. He - his - he really couldn't function very well as a doctor at all, and-----

Was this something obvious to you or did you have to have it reported to you by other doctors?-- Well, it was obvious to me but it was well-known in the hospital. It had been discussed at various forums about how bad Dr Qureshi was and it was something that was well-known within the hospital. At one point they actually wanted to put him in ICU to work because then we could have kept a better eye on him because we were a closed unit. So a way to fix the problem, which was that we had a non-performing doctor, was to put him in an area of high acuity because there were more people there to keep an eye on him.

Would that have affected the quality of care delivered in the intensive care unit?-- Yes, it would have, and the anaesthetist, when he found out about that, actually refused to have him in the unit.

Which anaesthetist was that?-- That was Dr Carter.

COMMISSIONER: Mr Andrews, I see that the name of one of the nurses who complained of sexual harassment is mentioned in paragraph 39. I assume, Mr Allen, you would want a similar order in relation to that name?

MR ALLEN: My instructing solicitor is getting instructions on that. The reason being that that particular person has in fact provided the Commission with a statement under her name dealing with those matters, amongst others, so if I could have the opportunity to seek instructions on that before the end of the afternoon and then raise it with you, Commissioner?

COMMISSIONER: I simply ask the press and media not to report the name of the nurse mentioned in paragraph 39 until we have had a chance to resolve the situation.

MR ALLEN: Yes, thank you, Commissioner.

COMMISSIONER: Thank you.

MR ANDREWS: You yourself had observed Dr Qureshi in the ICU.

What do you mean that you noted his poor communication skills? Was it a language problem or something-----?-- He-----

-----personal?-- I am not sure if it was language - if he had problems with comprehension but we had problems understanding what he was saying, and he would talk really quietly so that - and come up really close to you so that you had to - you know, so you could hear him, and it was very unnerving.

His apparent lack of knowledge regarding assessment of patients, you have spoken of that. What do you mean by it?-- Just that he didn't seem to have any idea how - you know, what was the normal course of events if someone came in with a particular condition.

His lack of basic knowledge to order appropriate medications and treatment?-- Mmm.

What do you mean by that?-- Once again, just that he didn't seem to have the knowledge to order a drug or a dosage of a drug that was well-known. Basically just his overall incompetence in working as a doctor.

Now, the nursing staff consulted other doctors to check orders that had been made by Dr Qureshi?-- Yeah.

Who were the others that consulted?-- There would have been other doctors in Intensive Care, either the consultant or whoever was around.

And in your experience, is it a rare event for nurses to be checking with other doctors about whether they should follow the orders of a doctor?-- Yes, that's quite rare.

Now, you recall an anecdote or an occasion when you were in the company of Dr Keating and Linda Mulligan when Dr Qureschi was discussed?-- Yes. Linda - Linda Mulligan had - I was handing over to her and something had happened with Dr Qureschi and the police had actually gone out to or were going out to arrest him and I don't - I still don't know the exact details of this situation, but it was reported either that he'd been caught shoplifting or for whatever reason, I'm not quite sure what.

Do you believe that - had you heard, whatever the truth of it may be is another matter, but had you heard that he was in trouble with the police, that they were seeking to arrest him and was there a conversation about this between Linda Mulligan and Dr Keating?-- Yes.

In your presence?-- Yes.

And did you say, "I wonder who checked his references?"?-- Yes.

And what did you hear Dr Keating say?-- Dr Keating said that he didn't check his references and then he made a comment about something like, you know, in hindsight he would have handled this situation differently, and then that afternoon we were in a meeting and the police had gone to arrest Dr Qureschi and found that he had left the country the day before.

Now-----

MR ALLEN: Excuse me, Commissioner.

COMMISSIONER: Yes?

MR ALLEN: Could I ask for a non-publication order for the name of the nurse in paragraph 39 of Ms Hoffman's affidavit?

COMMISSIONER: Yes. Yes, I will make an order in relation to the nurse mentioned in paragraph 39 in the same terms as the order earlier made in relation to the nurse mentioned in paragraph 27. That is to say, the press and media are entitled to know the name but should not publish the name either in print or electronically unless the nurse becomes a witness in these proceedings or with the consent of the nurse involved.

MR ALLEN: Thank you Commissioner.

COMMISSIONER: Mr Andrew, we might just have a five minute break, if that's convenient?

MR ANDREWS: Most convenient.

COMMISSIONER: Thank you.

THE COMMISSION ADJOURNED AT 3.33 P.M.

THE COMMISSION RESUMED AT 3.38 P.M.

TONI ELLEN HOFFMAN, CONTINUING EXAMINATION-IN-CHIEF:

COMMISSIONER: Mr Andrews.

MR ATKINSON: Ms Hoffman, I'd like you to recall occasions where you observed that the notes didn't accord with the information you received on verbal handover when patients were transferred from theatre to ICU. You do discuss it in your statement from about the bottom of page 15; do you recall any such events now?-- Yeah. When a patient comes back from theatre, you will always get a verbal handover, usually from the accompanying nurse and anaesthetist, and often the patient, we'd be told we were getting a patient from theatre and we were told there'd been a complication in theatre, like, the patient's bowel had been nicked or the patient's spleen had been nicked or liver or something like that, but when you went to look at the theatre notes, it wasn't recorded in the theatre notes, and sometimes if it was recorded in the theatre notes, it was recorded as if it was meant to happen, like, it would just say - it wouldn't say "Spleen inadvertently nicked" or something like that, it would say "Splenectomy" so it looked like the spleen was supposed to just be removed. So this was actually very common, that we would receive patients back from theatre and we were told verbally that this had happened and something had gone wrong during the surgery by Dr Patel, but it wasn't recorded in the notes and neither were there any incident reports accompanying this - these incidents. Normally if something adverse happens in theatre, it should - an incident report should happen and this wasn't happening from theatre, they weren't being generated from theatre, so this was a concern and it was a concern that was bought up in a few meetings that we'd had at several forums about we've got all these complications but where are all of the incident reports that should be alerting people to these incidents?

Is there a protocol that describes who ought to be writing

incident reports and theatre notes?-- I don't know if there's actual protocol, but in with an incident report, whoever finds the - whoever discovers the incident first or does the incident, you know, performs the incident, accidentally, they should generally - the incident report should be generated from them.

So with these nicks, it would always be the surgeon, would it not?-- It should be the surgeon or whoever has witnessed it generate the report.

Well, on the occasions where the notes and the verbal handover differed, it was always Dr Patel who had been the surgeon?-- To my knowledge, yes, yeah.

D COMMISSIONER VIDER: Mr Andrews, could I ask Ms Hoffman please, if therefore notes were altered, who told the patient? I mean, the patient consented for a procedure, who then told the patient that they'd also had a splenectomy?-- I actually don't - I actually don't know because most of the patients would have come back ventilated, so the relatives would have been informed and-----

COMMISSIONER: Or not as the case may be?-- Or not as the case may be, yes.

D COMMISSIONER EDWARDS: But it was recorded in the notes though?-- No, Sir Llew, it wasn't often recorded in the notes, that's what the issue was, these things weren't being recorded in the notes and therefore these things weren't being picked up by other people.

COMMISSIONER: Do you have a separate set of notes in ICU?-- The ICU nurses do.

Yes?-- We have flow sheets and this is one thing that when I talked to our internal inquiry that Dr Patel would often write the surgery according to how it should have gone rather than how it actually went, so it looked like it was perfect surgery that was done but in actual fact that wasn't the case and but - and because, you know, he used to say "Stable" as well in the notes, that you had to actually marry the two, marry the nurses' - the ICU nurses' notes up very closely to what was written by Dr Patel.

Just to work through this a little bit one step at a time, in surgery itself, someone prepares surgery notes, I take it; is that the doctor performing the surgery or is that the junior doctor assisting in the surgery or is it a nurse, who would normally do that?-- It's my understanding that the surgeon writes his own notes.

Right?-- Mmm.

So if doctor - if there's "splenectomy" on the surgery notes, that would actually be in Dr Patel's handwriting?-- Yes, it should be, yes.

All right. And similarly, the surgeon should write up the incident report if he's the one who was handling the scalpel at the time of the incident?-- Yeah.

All right. Then there's handover, as you describe in your statement, from the surgery to ICU and staff in ICU start preparing your ICU records, whatever they are, but is there somewhere to fill in on those records the condition of the patient as he or she arrives in ICU?-- Yes, there is.

All right?-- There's the graph.

Yes?-- And then there's also notations as well, so - and then it would - also would have if they were on any of those drugs, for instance.

Yes?-- So they needed to marry up very closely what the nurses' notes actually said if those patients were on any inotropes or anything like that and what the nurses' condition - what the nurse has said the patient's condition was according to what, you know, Dr Patel was saying in the progress notes.

Well, let's take the case where a patient had a perforated bowel in the course of surgery?-- Mmm-hmm.

And that would tend to be a very serious accident, wouldn't it, because it involves all sorts of risks of not only long term problems with the bowel but also risks of some sort of infection finding its way into the other internal organs; is that right?-- Yep.

So you've got this perforation, the doctor should put that in his surgical notes but he doesn't; there should be an incident report, there's none?-- Mmm.

The patient comes into ICU; do you fill in on your ICU notes that there was a perforated bowel or how do you handle that?-- I think, you know, like, we did - there are occasions where that is - where that's what we've done is that the doctors or the nurses have written in, you know, "Patient reported to have perforated bowel" or the anaesthetist may have come in later and written in "Perforated bowel" or "Bowel perforated in surgery" or something like that.

Do the anaesthetists keep separate notes in the surgery?-- No. The surgery notes are separately written.

Yes?-- The actual surgery from the episode of surgery.

Yes?-- From there, then on everyone writes in the progress notes except for the ICU staff who write on the separate flow sheet.

Okay, fine, thanks.

MR ANDREWS: You deal with patient P49 at paragraph 45 of your statement. Perhaps you should look at TH9 to recall the

details relating to this patient. That's the exhibit, Ms Hoffman, TH9? You'll see it's an e-mail from you to Patrick Martin of the 25th of February?-- Yep. It's - one of my other concerns was that Dr Patel was booking elective large scale surgery for a weekend or on a Friday when the hospital was going to be running on skeleton staff over the weekend and I was - Patrick was the Acting Director of Nursing at the time and I was just informing him that there was a large elective surgery being done on the weekend when they knew an ICU bed would be required. The ICU already had - was already full and I'm just talking about how difficult it was to staff the unit for that weekend.

Should that elective surgery have been scheduled for a day earlier in the week?-- It should have been done, like, on a Monday or a Tuesday so that the patient had time to recover and leave the ICU by the time that the - that the staffing, you know-----

Before there was a skeleton staff?-- Yeah, before there was a skeleton - yeah, before the weekend.

COMMISSIONER: Mr Andrews, I'm sorry, I'm getting a bit lost here and it's almost certainly my fault, but if you look at paragraph 45 of the statement.

MR ANDREWS: Yes.

COMMISSIONER: This is the reference to the elective apronectomy relating to patient P49.

MR ANDREWS: Yes.

COMMISSIONER: P49 we see from the schedule is a lady whose surname begins with "S".

MR ANDREWS: Uh-huh.

COMMISSIONER: However, TH9, the e-mail, seems to be referring to a different patient, a lady whose surname begins with "B". Is it two different patients or is it just a mistake of the name?

MR ANDREWS: Yes. Patient 50 seems to have a name corresponding with the patient described in Exhibit TH9.

COMMISSIONER: Yes. It may be, for example, that 49 and 50 are the same person, but one is her maiden name and the other's her married name or something like that. It's just a little confusing as it stands at the moment.

MR ANDREWS: Are you able to assist with your other notes?

MR ALLEN: I'm instructed by Mr Rebetzke, who prepared the statement, that he may have made a slight error and that the statement in paragraph 45 should in fact refer to P50.

COMMISSIONER: P50 rather than P49?

MR ALLEN: Yes, Commissioner.

COMMISSIONER: All right. All right. Well, that makes sense then. We're really talking about the patient whose surname begins with the letter "B".

MR ANDREWS: Yes. And is the position that patient P50 went into an ICU in circumstances where it became necessary to have three patients ventilated during the weekend. Perhaps if you look at TH9, the exhibit?-- Yeah, by the Sunday morning, they had three ventilated patients by the Sunday morning, so on - when they started, like, they had one ventilated patient but by Sunday morning there were three ventilated patients, so it's basically just informing him of a very busy unsafe weekend in the ICU when an elective surgery was booked that shouldn't have been.

COMMISSIONER: And this was scheduled, was it? It wasn't - it didn't come up urgently or-----?-- No, it's a very elective surgery, an apronectomy, it's nearly cosmetic.

What is it?-- Oh, it's when someone's lost a lot of weight and they have, like, excess abdominal tissue removed.

Yes?-- Yeah, that's what it is. So it's almost cosmetic really.

D COMMISSIONER VIDER: Miss Hoffman, can I just ask for clarification, something you said earlier today, that it's an eight bed unit with five beds commissioned; is that correct?-- Yes.

But this e-mail would indicate that this would have been the sixth patient?-- Yes.

Do you routinely go beyond the five beds and open the others?-- Not routinely but in an emergency we do.

But-----?-- Perhaps just for a short period of time if we could staff - find the staff, yes, and it talks there about deploying staff from all over the place and that sort of thing.

Thank you.

COMMISSIONER: What should normally happen? Should the surgeon contact you to see if you'll have a bed available?-- The surgeon should, you know, first of all talk to the anaesthetist and the anaesthetist would probably talk to one of the staff, the person who was in charge of the Intensive Care Unit or the weekend and ascertain if there's a bed available, and if it's too busy and there's not enough staff, they should put the surgery off until later on in the week.

Yes.

MR ANDREWS: Now, Dr Carter spoke with you about the

possibility of employing more permanent nursing staff for the ICU?-- Mmm-hmm.

What advice did you give to him?-- Well, I talked to him about that overall statistically when our monthly stats, even those we had busy periods did only show that we were only 75 per cent full and that if we put in a business proposition to - a business case to increase our staffing in relation to that, we wouldn't - like, no-one would listen to us, like we didn't, it wasn't indicating that we needed on a regular basis to have more staff periodically, we needed to have more staff but not every shift. So he wanted - what Dr Carter was doing at that time is that he was - he wanted the ICU to become a Level 2 ICU and he was really pushing for that and at the - it was around that point in time that I felt that he was not - he was not proactively transferring patients through to Brisbane. He was holding off till the - you know - till the last minute and putting a lot of stress on the staff using a lot of overtime just to prove a point that we needed more staff, whereas previously he would proactively, you know, look towards transferring the patients out.

Would he have been subject to the criticisms of Dr Patel had he been proactively transferring patients out?-- Yes, he was subject to the criticism of Dr Patel and also Dr Patel still was saying, you know, he didn't want patients - he wanted his patients to be kept there, he didn't want them to be transferred to Brisbane and Dr Carter and I had several conversations about this where, you know, Dr Carter criticised me for not supporting him in, you know, wanting to get more staff for the ICU. He-----

All right. And you didn't feel that more staff at the ICU were warranted because you felt that there were too many occasions where it was only 75 per cent occupied?-- Yes, and that if we were acting within our scope of practice, there was certainly no reason for us to be requiring more staff, but we were consistently acting outside of our scope of practice with Dr Patel's patients.

COMMISSIONER: And also if you were only at 75 per cent capacity, if elective surgery was scheduled, to take up the slack within ICU you could have managed quite easily?-- Yeah. ICU is like, ICU always has its peaks and troughs.

Yes?-- It's like, you know, it will often have, like, three patients, three ventilated patients all at once instead of them being one one one one like that, you know.

Yes?-- It's just like any hospital you have peaks and troughs and you have to cope with the busy periods just like you have to cope with the quiet periods.

And I'm sure there are things you can't plan for, if there was a major road accident with a number of casualties involved?-- Mmm.

You might have more in ICU than you expected but-----?--

Yeah, that's right, and there's always in a hospital unexpected things like cardiac arrests or, you know, we care for neonates before they get transferred through to Brisbane as well, so we often would have to do that at a minute's notice, we'd get a very sick neonate in and have to stabilise them before they were transferred out, so there were always peaks and troughs but we were acting outside our scope of practice which is something that I was trying to get - was trying to get clarified.

Yes. Yes, Mr Andrews.

MR ANDREWS: Dr Miach, what was his position at the hospital?-- He's Director of Medicine, not Director of Medical Services but Director of Medicine and he's a physician and a nymphologist.

And just as Dr Patel was Director of Surgery?-- Yes.

Dr Miach was Director of Medicine?-- Yes.

And was there a time in 2004 or thereabouts that you became aware of an instruction Dr Miach had given about his patients and/or some of his patients and Dr Patel?-- Yes. The renal unit had done - Dr Patel was putting in the catheters in the renal unit and they, they were getting a very high rate of infection and actually they had 100 per cent infection rate from Dr Patel's patients, so Dr Miach stopped Dr Patel from operating on any of the renal patients.

D COMMISSIONER VIDER: Excuse me, are we talking about ordinary urinary catheters?-- No, vas caths - vascular catheters and dialysis catheters, yep.

I see?-- So Dr Miach stopped Dr Patel from operating on his patients and the patient - and I'm not quite sure how this worked, but the hospital got a private company to pay for these catheters to be put in at one of the local private hospitals by a vascular surgeon. All of this information was taken to the people in executive and I think this is better if someone else gives this other than me.

MR ANDREWS: Very good?-- Because they can talk about it in much better detail and much more accurately than what I can.

But you saw that catheters or these vas caths that you described?-- Mmm-hmm.

Were came to be inserted by persons other than Dr Patel?-- Yes, outside of the hospital, he didn't put them in.

COMMISSIONER: And Dr Patel had had 100 per cent failure rate?-- Yes, he did 100 per cent complication rate and I actually, I think there was one or two deaths associated with this.

MR ALLEN: For the assistance of the Commissioners, perhaps in relation to that topic, my instructing solicitors have filed a

statement of Lindsay Sigrid Druce.

COMMISSIONER: Thank you Mr Allen.

MR ANDREWS: Linda Mulligan became Director of Nursing?-- Yes.

That was in early 2004?-- Yes, March 2004.

And until she'd become Director of Nursing, you were the Acting Director?-- Just for three weeks.

And was that the - was that a normal event when a Director was on vacation, that someone else might from within the hospital might become Acting Director?-- Yes, it was, yes.

Now, during your period as acting director, you had a meeting with Mr Leck?-- Yes. An informal meeting.

And is that because he was then your line manager or-----?-- No.

-----had you chosen to go to him with some issue?-- No. I just - I chose to - I wanted to alert him to some issues that were going on and part of it was this - he'd been at some meetings where Dr Patel was wanting more staff and asking for more staff and I really, basically, wanted to put him in the picture about what was actually going on in ICU with ventilated patients and Dr Patel, and I - I had just written out a list of issues that were going on in ICU and a gave it to him.

And the document that you gave to him, is it a part of Exhibit TH10?-- Yes, it's part of it, to the end of the arrow.

Right. I'll put this up on the screen. Now, there's a line drawn down the side of the page. Is it only within the two arrows that there is information you'd have given to Mr Leck?-- Yes.

Now, the-----

COMMISSIONER: So you subsequently added to this document?-- Yes.

Down to the paragraph commencing, "This week we had a critically ill patient", was something you added on later?-- Yeah, I had kept the document on my computer and then I worked on it and handed it in later on with some other issues.

Sure. Yes.

MR ANDREWS: Was Mr Leck a person to whom it was appropriate to bring these issues?-- At that point in time he was - he was. He was aware that, you know, Dr Carter was asking for more nursing staff and he was aware of overtime - you know, us running huge overtime bills in the ICU because of Dr Patel's patients being there longer.

What was Mr Leck's position?-- He was the district manager.

What's his background? Is he a doctor?-- No.

Do you know anything about his background?-- No.

D COMMISSIONER VIDER: You were the acting director of nursing at this time?-- Yes, at that time, yes.

COMMISSIONER: District Manager is just a - really means he was manager of the hospital, doesn't it?-- The hospital and the district, because Bundaberg Hospital looks after several other hospitals.

I see?-- Like, Childers, Gin Gin, Mount Perry, I think that's

it. So he was, like, district manager of all of those hospitals.

All right.

D COMMISSIONER EDWARDS: The whole of the state is divided into regions like that?-- Yeah, yep.

COMMISSIONER: So he was, in a sense, the chief bureaucrat for the hospital. I don't mean that in a disparaging term?-- Yep. He was the big kahuna.

He wasn't the medical controller but he was the administerial or managerial controller?-- Mmm-hmm.

MR ANDREWS: In the hierarchy was he superior to Dr Keating?-- I don't how that works but I think so.

Looking at TH10, each of - the first issue that is highlighted in yellow, is that something you discussed with Peter Leck?-- Yes.

And, again, that was concerned with your concern that patients with too complicated a form of surgery were being ventilated for too long a period in your ICU?-- Yep, that's right.

And is that a concern for the wellbeing of the patient or the wellbeing of your staff?-- Well, our number 1 concern is the wellbeing of the patient and then number 2 is the wellbeing of the staff. And to cater for extra - you know, for patients that are being ventilated for longer than what we were supposed to, we had to bring - consistently bring people in on overtime which meant that they'd have to come in on their days off, we had to pull them in on their holidays, we had to pull them in on their long service leave, sometimes they'd work double shifts and, you know, we were running our staff to the bone.

COMMISSIONER: It's also for the benefit of other patients, isn't it, because if you have your ICU facilities fully occupied with, for example, elective surgery patients, then you don't have the capacity to deal with emergency cases?-- That's right. That's right. I mean, some hospitals even keep a bed for an emergency - an emergency. That's their emergency bed.

Yes?-- But we never had that. We don't have that luxury.

MR ANDREWS: It's correct that usually the process worked well except when Dr Patel's patients were involved?-- Yes, that's right.

Even as late as 2004 was he still consistently denigrating the ICU?-- Yes, he was.

Now, the comment that you quote, "This would not have been missed on the wards", relating to gentamicin, can you explain that?-- A drug gentamicin hadn't been written up by the

physicians in ICU because they thought it was a one-off dose. Sometimes that drug is given as a one-off dose; sometimes more. And he would just always make disparaging comments, like if something was missed in the ICU, he would say, "This would not have been missed in the wards", and, yeah, he was just always making derogatory remarks about the ICU and the physicians in the ICU, the doctors - the anaesthetists. And the next paragraph there, he stated to one of the RNs that he had contacts in Brisbane and he would use them to block patients being transferred. I don't know, we don't know who those contacts are but he did say that.

COMMISSIONER: It doesn't matter whether it's true. That's what he was telling your nursing staff?-- Yeah, that's what he was telling us, yeah. A lot of the things that Dr Patel told us, we don't know to this day whether they were true or not.

The next sentence you use the abbreviations PHO and JHO. That's house offices, are they?-- Yeah, primary house office - primary house officer and junior house officer.

Right.

MR ANDREWS: What are those designations?-- A primary house officer is - is someone who's been out of med school for a couple of years and are junior, one - just for a year or so. We don't-----

And who were those persons, their names?-- Oh, they-----

The primary health officer?-- Yeah, they change all the time. They change every three months in ICU. So, there were - there were a lot of different doctors over this period of time.

I see. And is it the position that the - that Dr Carter was usually supportive and pro-active about transferring patients except when they were Dr Patel's?-- Yes.

COMMISSIONER: You also make the comment in the highlighted passage, "He does not usually do ward rounds with the ICU physician"?-- No.

Is that the usual practice for a surgeon or even a medical doctor with a patient, to do the ward rounds with the physician in charge at ICU?-- They should do ward rounds together.

Yes?-- Both of them, the physicians and the surgeons and the anaesthetists, every single morning, every single day. But it's something that we've not been able to manage to get them to do in Bundaberg.

So it's not only Patel who didn't follow that-----?-- No.

-----protocol?-- Dr Patel, he would come in very early in the morning. He would come in sort of like 7 o'clock, 7.30 and see the patients then before a lot of - before the surgeons got there - before the anaesthetist got there.

Okay.

D COMMISSIONER EDWARDS: Could I ask, in your report on the ICU issues with ventilated patients, you make the comment that you accompanied Dr Joyner, I think it was, to meet with Dr Darren Keating about the oesophagectomies. Could you tell us the outcome of that meeting because obviously that was a fairly significant meeting?-- Yep, that was really early on. I think - I don't remember a great deal of detail about it but I think that we were just told that Dr Patel was used to doing this sort of large scale surgery, he was very experienced and that we just had to learn to work with him, and it was an expectation from Brisbane that rural - not rural areas but other areas would do these sort of large scale surgeries and that we just had to work with it.

D COMMISSIONER VIDER: So the adverse events occurring following this surgery was acceptable?-- Well-----

Was the message that you interpreted?-- Mmm, yes. That's right.

COMMISSIONER: Yes, Mr Andrews.

MR ANDREWS: Now, for those who wished to complain, what was the atmosphere that Dr Patel created for them? You speak about repeatedly doing certain things. What do you mean by repeated? How often would he be threatening to resign? Was it annually?-- Oh, no-----

Monthly?-- It was usually pretty much on a weekly basis and every time anyone would challenge him or say we couldn't take a patient or ask him about, you know - question his treatment or anything like that, he would threaten - threaten to resign. And then he would threaten not to put any elective surgery in ICU, and he would carry out these threats too. Like, not to put elective surgery into the ICU to the detriment of the patients involved, as we will see later on with that thoracotomy issue. But he would actually do these things for a short period of time and then he would sort of, you know, go back to whatever he was doing. But - you know, and you know, he would - he would consistently use Peter Leck and Darren Keating 's names as threats to us and we didn't know whether it was true or not and - yeah. So.

He told you he'd go straight to Peter Leck?-- Yes. "Because I've earnt him half a million dollars this year."

Now, you did give evidence before that it's your belief that it's by surgery that the Bundaberg Hospital can increase its earnings?-- It's my understanding that surgery - apart from the budget that you get, surgery is the only thing that brings in revenue.

Is it any kind of surgery or just - or elective surgery? I'm after your understanding?-- Yes, I'm just trying to think. I'm not sure. I'm not sure about that.

COMMISSIONER: Sir Llew was mentioning to me earlier that he was aware of a sort of bonus scheme that if a particular hospital assisted in reducing elective surgery waiting lists, they were paid, as it were, bonus payments for the surgery undertaken. Is that what you're thinking of here?-- No, that was separate. That was something that Dr Patel did tell us just before he left after that - after - later on in the year, that he was given a 10,000-dollar bonus from the hospital.

COMMISSIONER: And an airfare?-- And airfare.

D COMMISSIONER VIDER: Ms Hoffman, did Patel then have regular elective operating sessions? Like, did he have a Tuesday afternoon and a Thursday morning and an all day Friday or was he predominantly doing the major - doing most of the surgery in Bundaberg?-- He had - I'm - I think he had regular surgery times and I think he was also doing most of the surgery in Bundaberg, I believe. I think. It's certainly - because I was in intensive care and we're sort of sealed off a bit, the patients that we saw the most of with the complications were Dr Patel's patients. We very rarely saw other surgeons with complications in - you know, other patients that had different surgeons have complications in ICU. They were mainly Dr Patel's patients.

Just one other question, I think I have read that some of the initial elective surgery that ended up with complications were things like removal of gall bladders?-- Yes.

Is what the patient went to hospital - went to theatre for?-- Yes, yes.

And repair of hernia?-- Yes.

And ended up with complications like-----?-- Yes.

-----a nicked bowl?-- Yes.

And having their spleen removed?-- Yes.

And a nicked liver?-- And a nicked liver. And at one point he even managed to perforate someone's diaphragm when that's had - can I just refer to this note because he actually managed to - I can't find it now. But one - one particular patient went in for some - I don't know if it was fairly minor but it wasn't that bad a surgery - oh, here we go. That's right. A patient had a perforated oesophagus and he actually perforated the patient's stomach through their diaphragm. So it's sort of - it's even hard to figure out how you would go about doing that.

COMMISSIONER: Was this laparoscopic surgery or was it done-----?-- Some of it was laparoscopic. Some of it was laparoscopic surgery, yeah.

D COMMISSIONER EDWARDS: I was going to ask Miss Hoffman, is there an official record of complications of surgery within

Bundaberg Hospital as an example or throughout the state so that should a procedure have a complication or go wrong, that that is recorded so that there can be an assessment of the outcomes of the surgery and perhaps avoid it in the future?-- Apparently there is, Sir Llew, but it wasn't being done at Bundaberg Hospital. Dr Patel was doing his own audits.

COMMISSIONER: This is the sort of adverse incident report that you were talking about earlier, is it?-- Yeah, yeah. That was one of the things that Gerry Fitzgerald in his report said that, you know-----

D COMMISSIONER VIDER: So Dr Patel was auditing his own clinical records?-- Himself, yes, yes.

Thank you.

MR ANDREWS: Does Queensland Health have a system of codifying outcomes, does it not?-- Yes, it has a system of coding, yes. That's when we run-----

But the coding is done after one receives the theatre notes?-- Yeah.

I see?-- Yeah.

So if Dr Patel's theatre notes are inaccurate, so will the codes be?-- Yes.

This document that we're looking at, TH10, did Mr Leck say anything to you about this document, in particular that. Dr Patel was earning Peter Leck half a million dollars that year?-- No, I think he rolled his eyes at that and what he did say to me was, "That explains a few things", but he didn't say anything else. That's all he said. He just said "that explains a few things" to me, and he did roll his eyes about the half a million dollars. And I - I just want to make it clear that I did ask Peter Leck not to officially do anything with this knowledge at this point in time because I was going back to the ICU and I wanted to try - I was going back after my period of relieving and I wanted to try again through Dr - with Dr Carter's help and that to try and work out some sort of working relationship with Dr Patel.

There had been periods where Dr Patel wasn't speaking with you?-- No, he still - he didn't speak to me ever again.

COMMISSIONER: Mr Andrews, I see Mr Boddice is back, did you have something further instructions?

MR BODDICE: Only to indicate that further to the application this morning, where leave was refused, that I seek leave to withdraw on behalf of myself and my juniors.

COMMISSIONER: So the-----

MR BODDICE: Application is not pursued.

COMMISSIONER: -----application for leave to appear for Queensland Health is not pursued?

MR BODDICE: No, the application for leave to appear with Queensland Health is pursued but that has been refused. Mr Chairman, you offered you may give leave on another basis and I am not seeking leave on that basis.

COMMISSIONER: I am sorry, I think this will take a little while, so you are excused for the evening. If you want to leave the witness-box and we will see you back here at 9.30 tomorrow, is that convenient? Thank you.

WITNESS EXCUSED

COMMISSIONER: As I understood it, this morning you indicated you had instructions to appear on behalf of Queensland Health, plus a class of employees, both present and future, including the Director-General.

MR BODDICE: That's so.

COMMISSIONER: Right. I indicated that I would allow that in part to include the Director-General and other members of staff as indicated from time to time. So it is not that I rejected your application in toto, I allowed it in part and refused it in part. Are you now withdrawing the part that's been granted?

MR BODDICE: Well, in-----

COMMISSIONER: Is that the position?

MR BODDICE: In my respectful submission, I asked for leave on the basis of Queensland Health and its employees.

COMMISSIONER: Yes, you wanted to represent 65,000 people and I said you can't.

MR BODDICE: Yes, you ruled-----

COMMISSIONER: And now you say you don't want to represent any of them.

MR BODDICE: You ruled that you wouldn't grant leave to help Queensland Health. My instructions were to represent Queensland Health and its employees.

COMMISSIONER: Yes.

MR BODDICE: My instructions are not to simply just represent the Director-General.

COMMISSIONER: Or staff, as advised from time to time.

MR BODDICE: And staff as advised from time to time because at the moment we don't know the names of those people, so I don't-----

COMMISSIONER: I see.

MR BODDICE: -----seek to pursue that.

COMMISSIONER: I see, so the assurances that the inquiry has received from the Director-General repeatedly over the past four weeks that he wishes to cooperate with this inquiry have come to an end, have they?

MR BODDICE: Absolutely not.

COMMISSIONER: He doesn't want to be here, doesn't want to

participate in the inquiry, doesn't want to help us by producing documents, doesn't want his viewpoint to the inquiry, is that right?

MR BODDICE: With respect - with respect-----

COMMISSIONER: Does he want to be here or not?

MR BODDICE: That does not follow at all, with respect. The offer of cooperation remains and the inquiry can speak to Queensland Health and the Director-General at any time and documents will be provided, and if the inquiry wishes to hear from the Director-General, he will give evidence. That has not been withdrawn. The request for leave to appear was on behalf of Queensland Health.

COMMISSIONER: And its staff.

MR BODDICE: And its employees, past and present, who may not seek to be separately represented.

COMMISSIONER: Yes.

MR BODDICE: The indication of your ruling was that you would not grant leave to represent Queensland Health.

COMMISSIONER: Yes.

MR BODDICE: You would grant leave to represent the Director-General and staff members who were advised in writing - names of staff members advised in writing to the Commission.

COMMISSIONER: Yes.

MR BODDICE: My instructions were to seek leave on behalf of Queensland Health.

COMMISSIONER: Yes.

MR BODDICE: That has been refused. I am not pursuing any alternate application.

COMMISSIONER: But you are withdrawing.

MR BODDICE: I am seeking leave to withdraw.

COMMISSIONER: You are withdrawing the part that you applied for and I granted in part, that is to represent some of the Queensland Health employees which included the Director-General.

MR BODDICE: The application was to represent Queensland Health and its employees. It was not simply to represent the employees.

COMMISSIONER: It was to represent a group of people which included Queensland Health, whatever that is.

MR BODDICE: No.

COMMISSIONER: A morphous entity, plus its staff and that was granted in part.

MR BODDICE: No, it was - but the application was to represent Queensland Health that has practices, policies, procedures and systems. That has been denied and my instructions in those circumstances are to seek leave to withdraw.

COMMISSIONER: Well, I am not at the moment disposed to grant leave to withdraw, in so far as I have granted your application in part and allowed you to represent the Director-General.

MR BODDICE: Well, my application was not - my application was that, indeed, with respect, when your ruling was given I indicated those weren't my instructions and I would have to obtain instructions in respect of them, which is what I have been doing, and my instructions were to represent Queensland Health.

COMMISSIONER: I am sorry, Mr Boddice, the transcript will speak for itself. You told me this morning that you wanted to represent Queensland Health, plus its staff, past and present.

MR BODDICE: That's so.

COMMISSIONER: And I put to you that that was some 65,000 people, and you said you didn't even know how many there were.

MR BODDICE: I said there was a lot, actually.

COMMISSIONER: A lot.

MR BODDICE: Mmm.

COMMISSIONER: But you didn't know how many.

MR BODDICE: The application was to represent Queensland Health and its employees. I accept that.

COMMISSIONER: Mr Boddice, how can you represent tens of thousands of people? How could you possibly do that?

MR BODDICE: In the Fitzgerald Inquiry leave was granted to represent the Queensland Police Department.

COMMISSIONER: But not its staff, past and present.

MR BODDICE: Well, if you are prepared to grant leave to represent Queensland Health, then that was my instructions, to seek leave to represent Queensland Health.

COMMISSIONER: But that's not the application you made this morning. It was to represent Queensland Health, plus its staff, past and present.

MR BODDICE: Yes, that's so.

COMMISSIONER: And I have indicated that I would accede to that application to the extent of certain named staff, namely the Director-General and others that you indicated to the inquiry from time to time.

MR BODDICE: But not Queensland Health.

COMMISSIONER: But not Queensland Health.

MR BODDICE: And the application was Queensland Health and its employees.

COMMISSIONER: Well, just so I understand this, tell me, please, what it is that you describe as Queensland Health that you want to represent? You accept it is not a legal entity.

MR BODDICE: Yes.

COMMISSIONER: It is a branch of the Crown in right of the State of Queensland.

MR BODDICE: It is under a public sector, effectively, branch.

COMMISSIONER: Yes. So you want to represent one part of the Crown.

MR BODDICE: That's so.

COMMISSIONER: I see. And unless I let you conduct the proceedings the way you want to conduct them, you are going to pick up your bat and ball and go home altogether.

MR BODDICE: With respect, that's completely unfair and not so.

COMMISSIONER: Why is that unfair, Mr Boddice?

MR BODDICE: Because you are denying-----

COMMISSIONER: Why is that unfair?

MR BODDICE: You are denying representation, with respect, to the very organisation that I have instructions to act for.

COMMISSIONER: Look, let's put it this way: if you want to challenge my decision in the Supreme Court, who would you be appearing on behalf of? You couldn't go to the Supreme Court and say, "I appear for the department of health." The Supreme Court would say, "There is no such legal entity."

MR BODDICE: I am not challenging your ruling, I am indicating I am accepting your ruling and in those circumstances I am seeking leave to withdraw.

COMMISSIONER: Well, as I said, I am not disposed to grant such leave to withdraw and I would like very much to know what

the Director-General's attitude is to these proceedings, given the assurances he has provided to me, not to mention to the Premier of the State and others of his support for this inquiry that he now doesn't want to have any involvement here through legal representation on his behalf.

MR BODDICE: That is, with respect, not so at all. When he comes to give evidence, it may well be that he seeks leave to be represented-----

COMMISSIONER: He would only want to be represented when he gives evidence?

MR BODDICE: I can't speak in relation to that.

COMMISSIONER: He is one of your clients. You told us this morning he is the person from whom you take your instructions.

MR BODDICE: Yes, I expect that will be his position. When he gives evidence he will seek leave to be represented, but only at that time.

COMMISSIONER: I see.

MR BODDICE: There is no suggestion and it would be, with respect, grossly unfair to suggest that because leave having been refused there is going to be a denial of cooperation. That's not so at all. The Queensland Health has cooperated fully and will continue to cooperate fully with this inquiry. It will provide access to any staff that this inquiry asks for.

COMMISSIONER: Mr Boddice, it doesn't help to make propaganda statements from the Bar table. You talk about cooperating fully. Now, in the press over the weekend, we read about a report from a very senior intensivist at the Mater Hospital which he - Dr Peter Cook which he sent raising his concerns about Dr Patel. It must be over a week ago I signed a summons to Queensland Health saying that we want such reports of intensivists, and still nothing has been forthcoming. I don't know why we have to learn about these things from the AMA and other organisations when Queensland Health should be able to provide us with these documents, if it is serious about providing the level of cooperation that you are suggesting it intends to provide.

MR BODDICE: Well, I understand that to date 20,900 odd pages have been supplied to the inquiry of documents. I do not know whether that document is within there because the sheer volume has been enormous, but everything that has been asked for has been provided and there is ongoing processes of providing those documents. There are multiple hospitals that those requests have related to, multiple hospitals, and the Queensland Health is endeavouring to meet all of those requests in a timely fashion as quickly as they possibly can in all of the circumstances.

COMMISSIONER: Well, I don't recall asking for 20,900

documents, and, frankly, that sounds to me like an attempt to overbranch us with documents so we can't see the trees. We asked for reports about intensivists who had raised concerns about patients' transferred to Brisbane hospitals. We then have to learn for the first time in The Courier-Mail on Saturday morning that such a document exists and raises very serious concerns that your department has chosen not to bring to our attention.

MR BODDICE: As I said, Mr Commissioner, I can't say whether in fact that document may already have been provided.

COMMISSIONER: That's the problem, isn't it, none of us have the time to go through over 20,000 documents looking for something. I should have thought that if your department was serious about helping us, they would say, "Well, look, you know, it will take a while to find all of the reports from all of the intensive care units but no doubt the one you are really interested in is Dr Peter Cook because he is the one who blew the whistle."

MR BODDICE: Well, with respect, one of the summonses, for example, related to 18 categories of documents which involve medical records, things are kept in different bases. Some are kept within a file, a medical record. We are endeavouring to meet every one of the requests and we will continue to meet every one of the requests. We are providing the documents that fall within those categories as quickly as we possibly can in a timely fashion. Physically nothing more can be done. Mr Commissioner, it must be remembered that we're also getting requests from the Forster Inquiry in relation to documents. There aren't just one set of requests that are occurring in relation - and rightly so. There is a number of inquiries occurring at once and my client is endeavouring - our client is endeavouring to meet those requests as quickly as they possibly can.

COMMISSIONER: Well, one of the things I would like to explore is this: if what you are telling me is that if I won't give leave to this non-entity that you call Queensland Health to be represented in proceedings here, a body which could not be represented in any legal proceedings anywhere in the country under the name which you attribute to it, the Director-General himself won't allow himself to be represented. Is that the position?

MR BODDICE: No, I have indicated-----

COMMISSIONER: Except when he is giving evidence.

MR BODDICE: That's right.

COMMISSIONER: Well, if that's the Director-General's attitude, I wonder whether we shouldn't be issuing a summons for him to be present personally here throughout the proceedings so he can personally give us the cooperation that obviously you have been instructed not to give once withdrawal-----

MR BODDICE: With respect, that is unfair, and that suggests a predetermined view in relation to things.

COMMISSIONER: As to what Mr Boddice-----

MR BODDICE: Predetermined view that Queensland Health aren't going to be cooperative in the circumstances they have been cooperative. I understand not one request, from counsel assisting, have not been one-----

COMMISSIONER: Where are the documents from the intensive care units?

MR BODDICE: I understand documents have been supplied in the categories that are asked for and we are continuing to search for those documents.

COMMISSIONER: I wonder who managed to find out about why Patel's air ticket - who authorised that the day after the man resigned.

MR BODDICE: Those documents were supplied to the Commission, as I understand it, last Thursday night.

COMMISSIONER: Well, not by Queensland Health, the Premier's Department supplied to us last Thursday night documents showing that your organisation, Queensland Health, had paid for the air ticket, but nothing to explain how he made that application and in what circumstances it was approved the day after he had retired. Nothing to explain the inconsistency between what happened in Dr Patel's case and the information which our investigative staff have been gathering which suggests that for most surgeons in Queensland Health it takes of the order of three months to get any international travel approved, why it is that this was expedited so quickly that the day after the man retires, Queensland Health is signing off for him to travel one way to the United States business class. You know, I would have thought that is the sort of thing which since Thursday night Queensland Health would be pulling out all stops to find out.

MR BODDICE: My instructions are that Thursday night under the Crown Law office letter, copies of document was supplied to the Commission.

COMMISSIONER: Thursday night - the only communication I am aware of on Thursday night came directly from the Premier's Department but I am not going to debate that with you now.

MR BODDICE: I understand a letter was sent by my instructing solicitors enclosing the documents to the Commission.

COMMISSIONER: Mr Boddice, if your instructions are as I interpret them to hold this inquiry, to brand some of it, unless we will consent to give leave for Queensland Health to be represented under that name, you are going to walk out now, then I feel compelled to give you that leave and I do so. I

will see you tomorrow morning at 9.30. Anything else anyone wants to raise at this stage?

MR ANDREWS: No, thank you, Commissioner.

COMMISSIONER: Thank you, Mr Andrews. Anyone else? We will adjourn until 9.30 tomorrow.

THE COURT ADJOURNED AT 4.34 P.M. TILL 9.30 A.M. THE FOLLOWING DAY