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 24/05/2005

..DAY 2

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THE COMMISSION RESUMED AT 9.31 A.M.

MS S HUNT (instructed by Brian Bartley & Associates) for Linda Mulligan

COMMISSIONER: Good morning, ladies and gentlemen. Before the evidence resumes this morning, I wish to bring to everyone's attention a letter which I received - in fact, I only saw it this morning, although it came through last night from The Honourable The Premier of Queensland, Mr Beattie, and I'll read out the contents of the letter:

> "I have promised to keep you informed of any developments affecting your inquiry that I learn of. As you know, I have instructed that Queensland Health should keep searching their records to ensure that you are provided with all relevant information. Shortly before 7 p.m. this evening, my department forwarded to my office an e-mail which it had received shortly before from the Office of Director General of Queensland health. It read: `Information has just been received which would seem to indicate that there are potentially 40 more cases that require review. Of these, 20 are deceased and have Dr Patel listed as being involved in their care. The remaining 20 are listed as being transferred to other facilities for ongoing care. Likewise, Dr Patel is listed as also being involved in their care. Since the original search was conducted, staff have continued to refine and run their queries in order to exhaust all possible linkages to Dr Patel. Some of the linkages are rather obscure but the review team will now assess all of these patient charts in a similar manner to all other identified cases.'

That's the end of the Premier's quotation from the e-mail which he received from the Director General's office and then the Premier's letter continues:

> "I am told that this information arose as a result of the original searches at Bundaberg Base Hospital being checked for accuracy. I am also told that this latest information needs to be collated and checked to ensure that it is accurate. I have directed that this information should be made available as early as possible and forwarded to you as a matter of urgency. I have sent copies of this letter to the Minister for Health, Gordon Nuttall, and to the Director General of Queensland Health, Dr Steve Buckland. Yours Sincerely, MP, Premier and Minister for Trade."

I'd like to place on the record this inquiry's thanks for the continuing support that we've received from The Premier and his office and this is just another indication that this inquiry has been exceptionally well served by the Executive

Government of the State in the support which is received and the ongoing supply of useful information which we are receiving.

Mr Andrews?

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

COMMISSIONER: Thank you, Mr Andrews. And I'll ask the secretary to mark that letter as an exhibit.

TONI ELLEN HOFFMAN, CONTINUING EXAMINATION-IN-CHIEF:

MR ANDREWS: Good morning. Ms Hoffman, yesterday, you'd taken us through events until about February/March of 2004. In February 2004, you were Acting Director of Nursing and you briefed the incoming Director of Nursing, Linda Mulligan?-- Yes.

During that time, you were careful not to make adverse comments about Dr Patel, I understand?-- Yes.

So when Linda Mulligan observed to you that she'd heard that Dr Patel was excellent clinically, why didn't you inform her of your concerns?-- I did make one comment, I just said that wasn't - that wasn't my opinion or that wasn't how I, how I saw it, but I wanted, I wanted it to come from someone else other than me because I just felt it was important that her coming into a new position shouldn't be prejudiced by someone, someone else's opinion.

Mmm-hmm?-- That it was important to her to hear it from the other areas that had issues, like the renal unit and theatre and the surgical ward.

Thank you. Until Ms Mulligan's arrival, had there been a practice for the Director of Nursing to be quite accessible to the nurse unit managers?-- Yes, very accessible.

And was that as a result of a review that had been done in 2001 of the nursing structure at the hospital?-- I believe it was the DON in 2001 from the Toowoomba Hospital.

You mean the Director of Nursing from Toowoomba Hospital?-- Yes, yeah.

And had that person suggested that Directors of Nursing and Assistant Directors of Nursing should be more accessible to the Level 3 registered nurses?-- Yes, that's right.

And from 2001, how was that system implemented? How often would you, as a nurse unit manager, see either the Director or the Assistant Director of Nursing?-- Every day we would see one of them. They did - they alternated areas and the DON,

the DON would come see one area one day and the A/DON would see the other area the next day, so we had access to one or the other every day - on a daily basis. We also had access to the Director of Nursing via a free-set that - everyone carries around a free-set at the hospital.

Is a free-set a-----?-- It's an internal phone system and so we could just, if there was - something that we had to run by her, we could just pick the phone up and call her and when Linda came, we had to - she took her phone number off the e-mails and we actually had to go through a secretary to speak with her.

And when Linda Mulligan came, did she implement a system that was different from the procedures since 2001?-- She didn't do rounds, she didn't do rounds probably I think in the whole time she was there, we saw her only about four times in ICU.

Did that - well, was there another convenient way in which you were able to communicate concerns with Linda Mulligan?-- No, it was very difficult. Even after a particularly upsetting event in July, I wanted to speak with her quite urgently and I was told I had to wait two weeks to speak with her.

COMMISSIONER: Mr Andrews, I'm sorry, can you just remind me is Ms Mulligan represented in these proceedings?

MR ANDREWS: She is, as I understand it, represented by Mr Bartley.

COMMISSIONER: Oh, yes, I understand. And Mr Bartley's not present?

MR ANDREWS: I hadn't looked around the room to determine these matters. In his absence, I submit that it is often the case that when the name of a person is raised in a way that might be regarded as critical, there's commonly an application made to suppress the publication of that name until such time as there has been cross-examination of the critical - of the witness who's criticising the other person, and in Mr Bartley's absence, I should raise that as a possibility.

COMMISSIONER: I'm reluctant to do that, and not out of any lack of concern from Ms Mulligan's name and reputation, but the problem is if we start doing that, the flow of information dries up. What I'd ask is if one of the Commission staff, perhaps Mr Stella, if you'd be kind enough to telephone Mr Bartley's office this morning and see whether he wishes to attend and make such an application on his client's behalf. Until I've heard from Mr Bartley, I'd ask the press to be sensitive in mentioning Ms Mulligan's name but I'm not going to make any order at the moment. Mr Allen, I take it you have no interest in this particular matter?

MR ALLEN: No, no. I do not appear for Ms Mulligan.

COMMISSIONER: No. And she's not one of your 65,000 members, Mr Boddice?

MR BODDICE: Well, I understood it's been indicated that she's being separately represented through the Commission.

COMMISSIONER: Yes.

MR ANDREWS: Now, under the procedure that had existed from 2001, the Assistant Director of Nursing had been, at least every second day, doing rounds to make - to be accessible. Under Ms Mulligan's regime, what happened to the rounds of the Assistant Director of Nursing?-- She continued to do her rounds but most of her authority in relation to us, because previously she would have been our direct line manager and then through her to the Director of Nursing, but with Ms Mulligan starting, her - all of her - all of our reporting abilities to her were taken away from her, so, so she had very little - there was very little she could actually do for us.

Do you mean that once Ms Mulligan started, your line manager became Ms Mulligan?-- Yes.

COMMISSIONER: Who was the Assistant Director at that time?-- Carolyn Kennedy.

Right. Now, on the 8th of April 2004, you make reference to a patient, Ms P14, who underwent an operation, and you might be able to refresh your memory as to this by looking at paragraph 56 of your statement; do you recall the age of P14?-- No, I think she probably would have been in her late 60s.

Now, Dr Patel assessed her and booked her for a sigmoidcolectomy?-- Yes.

For cancer of the sigmoid colon?-- Yes.

What's unusual about the way this patient was dealt with?-- Well, she was actually found to have ovarian cancer when they did the surgery and then later on, she had a wound dehiscence where she had a complete evisceration of the wound and she had to return to theatre.

Now, what is the purpose of drawing to our attention the staging CT scan?-- Most patients, once they're diagnosed with cancer, have a CT scan of just about nearly their - well, nearly their whole body to make sure there's no metastatic lesions, make sure there's no spread of the cancer to anywhere else in the body.

Is it the case that if the scan shows the spread of lesions, that it's an indication that perhaps surgery shouldn't be undertaken?-- Yeah, they might offer the patient a different therapy, like chemotherapy or radiotherapy.

COMMISSIONER: Well, in this case the operation was to remove the sigmoid colon, there wasn't much point in doing that given the presence of ovarian cancer?-- Yeah, Mmm, that's right.

It was really not only a waste of money, but also putting the patient to unnecessary stress?-- Mmm, and she had a lot of,

you know, stress post-operatively obviously with the wound completely coming apart and her intestines were exposed.

Yes.

D COMMISSIONER VIDER: Mr Andrew, could I just ask Ms Hoffman, would a sigmoid colon operation routinely go to Intensive Care Unit?-- No, it wouldn't.

No?-- No.

So this patient was admitted to the Intensive Care Unit because of complications?-- Yes, yes.

From the operating theatre or following the wound dehiscence?-- Um, I can't remember the exact sequence of events for her, I'll just have a look and see if I've got it down here. I think she actually came, she may have suffered a intraoperative - some sort of heart episode, so I think she came to ICU because of that, according to my notes here, and she went to - she did end up going to the ward quite - she was admitted to ICU on the 9/4, went to the ward on the 10/4, the wound fell apart on the 11/4 and she came back to us after that.

COMMISSIONER: But really what you're telling us is that this unfortunate woman shouldn't have been operated on at all if the CT scan had been taken and her ovarian cancer had been detected, that there was just no point undertaking the surgery?-- Or they may have offered her a different form of treatment.

Yes?-- Yep.

Yes?-- And we had quite a few patients - we've had quite a few patients that even just now are coming back to us because they're showing metastatic lesions because they hadn't had a staging CT done.

Yes.

D COMMISSIONER VIDER: Ms Hoffman, this particular patient, was this dehiscence - in previous evidence you've indicated that the wound dehiscence was due to poor surgical technique and was even suggested that the nature of the suture material was to blame whereas wound dehiscence is often associated with infection. In this particular case, was this wound dehiscence the same - put down to the same cause or had there been anastomosis breakdown, and for the benefit of everyone, that's when the bowels are dissected and the bits that are sewed back are referred to the anastomosis?-- I think it was too early for infection and so I think it must be - the - I mean, the only thing I can think of is technique. Because, I don't - because she'd probably - she didn't have the colectomy, there wouldn't have been anastomosis.

Oh, that didn't go ahead?-- Yeah, I'm not sure what he actually did when he got in there.

So the sigmoid colectomy didn't go ahead?-- No, not to my knowledge, no.

D COMMISSIONER EDWARDS: Ms Hoffman, were you then saying where there's a dehiscence of the wound two or three days over, it's more likely due to technical reasons than infection?-- Well, that's my understanding, Sir Llew.

Thank you.

MR ANDREWS: Were there monthly meetings of the anaesthetic surgical pre-admission and intensive care staff?-- Yes, there were.

Attended by the nurse unit managers and each of the medical directors of those sections?-- Yes, attended by the nurse unit managers, the Head of Anaesthesia, Mark Carter, the Head of Infection Control, the nurse in charge of Infection Control and then sometimes Darren Keating, sometimes Peter Leck and usually Dr Patel came as well and then the other nurse unit - the other people in the unit, unit managers of other areas, like day surgery, unit pre-admission clinic, quality improvement.

I see. Now, three days after the wound dehiscence of patient P14, was there one of these meetings which you call, I think, ASPIC meetings?-- Yes.

And you were - at TH11 appended the notes of that meeting, don't you?-- Yes.

And do your notes reveal that there were apologies from Dr Patel?-- Yes.

And do they reveal where I've used the highlighter on subsequent pages things that you raised at that meeting? For instance, with respect to ICU, did you raise something?-- Yes, I raised that we had several long term ventilators for long periods and that our overtime budget was way over and that once again, I'm asking the Director of Anaesthesia Surgery and the - myself and the Director of Medical Service or the Director of Nursing Services need to have a proactive meeting about transferring ventilated patients.

Is this because ventilated patients were staying in ICU for longer than 48 hours?-- Yes, much longer.

And you raised something else in that meeting?

COMMISSIONER: Just before we go off that page, the last line - it may be entirely irrelevant - but it's said "Theatre bookings - Muddy doesn't have any money, Darren won't give her any."; what does that mean?-- Muddy's the - everyone in Bundaberg has a nickname.

Yes?-- And Muddy is the nickname of the theatre booking person, she didn't actually have a budget.

Yes?-- And so we used to have a - and do a round table budgetary report and she just said she didn't have any money because Darren wouldn't give her any, that's all.

Okay, it just seemed to be part of the same item on that table.

MR ANDREWS: Now, there was a note made about wound dehiscence; who raised that topic?-- I think it was either myself or Gail Aylmer who raised the topic. We as a group, including the number of surgical NUM, were concerned about the number of wound dehiscence and we were concerned that it wasn't being captured in any central area and that is when we decided that Dianne Jenkins, who is the NUM of the Surgical Ward, would be the surgical person and we would notify her if a wound dehiscence would occur so we could capture the data properly because we weren't capturing the data through the ordinary channels.

The concern being that those who coded these things would not know about the wound dehiscence, wouldn't be able to code it and no-one would know when looking at summaries that could be created from the codes that there was an emerging problem?-- That's right. And we - that's when we also requested a definition of wound dehiscence because we'd had that previous discussion with Dr Patel about what was a wound dehiscence and what wasn't.

Now, while on that topic, do you recall which junior doctors were told by Dr Patel not to use the word dehiscence?-- I don't recall the names of the doctors but I remember it being discussed in intensive care on pretty much on a daily basis, and one of the doctors that was there at the time was a Dr Risson, David Risson.

R-I-S-S-O-N?-- Yeah, and then because we had so many doctors from Britain and that one of the other doctors was named Dr Alex Davies but she's gone back to Britain now.

And Dr Risson, whereabouts is he?-- I believe he's in Dalby.

Thank you.

COMMISSIONER: In the passage there on wound dehiscence, about six lines down it mentions that all areas would let Di know as a central person is that someone in the administration?-- No, Di Jenkins was the nurse unit manager of the surgical ward.

Right. It also says that, as Mr Andrews noticed, a definition of wound dehiscence was requested. Was such a definition ever provided?-- There was a discussion about the definition of wound dehiscence but I don't know if it was in relation to this request or not.

Okay?-- Which is still another meeting.
And just for my benefit, it says "First action is to fill in an adverse event form and send to DQDSU."; who would that be?-- That's our quality control department.

Right?-- And that's, theoretically where all incident reports should go to first so that they can be recorded and then sent off to the appropriate people.

D COMMISSIONER EDWARDS: Do you recall was the level of wound dehiscence from surgery conducted by Dr Patel higher than the average of other surgeons?-- I don't recall any from any other surgeon, doctor - Sir Llew, I don't recall any other from any other surgeon during the period of time.

Thank you.

D COMMISSIONER VIDER: Ms Hoffman, when you look at the information that's gathered that you come under the banner of "Clinical Indicators"?-- Yes.

If you collected these sorts of indicators, where does it go to?-- Well, it should go to this, the quality group, there's a big quality, you know, there's quite a few people - few people that sit in that area and then they send them off to benchmark against other hospitals, I don't know where they actually go to from there.

You don't have a group of internal clinical committees that would review - you don't have a surgical services committee by whatever name, you don't have? You have an infection control committee?-- Yeah, the ASPIC committee should look at any adverse events.

Of a clinical nature or?-- Of a clinical nature but we weren't getting any to look at.

Oh, okay?-- So they should look at that and the medical services forum should look at the ones coming from medicine.

Yes?-- But because there was this absence of incident reports being written, we didn't ever really see them.

Do you have any idea why there were no incident reports written? I mean, were you encouraged to write them? Not write them? Were you too busy? Did you just have any feeling as to why there were no incident reports?-- I think because people were confused about where perhaps they should have been written. If the wound dehiscence, like, if it's a theatre indicator about wound dehiscence or return to theatre, so we thought that those sort of incident reports should have been generated from there, something that's done in ICU that's an adverse event should have been generated from there, so I don't know why, why they weren't written.

So you're not aware of any formal structure or process within the Bundaberg Hospital that would have allowed review of clinical indicators that would be fairly common in hospitals, like unplanned return to the operating theatre?-- Yes.

Infection rates, infection wound dehiscence, deaths in the Intensive Care Unit?-- No, we don't have any structure, morbidity or mortality meetings or anything like that, no.

Thank you.

COMMISSIONER: With the adverse event forms, who had authority to prepare one? Obviously, if the surgeon was - had an adverse event in the operating theatre, the surgery, he or she could prepare such a form, but was the anaesthetist or the nurse or someone else in the operating theatre or your staff in ICU when the patient came through to ICU, were any of you entitled to submit one of these forms as well?-- Anybody's - anybody's entitled to fill them in.

Yes?-- But it should be the person who either finds the error or commits the - not commits the error but, you know, who performs the mistake or whatever you want to say-----

Yes?-- -----that fills the form in. So it should really be generated from that area. So if it's from theatre, like, a patient's bowel's nicked or whatever in theatre, the incident report should be generated from there. I can't - once they came through to ICU, it's not - I can't really write it there because I didn't see it.

Yes. You can - you can write an adverse event form for a problem that happens while the patient is in your care in ICU?-- Yeah.

But you can't do a - rewrite history by doing one for-----?-- Yeah, I can't do a retrospective one. I shouldn't do a retrospective one.

See, one of the things that is going through my mind is with all the criticism that we're hearing about Dr Patel, presumably there was an anaesthetist present at each of these operations and it seems surprising that we didn't - we're not seeing adverse event forms from the anaesthetists of these operations. Could that be a standard practice?-- It would be a standard practice and I think that's an excellent point. We - in the Bundaberg Hospital, we - the nursing and other staff, we got sent away to do a lot of courses on risk management and incident reporting and we spent a lot of time away at these courses, but in reality it wasn't happening in our hospital. We were being sent away to learn how to do these things but in reality it wasn't happening. When I filled in an sentinal event form for something that happened in a few months' time that we'll talk about later, it was downgraded from an sentinel event form to a less serious form and we didn't hear anything about it.

Never having worked in a hospital myself, and that's where the two Deputy Commissioners have an advantage over me, I perhaps don't have a sense of the command structures, but take the example of a scrubs nurse in the operating theatre. Technically, he or she could fill in an adverse event form presumably, but I guess there'd be a lot of resistance to doing that because you're, in effect, overriding both the surgeon and the anaesthetist. Would that be right?-- That would be right but - no, as nurses, we have - we do have a duty of responsibility and a duty of care if we see something that's wrong we should report it, but often these incident reports would disappear into a black hole and no-one would ever hear anything about them. I don't know about how many were ever written in theatre because they would go to their - that NUM, that nurse unit manager, but we certainly didn't ever see any that were generated from theatre in ICU, or hear about them.

Now, you mentioned earlier that the M&M meetings, morbidity and mortality, or was it the other way around, mortality and morbidity, I have heard that they are increasingly common in at least the major hospitals. Do you consider that at Bundaberg you are disadvantaged by not having those meetings?-- Very much so. Even when I worked in Saudi Arabia we had them on a weekly basis, every Wednesday morning, and they ran beautifully. So I was very - I was quite concerned about why they - why we couldn't do the same thing in Bundaberg. There's a couple of areas in Bundaberg that did do them, the neo - the women's unit, the - you know, the family unit.

Maternity?-- Maternity.

Yes?-- They had their own - they do have a morbidity and mortality meeting, they call it something else, and the paediatric unit also looks at their morbidity and mortality. But that was generated by the type of doctor that they had in charge of the unit but we didn't have anybody to generate the morbidity and mortality group.

And you said just a few moments ago about adverse event forms disappearing into a black hole. What should have been the paper trail with them, where should they have gone to?-- Well, they should have gone - they should have gone to this DDQSU, this department that's supposed to - it stands for division of quality - quality and decision making unit. That's what it sort of stands for. And then a group of people should look at the process because it's - you're supposed to be looking at what actually went wrong, not blame someone for doing something wrong. You're supposed to be looking at the process and then recommendations come back to the area from where the report was written, generated from.

Who was running the DQDSU at the time?-- A manager named Jennifer Kirby.

So a non-medical person?-- No, she is a nurse.

A nurse. And she was manager of that unit?-- Yes.

Was that her full-time job or was she doing other-----?-- No, that was her full-time - full-time job and then there was someone else who was involved with quality management as well who would assist her. I mean, Jenny Kirby would do other things as well. She was involved in transition to, which is a coding system within the hospital, and sort of that sort of area. It was about information gathering.

D COMMISSIONER EDWARDS: Could I ask, Ms Hoffman, as I understand it, the resident or registrar writes up the process of the procedure that's being undertaken in theatre, or the surgeon, whoever that might be. Do nurses, say, the senior nurse assisting or in charge of the operating theatre, do they write a report of any what they consider to be adverse events during surgery and is that included in the clinical notes?-- I've never seen it, no.

Do you have a view on that?-- It would be a good idea. Mmm.

COMMISSIONER: Thank you, Mr Andrews.

MR ANDREWS: You speak at paragraph 58 of patient P41 as opposed to P14, who you had discussed at paragraph 57. Do you recall the date and age relating to P41?-- Sorry, what paragraph was that?

Paragraph 58 on page 21?-- Which patient?

P41?-- The age of the lady?
The age and the date of the incident?-- The date was the 27th of the 4th and she'd also gone in for a leaking - a total

colectomy and she had a wound dehiscence as well.

COMMISSIONER: What was the procedure you mentioned?-- A total colectomy.

And she again suffered wound dehiscence?-- Yes.

So this was two or three weeks after the meeting at which that problem had been reviewed?-- Yes.

MR ANDREWS: At paragraph 59 you write of patient P1. Do you recall the age of that patient?-- No, I think that lady was in-----

Is this a patient whose notes you reviewed at a later time when-----?-- Yes.

-----you determined that it was proper to do an audit?-- Yes. That's right. I think that lady was in her late - sort of probably late 50s, early 60s.

COMMISSIONER: We don't have a name in your key for that lady?-- No, I do have a name for her though because I have gone back and done and - and done it.

I wonder if the gentlemen at the table could provide you with a piece of paper and you might write down the name for us. That name will be treated in the same way as the other names in Exhibit 5; that is to say legal representatives and the media may have access to the name but the name shouldn't be used in any broadcast or news report without the permission of the - well, the patient's deceased, so without the permission of her family. Is that intelligible to everyone?

MR ANDREWS: Thank you.

COMMISSIONER: Thank you.

MR ANDREWS: Now, about that procedure that you described-----

COMMISSIONER: Sorry, Mr Andrews. I'll also ask the secretary to add this name to Exhibit 5 so that the key is complete.

MR ANDREWS: I'm grateful for that, thank you. The procedure you describe in paragraph 59, is there anything unusual about it that you should bring to our attention?-- Just, once again, it describes a complication when Dr Patel was putting in a catheter.

Is that a vas cath?-- Yes, it's a catheter used for dialysis and it's temporarily usually put in here, and what he's - what's happened, he's perforated the patient's internal jugular and possibly also the patient's trachea. And as I've said there, I think I was actually on leave when that actually happened. I subsequently did note that patient's case in my written complaint to Peter Leck. They were the patients that

I wanted him to have a look at specifically.

The perforation of the internal jugular, is that a common event when inserting a vas cath?-- It's not common but it's - it was - it's not common. It all depends on who's doing the procedure I think. Like, if someone was really-----

COMMISSIONER: Was it common with surgeons other than Dr Patel?-- No.

MR ANDREWS: Now, on the 10th of July P37 underwent a laparotomy. What's the age of P37, do you know?--

D COMMISSIONER VIDER: Mr Andrews, could I just go back to P1 for one moment?

MR ANDREWS: Of course.

D COMMISSIONER VIDER: Ms Hoffman, presumably P1 died because that's - you're looking at the record retrospectively?-- Yeah.

Correct.

MR ANDREWS: Indeed, the statement does observe that P1 died.

D COMMISSIONER VIDER: What would be the stated cause of death if we've got a perforated internal jugular vein and a ruptured trachea?-- I don't know - I don't recall what the stated - what the death certificate stated on this lady. I would have to look at the notes again. I don't - I don't know what he wrote.

My statement's coming from yesterday's revelation that many of those complicated outcomes-----?-- Yes.

-----were never documented?-- That's right. And I talk about a bit further on when I did look at some death certificates which states some quite unusual causes of death on them.

D COMMISSIONER EDWARDS: Was there a mechanism by which in an adverse event such as this, that there was a report back for further noting and perhaps precautions to be taken if there was an impact - an activity undertaken that had been to the detriment of a patient?-- See, Sir Llew I don't even know that an adverse event form was done for this. It should have been but I don't know if it was.

You feel that it should be mandatory for adverse event forms to be filled after any adverse event?-- Yes, I do, yeah.

COMMISSIONER: Mr Boddice, you're not able to produce any adverse event form or any death certificate relating to patient P31.

MR BODDICE: I will have some inquiries made in relation to it. Indeed, Mr Chairman, if you wish to give me a list of any others on that list, I can ensure that it's done all at once.

COMMISSIONER: Well, I'm really not keen to have another 20,000 documents. Can we just deal with them one at a time as they come up?

MR BODDICE: Thank you. I will have some inquiries made.

COMMISSIONER: Thank you.

MR ANDREWS: I will pass now to patient P37 at paragraph 60. Do you recall the age of that patient?-- No, I don't recall her age. She was, once again, a middle age lady. She-----

Is she someone you had contact with or someone to - about whom a report was made to you?-- I had some contact with her as well as a report was written to me about her.

Now, why do you mention that there was an attempted evacuation of a haematoma without any analgesia? Is that unusual?-- Yes, it's cruel and it's - and it severely distressed the patient as well as the nurse who was looking after it - after the patient. The patient was actually in the surgical ward and ICU nurses had gone into the surgical ward to care for that patient and when she saw what Dr Patel was trying to do, she was, you know, extremely distressed and wrote a report about it. And the patient was very distressed. She ended up coming into the intensive care unit - this is another example of the notes being not correct. That Dr Patel, on the ward round, had stated that the wound was - there was no problem with the wound, on the ward round early on the morning of the 25th of the 8th. And then the patient was transferred to ICU from theatre at 7 o'clock that night because the haematoma needed to be evacuated. So, once again, it was just another example, even though the wound was reddened and obviously inflamed and there was a haematoma there, that he stated there was no problem on the ward round and yet she required surgery that night, and then subsequently required intensive care for the night. This particular lady's family were extremely distressed at the sequence of events, were very angry about the whole thing. And Dr Patel had noted in his notes that the patient was doing well when the wound remained infected and oozing.

COMMISSIONER: What is a laparotomy?-- A laparotomy is an operation that they do, usually with a midline incision on your abdomen to - if they're not quite sure what's wrong with you and they want to find out.

So it's an observation rather than-----?-- It's usually an exploratory operation.

D COMMISSIONER VIDER: Did the patient's family - you've stated that they were upset and angry. Did they do anything with their distress?-- Yeah, I don't - I can't remember whether they did or they didn't. A lot of patients would wait - a lot of families would wait till their patients were out of hospital before they would make a complaint because they were worried about any sort of retribution that may occur

to the patient if they made a complaint while the patient was in the hospital. So I'm not - I'm not sure if that lady's family did make a complaint later or not.

If families were fearing retribution, was that purely a perception or was there any evidence that families that had spoken out had been treated adversely?-- I think it's - sorry, could you just repeat that.

I just said is there any evidence to say that if patients or relatives, that if they did speak out, were treated poorly or their fears of retribution were in actual fact real, or is it just their perception that that might happen to them?-- I don't know. I think that's a common perception amongst patients that if they do speak out, that the - they may not be treated as well. I think that is quite common.

So it is no different to what was-----?-- Yeah.

It was nothing in particular?-- No, nothing in particular, no.

MR ANDREWS: At paragraph 61 you discuss patient P17. Can you give the age of that patient?-- No, I can't give the age but, once again, I remember that he was probably in his late 60s I think.

COMMISSIONER: References to a Whipple's procedure - obviously there'll be witnesses later on who will perhaps give us more technical descriptions but can you just explain generally what a Whipple's procedure is?-- It is surgery for cancer for the head of the pancreas. It is very complicated. It is a very complicated procedure. Once again, should be done in a tertiary hospital. Most time it is, to my knowledge, a palliative procedure, but sometimes it's curative. This patient was, as I said, quite sick for 12 days in the ICU and after going to the ward, he actually went to X-ray and actually had a cardiac arrest in X-ray and died, and his death certificate was one that I was concerned about because on the death certificate it stated that he died from klebsiella pneumonia and inactivity. Of course, now I'm aware in hindsight that this was the type of procedure that Dr Patel was actually prohibited from doing in the States.

Is there anything to indicate that he actually had pneumonia?-- I'd have to go back and look at the notes about that. I know that on the death certificate, even though it didn't say - it's got cause of death 1, 2 then right at the bottom it's, "Whipple's procedure 12 days ago." But, certainly, inactivity isn't a cause of death and it shouldn't have been on the death certificate. I mean, a death certificate is very precise what you should and shouldn't put on the death certificate as a cause of death, and inactivity isn't one of them.

But it sounds like pneumonia - perhaps he did have pneumonia?-- Yeah, pneumonia.

But it was secondary to other factors, apart from inactivity?-- Mmm.

MR ANDREWS: Who was the author of the items included in a death certificate?-- Any doctor can write a death certificate but if there's an incidence where it should be a Coroner's case, then the doctors shouldn't write the doctor's certificate until it has been cleared by the Coroner. So there's a group of guidelines that we should follow in relation to that.

Did you, during 2004, begin an audit of charts of persons who've died in intensive care?-- Yes, I did.

And do you discuss that audit from paragraph 67 of your statement?-- Yes, I do.

Now, the first patient mentioned at paragraph 68 is P12. Is that - do you recall whether that's a patient with whom you personally had contact?-- Yes, I did, yes.

Do you remember the age of P12?-- He - he also was a middle aged gentleman.

Do you remember the date that he came into ICU?-- The 7/2/04.

COMMISSIONER: 7th of the 2nd?-- Oh, no, the 6/7/03.

6th of the 7th?-- Mmm.

'03 or '04?-- '03.

6th of July 2003?-- Mmm.

MR ANDREWS: Now-----

COMMISSIONER: I'm sorry, Mr Andrews. Ms Hoffman, you've described him as middle age. I guess all of us think of middle age as meaning people who are older than we are?-- Yeah, he's much older than us.

I think of Sir Llew as middle age?-- Oh, no, he's much older than Sir Llew. No, he would have probably been in his 60s I think, yeah.

MR ANDREWS: And what about his treatment is unusual or noteworthy?-- Just, he was a patient that was quite sick. He was found in the park and we don't know how long he had been in the park for - you know, exposed. And he was actually quite ill. He had a perforated duodenum ulcer and he needed to go to Brisbane and it was just another example Dr Patel refusing and delaying transfer to Brisbane.

Why is it that you say that he needed to go to Brisbane?-- Because he required prolonged ventilation in the ICU. He was in the - he'd already been in there five days and he - he needed to go to Brisbane.

Was the need to transfer him to Brisbane to free up ventilators in the ICU or was it for the benefit of the patient that he should go to Brisbane?-- For the benefit of the patient.

COMMISSIONER: Would you happen to know, when a patient is transferred from Bundaberg to a hospital in Brisbane, say by air or by fixed wing or by helicopter or whatever, which hospital picks up the tab for that?-- Actually, neither. It comes from a different pocket of money.

Okay?-- And I'm - I don't know where but that's something that they were talking about changing.

Yes?-- Whereas the hospital who was sending the patients would pick up the tab, and you can imagine it's extremely expensive - I think it's around 11 or $12,000 a transfer. So at this point in time, to my knowledge - like, if the retrieval team was coming from Royal Brisbane, they would be paying for the Doctors, but the actual transport of the - you know, of the helicopter or the fixed wing comes out of a separate pocket of money.

I'm just wondering what incentive Dr Patel might have had to keep patients in ICU at Bundaberg, whether it was a matter of pride, a matter of not having doctors at other hospitals pick up his mistakes or whether there was also a financial consideration as well?-- There was no financial gain to the patient staying in Bundaberg from Bundaberg's point of view, and I don't think from his point, I don't know. But there's certainly - I believe that it was so that people couldn't pick up on the things that were happening in Bundaberg.

D COMMISSIONER EDWARDS: Who was Dr Patel's direct report to?-- Dr Keating.

Thank you.

MR ANDREWS: With respect to patient P12 you observed that Dr Patel kept saying the patient had sepsis caused by an infection in his chest and that he didn't have bleeding or infection in the abdomen. Now, you said that he obviously had an acute abdomen. How certain are you that you were correct and that Dr Patel was incorrect?-- The man - the man's abdomen was distended, it was red, he had no bowel sounds. He was - he had a temperature. He was showing signs of obvious sepsis from a wound that you could see - from an abdomen that you could see was obviously what they call acute, whereas he didn't have any of these signs that this was coming from his chest.

Thank you?-- That wasn't just my opinion either. That was the anaesthetist's opinion as well.

COMMISSIONER: You mention in your statement, I think, that you heard discussions between Dr Patel and other people, between Dr Patel and the anaesthetists and between Dr Patel and nursing staff. Was there debate as to the nature of the

patient's condition?-- There was a debate about that and, also, they were urging Dr Patel to send the patient to Brisbane for the patient's benefit.

Thank you. I know it doesn't matter at all in the sense that every Queenslander is entitled to the same level of medical care but when you say this man was found in a park, was that suggesting he's a - he was a homeless man or something like that?-- He - he - I believe he was a homeless man and I think the reason why I said that was not because he was homeless but to suggest that his condition mightn't have been good as someone else's in terms of nutrition.

Yes?-- And that type of thing, not the fact that he was homeless, just that-----

I understand exactly, yes?-- Yeah.

MR ANDREWS: Patient P27. Do you recall the age of that patient and the date of his treatment?-- He was - I think he was in around - in probably his late 40s, early 50s, and he fell from a bridge at quite a height. The date was 27/1/04, and he - they expected the man to pass away because he had so many injuries, nearly every bone in his body was actually broken. He - this was an attempted - he had attempted suicide. And once again Dr Patel was trying to interfere with him going to Brisbane. He needed to go to Brisbane because of the extent of his injuries.

COMMISSIONER: Just to understand the circumstances of that case, are you suggesting that his life could have been saved in Brisbane, or that his care could have been better in Brisbane, or was it simply a concern that he was using the Level 1 facilities at Bundaberg longer than was necessary, and that, in a procedural sense, he should have been evacuated?-- No, at that point in time I was concerned for his well-being and that he needed to be in Brisbane to be under the care of an intensivist, and doctors that were more specialised than the ones that we had in Bundaberg.

He ultimately died, did he?-- Actually, I believe he lived, actually, yeah.

Yes.

MR ANDREWS: He was ultimately transferred to Brisbane?-- He was, yes, yes.

Patient P32, do you recall the age of that man?-- No, I don't recall the age of him. I believe he was in his 70s, this man.

And what about his treatment causes you to include it in your statement?-- He was a patient that came in with a bowel obstruction. He went to theatre, according to my notes, on the 7/2/04 and had a resection of his small bowel with anastomosis. That's when they join it back up together again. And on the 11th of the 2nd he was transferred to Brisbane. On the 12th of the 2nd he had a laparotomy in Brisbane at the Royal Brisbane which showed that he actually had been transferred down there with a perforated bowel and peritoneal soiling, so he actually had faecal matter in his peritoneum.

COMMISSIONER: Had that led to peritonitis or infection?-- Yes. That's what I was trying to highlight, for his chart to be reviewed because of that. I mean, that's quite - you know, that's fairly serious, that we should send somebody down to Brisbane with that - in that condition.

That sort of infection would normally be detected by haematology results, wouldn't it?-- Yes, haematology results, temperature, you know, the overall picture of the patient, whether their blood pressure was high or low, yep, all of those sort of things.

This wasn't an ICU patient?-- Yes, he was an ICU patient, yes. He was in ICU for about five days.

It is just - I wanted to be fair about these things. This comes across as a criticism of Dr Patel - and it may well be, in the sense that he is the one who ruptured the bowel and led to the infection - but isn't it also something that should have been picked up in ICU if he had an infection and was suffering peritonitis?-- That's right, and I think probably when we review the notes we probably would find out that that was questioned in ICU by the anaesthetists, but, once again, you know, if Dr Patel was refusing to take him back to theatre, there was often these sort of discussions and arguments that went on in the ICU about what the anaesthetists thought should happen compared to what Dr Patel would or wouldn't do.

Thanks, Mr Andrews.

MR ANDREWS: Ms Hoffman, do you suggest that there are occasions where a patient in ICU appeared to need further surgery but Dr Patel refused to have them back in his theatre?-- There were occasions when that happened.

And if it was the view in ICU that further surgery was needed but Dr Patel was refusing to perform it, what would be done with the patient?-- Well, the anaesthetist, depending on who it was, would argue the point, and I think probably he would have to go and take it up with his line manager which would have been Dr Keating. Because Dr Patel was the Director of Surgery, it was very difficult for anybody to actually argue a point with him because there was nobody really higher to go to, except Dr Keating.

COMMISSIONER: In a medical sense, leaving aside the administrative or managerial functions, I assume that Dr Keating, the only person he would report to would be the Chief Medical Officer in Queensland Health, Dr Fitzgerald. Are you aware of that?-- I am not aware of the relationships above Dr Keating but I think you are probably right.

Yes. Is there any scope for someone in your position to go over the head - in a medical sense; not go over people's heads in an administrative or bureaucratic sense, but to go over the head of medical staff at the hospital and report to people in Charlotte Street, for example?-- There is because this is - there is. And this is the difficulty that I had later on.

Yes?-- Because with Dr Patel I had obviously reported all of these things to so many people and I didn't know who else really to report it to, and that's - Mr Andrews has just - there is one patient that I refer to in paragraph 67 which was actually the pivotal patient, where we just decided that we could not let Dr Patel operate any longer, we had to actually do something really drastic, and that's when I called the union and the union gave us directions about who we could go to. And some of the people that we could go to were we could directly or they could directly go to the D-G, the CMC, or I

forget the - I think there was another person.

And this really arose out of patient P11?-- This arose out of patient-----

MR ANDREWS: P11.

WITNESS: P11, yes.

COMMISSIONER: You were coming to that.

MR ANDREWS: Yes, P11 is some months later in the-----

COMMISSIONER: Yes. I notice, Mr Andrews, if we're following the statement through chronologically, the next segment is on page 25 which deals with the new Director of Nursing. In that context I wonder if we have heard back from Mr Stella?

MR ANDREWS: Instructions have been obtained. Mr Bartley is interstate today. A Sellina Hunt from his office indicated that she would attend at 10 a.m., but you will have recalled there was an alarm that we heard and if she wasn't here before the alarm sounded, she will not be here-----

COMMISSIONER: Apparently she is here now.

MS HUNT: I am here now.

COMMISSIONER: Thank you, Ms Hunt. Perhaps it would be a convenient time - I know it is a little early, but if we take the morning break now, Ms Hunt can be brought up to speed on what's happening and inform you of her position. Would that suit you, Ms Hunt?

MS HUNT: Yes, thank you.

COMMISSIONER: Thank you for coming at such short notice. I appreciate that very much. Well, we might rise now for a 20 minute break and resume at 11 o'clock.

THE COMMISSION ADJOURNED AT 10.40 A.M.

THE COMMISSION RESUMED AT 11.03 A.M.

TONI ELLEN HOFFMAN, CONTINUING EXAMINATION-IN-CHIEF:

MR ALLEN: Excuse me, Commissioner, a small housekeeping matter.

COMMISSIONER: Yes, Mr Allen?

MR ALLEN: That is as to whether or not the non-publication orders that have been made in respect of particular patients' names is also meant to extend to the publication of the transcript which is on the Commission's website.

I raise that only because at page 69, lines 5 to 10, a surname appears which was as the result of an inadvertent mention which then resulted in a non-publication order by yourself.

COMMISSIONER: I am very pleased you have brought that to our attention. The Secretary isn't here just at the moment but you might make a note of that and ensure that the copy on the website is blacked out or the name is deleted.

MR ALLEN: Yes, thank you, Commissioner.

COMMISSIONER: I am very grateful you have raised that. I should say, for the benefit of everyone here, including the press, we have experienced some technical difficulties in getting things on line as quickly as we would like. In no sense should that be viewed as a deliberate attempt to hide information, it is just that obviously we're going through teething problems at this stage with the inquiry and we hope as things go on it will become more efficient.

Mr Andrews, how do we stand with the matter that was raised just before the break?

MR ANDREWS: Ms Mulligan has a legal representative in the Court who is listening to events on Ms Mulligan's behalf.

COMMISSIONER: And no application has been made at this stage for an order suppressing her name?

MR ANDREWS: That's correct.

COMMISSIONER: All right, we will continue from there. I should indicate that in those circumstances, given that Ms Mulligan is represented and that there is no application to suppress her name, that the earlier comment I made to the press and media no longer applies and they should feel free to report details as they think fit, bearing in mind, of course, that any evidence we hear about Ms Mulligan is evidence which she hasn't yet had an opportunity to respond to, and the press should, and the media should, of course, be careful to point

out the fact that we haven't yet heard Ms Mulligan's side of the story.

Is that adequate, Mr Andrews?

MR ANDREWS: Yes, thank you.

COMMISSIONER: Thank you.

MR ANDREWS: When Ms Mulligan became Director of Nursing, you told us that you initially briefed her while you were acting as Director. Thereafter, she convened meetings with staff, didn't she?-- Yes.

And at those meetings did you have the opportunity to raise with her your concerns about Dr Patel?-- Yes, I did.

And did you brief her fully? Paragraph 72, you advise us that you "touched upon various issues relating to Dr Patel, in particular the issues regarding ventilated patients being kept in the unit for longer than necessary."?-- That's right. I don't - I don't think I went into the detail that I would have later because some - when I first saw her, some of the things that happened later hadn't happened yet, if that makes sense.

It does. At about what date did you have this meeting with Ms Mulligan?-- There were lots of meetings that were made with her but several were cancelled and I think - did we put that in as a - yeah, TH14 there is a list of meetings that I had with her. As I said, they were often cancelled or rebooked, so some of these meetings I am not quite sure whether they went ahead or not.

I see. Well, at your initial meeting you touched upon some relevant issues?-- Yes.

In a limited time?-- Yes.

Now, by the 3rd of May 2004 you received from Ms Mulligan a template letter which she suggested to you and the other staff was to be used on any occasion when there was to be a complaint made about staff members?-- Yes.

And do you see a copy of that template on the monitor?-- Yes.

In that meeting, you had a meeting with Ms Mulligan in company with some other persons?-- It was a Level 3 meeting, so all of the nurse unit managers, and the A/DON, and Ms Mulligan were present at this meeting.

I have highlighted a section on the template in orange. Did you raise that section with Ms Mulligan?-- Yes, I did.

Why did you do so?-- Because I felt that this was not a fair document, that if someone has made a complaint about somebody, you may need to discuss this with somebody at work, and that I felt that it was denying someone a democratic right to discuss an issue with someone, and she made it clear to us that if we

should discuss anything that was relating to this letter, that we would be disciplined. And she gave an example of myself and Gail Aylmer, if we happened to discuss - say this letter was written to me and one of my staff members had complained about me, that if I discussed it with Gail Aylmer, then she would discipline myself.

But she did in the letter suggest that if you - if a complaint had been made about a staff member, that staff member was free to go to the Employee Assistance Service?-- Yes.

And what did you find unsatisfactory about that as opposed to going to some other staff member?-- Well, the employee assistance scheme usually is for something that's more serious, like if you needed debriefing or something like that, something that was fairly traumatic. Whereas this could be something that was very petty that hadn't even been investigated yet, and you may just want to run it by your friends or your family, or something to that nature. And I just felt very much - I felt very strongly about it, actually, that it was part of a way to try and divide and conquer the nurse unit managers at the hospital because we were fairly - a fairly close group. And some of the people - some people don't come from Bundaberg, don't have any family or friends other than the people that they work with in Bundaberg, so they would have been increasingly isolated. And prior to this being discussed at this meeting, that had actually happened to one of the nurses at the hospital, one of the Level 3 nurses, and she had been devastated by receiving a letter like this with an unsubstantiated allegation and was unable to speak to any of her colleagues about it and felt very isolated and very alone.

COMMISSIONER: And couldn't defend herself. That's the worst part, as I see it?-- Yeah.

You know, you get-----?-- It was really horrible, and I felt like - you know, I just felt very strongly that we're a democracy and we should be able to speak to who we want to outside of work. I can understand if she was saying to me, "Don't discuss anything professional about this at work", but outside of work, if I have got a particular friend or something, I just felt that it was my democratic right to be able to speak to whom I wished to. And I - I was quite vocal about that.

Let's take a concrete example so that we can understand this clearly. Let's say a complaint comes in that in ICU you fail to give a patient their medication at the due time. I would have thought that there are a variety of people you would want to talk to about that. It may be that you asked someone else to attend to giving the medication. It might be that the doctor had told you not to give the medication. It may be a situation where you were called away to something more urgent and you would need to explore all of those things with your colleagues?-- Mmm, yes. This was more or less not so much for clinical issues but, say, a nursing staff had complained that I didn't give them a good roster.

Yes?-- Or they were making a complaint like that. It was more to do with that type of thing, a managerial or other sort of issues.

All right?-- Rather than-----

Looking at the letter it says, "I have received a complaint concerning your alleged behaviour from a client." I assume "client" was bureaucratic speak for "patient"?-- Yes.

Rather than another member of the staff at the hospital?-- Except that when it was used for that it was used for another member of staff previously.

I see?-- Yeah.

So even as a pro forma, it was not internally consistent, it looks as if it is a document to be used for complaints from patients, but that's not how it was used?-- No, no. And I don't know but I certainly am not aware of any time that it was used after that time either because it is just not - it is just not a usable document.

All right. You were talking earlier about the Employee Assistance Service. Did that service have a representation in Bundaberg?-- Yes, there is - there is - they outsource it, and there is a group of psychologists, three psychologists that will provide support to the staff at the hospital should they need it, but when you need it you can't get it because they themselves are short-staffed. And we tried to - I tried to access the EAS after this particular incident, which I am sure we'll go in some detail later, and we couldn't get in to see anybody for two or three weeks.

Yes, thank you, Mr Andrews.

D COMMISSIONER VIDER: Mr Andrews, could I have a couple of questions? In this direction, this is written to Level 3 nurse unit managers-----?-- Yes.

-----to action this. This is what you have got to do as the manager?-- It is, yes, what I would be expected to use as a template as a manager, or if someone had made a complaint about me, Linda would hand that to me.

It says in here that, "Should you fail to follow this lawful direction, disciplinary action may be instigated."?-- Yes.

What would disciplinary action be?-- Well, it was my understanding that we would be suspended. That's my understanding.

Yeah?-- That we would be suspended. I don't know what else she could have done to us.

Prior to this direction being given to you, what was the process that you would have followed then normally, because,

as the Commissioner has clarified, I thought this was directed to complaints from patients, referred to you as "clients"?-- Mmm.

But you are saying it is really an internal staff to staff?-- That's what it had been used for, internal staff to staff. Prior to this happening, if there was a complaint, the Director of Nursing would call you up and ask you, you know, what had happened. And then perhaps if there was a written complaint, then you would answer that complaint. And then, if needed, you know, you would have some mediation or whatever - whatever you needed to do afterwards. I mean, it may progress to a grievance and you would use the HRM, human resource people as well to help come to some sort of conclusion. But I never had any - I have never had any instances like - you know, to deal with something like this.

Prior to this would it have been your experience that the example you gave, someone might have been unhappy with the roster, whatever, they developed, would they have just come to you and said, "I have got a difficulty with the way the roster is developed or the shifts I've been given", or whatever, and you would have attempted to hear one another out and reach resolution?-- Yes, that's right. And then if they felt that they didn't receive a resolution from me, then they could take it further, yeah.

Thank you?-- That's right, yeah.

D COMMISSIONER EDWARDS: Ms Hoffman, in the letter it also says about if you fail to - if I read it correctly - fail to follow the lawful direction, disciplinary action. Between this letter and the alleged lawful direction, what would happen? Would you be given, or the person who was being investigated be given an opportunity to respond to any allegations?-- Yeah, they would have been given a - the opportunity to respond, yes.

In person or in writing?-- Probably in writing.

COMMISSIONER: But, as you point out, it is not much point being given an opportunity to respond if you are muzzled from speaking to the people that can assist you to respond?-- Yeah. It was very disturbing, very upsetting incident to be given this at a Level 3 meeting.

D COMMISSIONER EDWARDS: Do you know if this has been extended through the whole health system or just Bundaberg?-- Oh, no, I don't think it has been through the whole health-----

COMMISSIONER: This was just Linda Mulligan's invention at Bundaberg?-- I believe so, yes, yeah. I have never seen a document like this ever before.

Yes, thank you, Mr Andrews.

MR ANDREWS: Ms Mulligan became your line manager as opposed to the Assistant Director of Nursing. Did she - so she was

the one to whom you would be obliged to report?-- Yes.

Any concerns?-- Yes.

Now, had there been a practice that when the Director of Nursing was on leave that the Assistant Director of Nursing at the hospital would fill in?-- Yes.

What was the practice that Ms Mulligan instigated for occasions when she went on leave?-- She - the first time I think she went on leave, she actually used someone else within the hospital. The nurse who was acting as - well, he was the zonal coordinator for Sexual Health, Patrick Martin, who had relieved in that position before.

I see?-- Then when she went on holiday just lately, they actually - we actually questioned that because part of the career structure is that Level 3s and Level 4s should be given the opportunity to act up into higher positions. That's part of the Queensland Health career structure and that wasn't happening at Bundaberg, and then this last time when she went on holiday, they actually - she said it was the district manager's decision who was going to be acting into the Director of Nursing spot and they arranged for an A/DON from Rockhampton to come down and relieve her.

How did that make you feel?-- Oh, it didn't bother me per se because nobody particularly liked working in - up there very much in the executive area, but it was - it didn't allow us to develop professionally in any way or form. So we felt that that was unfair and we felt that it should be opened up to everybody who had the qualifications.

D COMMISSIONER VIDER: From the organisation's point of view, in the preceding times when one of the Level 3s had acted up and relieved the Director of Nursing, had there been any incidents, events or any indicators that might have existed whilst somebody was acting in the Director of Nursing in her absence that could have perhaps been a reason why this change in direction happened and external people being called in for relief?-- Not to my knowledge. Ms Mulligan had stated that she did not have any faith in her Level 3 nurses and she did not believe that one of her Level 3 nurses could make a decent decision. And that's actually in someone else's statement so I won't go into that any further, but she basically told us that we - you know, we - she did not have any faith in us as Level 3s, that we-----

COMMISSIONER: How long had she been in the job before she reached this decision?-- I think that statement was made probably about six months into her time there.

Yes. How many level 3 nursing staff would there be at Bundaberg?-- Oh, probably about - maybe about 20. 20, 25 maybe, mmm.

And she decided all of them were incompetent in one hit?-- Mmm, mmm.

MR ANDREWS: Were there meetings regularly scheduled with Ms Mulligan and the level 3, 4, 5 and 6 people?-- Yes, on a monthly basis.

At those meetings, was Ms Mulligan accessible to you?-- She was the chairperson at the meeting and she would say - often if we brought things up she would say to us, "This is not the place to discuss it", and then when you would try and make an appointment to discuss it with her, you couldn't get an appointment to discuss it with her. So, basically, she cut off all sort of easy means of communication between us and her.

Well, wasn't that simply overcome by you saying, "No, this is an important matter. I wish to raise it"? Couldn't you do such a thing?-- Yes, I suppose we could have, mmm.

COMMISSIONER: Or possibly said to her, "Well, if this isn't the time to discuss it, when is the time to discuss it"?-- Mmm.

But I take it from your statement that you were actively discouraged from pursuing matters of interest?-- We were.

Are you able to recall any specific examples of things that were of concern to you or of concern to other nursing staff, that they were let know Ms Mulligan just wasn't interested in discussing?-- Staffing issues on the surgical ward. There weren't enough staff on the surgical ward. That was brought up at one meeting. Another meeting I brought up issues of - that it was - it was after that particular incident in ICU, that the ICU staff were extremely disturbed and upset and asked if we could perhaps get some agency staff for a short period of time. And I think - you'll - there's a lot of other people that have said a lot of other things but they'll - they'll tell you themself.

Yes, yes, certainly?-- Themselves.

MR ANDREWS: Now, Ms Mulligan had no free-set. Were you able to telephone her?-- You could telephone her but you would have to go through her secretary, who was an AO2, and she would ask you what was the matter. So you actually had to tell her something which could be extremely confidential within a hospital before - and then the secretary would go in to Ms Mulligan and ask Ms Mulligan if she would then speak to you or not. So that's how that was deemed whether that was important or not.

D COMMISSIONER VIDER: So if you said to the secretary, "What I want to speak to her about is confidential", that was not

accepted. You had to say what the matter was?-- You had to say what the matter was. Yes.

MR ANDREWS: You made a number of appointments during 2004 and early 2005 to speak with Ms Mulligan concerning Dr Patel. Would you have announced to Ms Mulligan's secretary on each occasion that it was about Dr Patel that you wished to speak?-- Not - not necessarily, no. I would have said, you know, something - I would have used some other excuse rather than just say Dr Patel, really. Because Dr Patel had also ingratiated himself with the secretaries in the executive. He would buy them presents and they thought he was wonderful. Every time he went away he would bring them back perfume and things like that. So they were - they were very fond of him.

I see. Was he a man capable of charm?-- Not for me.

COMMISSIONER: Ms Hoffman - I'm sorry, Mr Andrews I'm going to interrupt again - but just going through your statement, I really want to get a picture in my own mind of how the administration works. You've mentioned in your statement that Ms Mulligan had her office in the executive part of the hospital?-- Mmm-hmm.

And I assume it's the same in most regional hospitals: that's a glassed off area; the public has no access to it and medical staff, clinical staff have no regular access to it. Is that-----?-- Yeah, that's right. Yeah.

You really need an appointment to see someone behind the glass wall?-- Yeah, you do, yeah.

All right. And in my experience, which is fairly limited, a medical superintendent or a director of medicine or a director of surgery is someone actively doing the job. They're a doctor who is actively doing medical work. But one gets the impression from your statement that as Director of Nursing, Ms Mulligan really did no nursing at all?-- Oh, no, she didn't do any nursing at all. As I said, we probably only saw her around - in that first year, about - probably about four times in the intensive care unit, and that - that's why I think it's really so important for the executive to get out there because they would see what was going on. They would - you know, they would see that that patient was in that bed for so long and they would be thinking themselves, "Why is that patient in that bed for so long?"

Yes?-- It is an exposure for them as well as us being able to run things by them.

How did this contrast with other directors in nursing that you've worked with?-- They'd come around every second day and they'd say, "Why is that patient still here?", or, "What's wrong with that patient?" You know, you could tell them what was wrong with the patients and they took an active role in what was actually going on in the unit. And I'm sure in the wards as well.

You talk about making appointments or speaking with Ms Mulligan's secretary. Did she have a full-time secretary in her office, or perhaps shared a secretary with other staff?-- She had a secretary, yeah. I'm not quite sure how many hours, like, was for her and, you know, how many hours was for someone else but she did have a secretary. She was very regimented in her way of doing things. Like, the secretary actually had to have - if she had a document to sign, the secretary would sign all the documents. She would hand them to Ms Mulligan and she would sign the documents. That's the way that she sort of acted.

I'm just interested - it's not so relevant to the evidence you've given but some of the matters which have emerged in other areas of investigation by the Commission of Inquiry are situations where very senior surgeons, people like cardiac surgeons and so on, can't get any secretarial assistance. They have to sit down at a computer and type their own reports and correspondence because there's no-one made available to type for them?-- Yep.

Was that the situation at Bundaberg?-- They still have to do their work. They still act as surgeons, or whatever.

Yes, yes?-- So they not only have to do all that sort of thing; they have to do their work as well, act as - be surgeons as well. So there is a huge dichotomy of sort of the way things are done. But that - but the way Ms Mulligan did things isn't the way other people do things. Like-----

Yes?-- And it's not what I would regard as the modern way of management. To me, management should enable people to be the best they can whereas what I found Ms Mulligan did was disable us by constantly criticising us and that sort of thing, and it doesn't bode well in a hospital where your - you should be enabling people to do the best they can, to be the best they can for the patient's sake.

I will put it in my words rather than yours but would you agree that desk staff in a hospital, to use that general term, should be there to support people at the clinical interface rather than to oversee them?-- Yes, very much so. Actually, if you look at what the - the increase in Bundaberg Hospital's administrative staff compared to their clinical staff in the last few years, you just see an enormous increase in administrative staff and, you know, a decrease in clinical staff.

And as you've said, you're short of staff in ICU, short of staff in surgery, short of people looking after patients while the bureaucracy is increasing?-- Yes, that's right. And we only had two hours clinical - we only had two hours clerical support a day in ICU, so that's very little for all the things that we had to do. So the nurses pick up all of the other clerical duties when they should be doing other things, caring for the patients.

D COMMISSIONER VIDER: Your comments regarding your

expectation of Ms Mulligan's acting out the role as Director of Nursing, I think, would you agree that it's not necessary that she actually did a round every day or every second day; what you are looking for though is the support from the person above you to be accessible to you?-- Yes, yes.

So that you feel supported?-- Yes.

Now, whether that's by doing a round and making that sort of contact, whether it's just coming to the unit, whatever?-- Yes.

But if you want to contact that person and say, "I need to see you", "I'm available to you"?-- Yes.

And that's regardless of what it is?-- Yep.

Or else I say, "I'm doing something right now but I'll see you at 2 o'clock, 1 o'clock", or whatever?-- Yes.

But certainly a lot shorter time than a fortnight?-- Yes, that's-----

So that what you're really looking for is to be enabled to do your job?-- Yeah.

And where it's required by you, that you've got appropriate support?-- Yes. That's right. To feel comfortable enough that, you know, if you ring up that-----

Yes?-- You know, that she will listen to you because otherwise, if it wasn't important enough, you wouldn't be ringing.

Yes?-- But that's right, that's exactly right. Because after the - that review, when the Director of Nursing was coming around every second day, we didn't need to see her every second day.

No?-- But she continued to do it to her credit but we were still - we were comfortable enough and we built up a good enough rapport that you felt comfortable ringing her up and saying, "Glennis, can I just run this by you?", you know, "Is this right?", or, "Is this wrong?", that sort of thing. But we were acting in isolation for that length of time. When this - when these very serious events were going on as well.

And had you had the previous experience, therefore, whereby it was a two-way process, so at times your opinion was sought?-- Yes.

That might have been to do with something clinical?-- Yes.

And certainly something coming out of the management of the intensive care unit. But in terms of your own career advancement, that approach then enhanced your own feeling of worth and competence in your ability to make decisions?-- Yes, that's right. One of the other things, we were - every year

we used to fill in a form about what positions we wanted to act up into the next year.

Yes?-- We had a choice of things, you know, like the Ed Centre the Education Centre, or going to relieve in Mount Perry or Childers or Gin Gin or somewhere, and she stopped - she stopped that and she wanted us to submit a CV and a letter, covering letter, saying why we should - why we wanted to act up into those positions and why we should. And so, it was almost like you had to be applying for a job and addressing key selection criteria just to act up into a position, which a lot of people - it's just too much, you know, for a lot of people to do. And also, to submit a CV for every single acting up position was quite ludicrous because she should really have known what our qualifications-----

The CV would have been on file?-- Yeah, what our qualifications were.

COMMISSIONER: If she occasionally left her desk and walked into the wards, she would have known who was good at doing what anyway?-- Yes, that's right. And she would have seen the types of patients that were there as well. And that's one of my biggest concerns, was that she'd - anybody else would have - because they would have walked around and think, you know, "Why is that patient there? That patient was only booked in for a lap-chole, why is he in ICU? Why is he on a ventilator? Why is he going into theatre all the time? Why are all these things happening?" If you walk around the hospital, you see that, and neither Darren Keating or Peter Leck did any sort of frequent walking round the hospital.

Since you have mentioned Peter Leck in this context, was it the same of him? Did you need to make an appointment to see him or could you contact him when you chose to?-- He - you could contact him but you also had to go through a secretary and because he wasn't my line manager, anything that I had to take - to do with him, I really should have gone through my line manager to speak with him.

To what extent was he presence seen around the wards and the hospital generally?-- Not a lot but more than Linda Mulligan's was.

D COMMISSIONER VIDER: I've just got a curiosity about one other working relationship. Whilst your stories were coming out of the intensive care unit, what was happening in the operating theatre? Were you and your counterpart in the operating theatre discussing issues? You may wish to not answer that but I've got a curiosity?-- We were discussing issues, we had been all along, and I had been discussing them with the Nurse Unit Manager in the surgical ward as well. And I can't answer you to why they didn't support me.

No. And you're certainly the one that's put the documentation forward?-- Mmm. They did - they did take some documentation to whoever - like, whoever it was at the time, but I - I'm sure you will hear from them so I'll let them tell their

story. But they certainly - when I did ask for support, when I - because later on Ms Mulligan kept saying it was a personality conflict between Dr Patel and myself and I did ask the Nurse Unit Manager of theatre to support me in my complaint and she didn't at that time. And I also asked the Nurse Unit Manager of the surgical ward if she had issues with Dr Patel and she said she had issues with Dr Patel but she was dealing with them in her own way. So when I went to make the large complaint, I did so virtually by myself.

COMMISSIONER: I guess there's a difference though between lack of support. I mean, people - people may agree with you but not have the courage to or not be prepared to take the sort of risks that you've taken to expose problems. But when you spoke with your equivalents in other parts of the hospital, in the surgery unit and so on, did anyone say, "No, you've got the wrong end of the stick. Patel's a brilliant surgeon. You're totally mistaken about your concerns"? Was there any active defence of Dr Patel or was it simply, "We don't want to be involved"?-- There was a lot of, "I don't want to be involved", and there were some people who did stick up for Dr Patel even right to the end, yeah, there were a couple, and a couple who refused to speak to me after I made the complaint.

D COMMISSIONER EDWARDS: Ms Hoffman, were surgical audits done regularly and continuously during your time in ICU?-- Only by Dr Patel. He audited himself.

And who did - to whom did his reports go, to Dr Keating or-----?-- I'm not sure.

So as far as you were aware, he was the only one who audited himself?-- Yeah, he was auditing himself. They had - they - him and his junior staff met every week, they had a surgical meeting, but it was him that was running it and he always had, you know, obviously an answer for everything. And that's not to say that the junior staff weren't bringing up issues. The junior staff were bringing up issues-----

Of surgical complications?-- Of surgical complications, and some of them were horrified. But their hands were tied in terms of Dr Patel was signing off their - you know, their training thing, so.

Mmm-hmm?-- And he was-----

And the death certificates as well?-- Yeah. And so they knew Dr Patel was responsible for their career and, like, it's a huge thing when you get to - when you're in fifth year or sixth or seventh year of medicine and this person's responsible for your career, and so they went along with what he said, they didn't make waves. And a lot of them were foreign doctors who had visa issues. When I went to Dr Behrens - I told you that story yesterday. When I went to Dr Behrens, he said he would support me and tell the truth but he said he was afraid he would get sent home to Namibia and Dr Patel would get to stay. And I also had to be very

careful. I had to ask if someone - if people were willing to support me but not be seen to be going round the hospital gathering support, having a witch hunt against Dr Patel.

D COMMISSIONER VIDER: Yes?-- So I had to be very careful about the way I said things. So when I went to the Nurse Unit Managers, my equivalents, and they said they wouldn't act - you know, wouldn't support me. Well, I really didn't have - I had to do it by myself because I couldn't go round trying to garner support. That's - you can't do that.

COMMISSIONER: Thank you, Mr Andrews.

MR ANDREWS: You told us yesterday about the occasion in late May, early June 2003 when you first became concerned about procedures performed by Dr Patel and you mentioned that you went to see Dr Keating accompanied by Glennis Goodman, then Director of Nursing. Was the support given to you by Glennis Goodman typical of the professional support given at that time by a Director of Nursing to a Nurse Unit Manager or was it something special?-- It was what you would expect but in saying that, I think it was special, because she was someone who believed in her staff and, you know, and enabled them and supported them. And if you had an issue, she would take the issue up straightaway and deal with it. So, I felt very much supported by her. And she was - I also felt that she respected me as well.

TH14 you referred to before as meetings that you had with the Director of Nursing. Are these meetings that you - did you have these meetings or were they appointments that you made?-- These - these - I tried to - when all this came up, tried to look at when I had had meetings with Linda and these were the meetings that were in Linda's calendar that I asked the secretary to supply for me because I wasn't sure which ones had been cancelled and which ones weren't. It was very common for meetings to be cancelled. So, these are the ones that I think are the most accurate.

Of the meetings you successfully had?-- I think - I believe so, I think so.

Now, on how many occasions that you spoke with Ms Mulligan would you have raised concerns relating to Dr Patel?-- I think I probably would have raised them on every occasion.

And what feedback did you get from Ms Mulligan, at least until, say, September of 2004?-- Ms Mulligan said to me that it was - she said to me, "Why aren't I getting any complaints from anyone else? Why is it only you who's complaining?", and she suggested that it was a personality conflict between myself and Dr Patel and she gave me a book to read on how to deal with difficult people and told me to go away and read it, and told me to go and seek EAS support, professional support, from a psychologist to learn how to deal with difficult people.

Now, on the 28th of March 2004 there was a complaint by

another person relating to Dr Patel.

COMMISSIONER: Is this in paragraph 85, Mr Andrews?

MR ANDREWS: Yes.

COMMISSIONER: Thank you.

MR ANDREWS: Thanks, Commissioner. TH15 is the document you refer to in paragraph 85?-- Mmm. It was - I must have been acting as the Assistant Director of Nursing again at that time and this was written by one of the REs in the intensive care unit and-----

Would you have been her line manager at the time?-- Yeah, yep.

Otherwise you'd not have seen this report?-- No, she gave it to me because of Dr Patel actually going down to the unit and trying to tell my staff that I didn't support them.

COMMISSIONER: Just remind me, you've mentioned this before, but what was Dr Behrens' area of speciality?-- He was the anaesthetist. He was the most supportive anaesthetist in the unit.

And you've told us you didn't have a specific intensivist so you dealt mainly with anaesthetists as the doctors running ICU?-- Yeah, yep. He was actually the best - he's the best one in the unit for dealing with intensive care patients. And that's just another example of Dr Patel, you know, trying - just trying to bully the staff, saying that he was going to approach the executive about staffing increasing and - in the Bundaberg ICU to accommodate post-op ventilated patients. And I remember the conversation, we had a meeting earlier that day I think or later that day, and Dr Patel didn't actually bring it up, Dr Carter brought it up, about getting extra staff in and, once again, I brought up the fact that we still were only around 75 per cent occupied most of time and, therefore, it didn't really - it didn't warrant extra staffing if we were working within our scope of practice. And that's what this nurse is trying to say, that as long as we worked within a scope of practice, which was we were fully staffed for a level 1 unit, you know, we were okay. We didn't need more staff. But, you know, Dr Patel wanted to keep his patients there for longer.

There's a reference to a Dr Anderson. I don't think we've heard his name before. Who was Dr Anderson?-- Dr Anderson is a surgeon in town.

A private surgeon?-- Yes, and he does do some work at the hospital and he had been - I think he actually had been on staff before I started there, or he left the staff just after I started there.

Now, that raises something I was going to ask you at a later stage. Dr Anderson, when he did surgery at the Bundaberg Base Hospital, was that as a VMO or was he dealing with private

patients?-- As a - both.

Both?-- Both.

Right. He did some sessions as a visiting medical officer?-- Yes, yep.

Was he the only surgical VMO or were there others-----?-- No, there are a couple of others. There's a Dr Kingston.

Yes?-- And some - a couple of orthopaedic surgeons. I think - I think - and a Dr De Lacey. There's a Dr De Lacey as well, who's a general surgeon. And I think - I think that's about it. And we had some locum surgeons in for some periods of time as well.

I'm just interested for the moment in private surgeons practising in or around Bundaberg who might have been available as visiting medical officers rather than having Dr Patel perform surgery. In your experience, were there any complaints about the quality of surgery performed by the local private doctors when they were seeing public patients?-- No, not - no. Not - not - there may have been one or two adverse - you know, adverse events or a complication or something like that but there was nothing unexpected. There was nothing, you know, consistent.

How was a decision made as to whether a particular patient would have surgery from Dr Patel rather than, for example, one of the private surgeons who was available as a visiting surgeon in the public hospital?-- That was - would have been made in pre-admission clinic. We also had another surgeon, Dr Gaffield, who was on staff.

Right?-- Yeah.

When you say the decision was made at pre-admission clinic, who actually made that decision? Was it Dr Patel deciding which patients he'd operate on and which would go to the private surgeons or was there someone else who made that sort of decision?-- Yeah, I actually don't know.

Okay. Are you able to say, and you may well not be able to say, what number of sessions each of these VMOs had at the hospital and whether there had been any increase or reduction in the number of sessions?-- It's my understanding that there was an increase when Dr Patel was trying to get through - trying to meet these elective surgery targets. So it's my understanding that the theatre, it was actually increased.

All right. You told us yesterday about Dr Patel's 100 per cent failure rate with the vascular catheters that were inserted and that arrangements were then made for those to be inserted at a private hospital; is that right?-- Yes, that's right.

Who was that done by at the private hospital, do you know?-- I think it was done by Dr Thiele, who is a really well-known

vascular surgeon.

Dr Field from Brisbane?-- He is from Brisbane, Brian Thiele, but he lives in Bundaberg and has working - you probably know him or Dr - Sir Llew would know him. He's a very, very good surgeon and he did a lot of work at the hospital and I think he actually was the Director of Medicine at one point at the hospital, medical director.

And, again, was he available to perform VMO surgery in the public hospital?-- He was for a period of time but then he stopped altogether.

Yes?-- And only did private work.

Do you know if that was his decision or whether he was closed out?-- I think I have heard that he was closed out and what I have heard is that his salary and Dr Anderson's salaries or remuneration were actually decreased to give Dr Patel more money, but I don't know if that's true or not. That is what I've heard.

How much experience did you personally have in dealing with visiting medical officers?-- Oh, just - you know, on a day-to-day basis depending on if they had a patient in the unit or not. We had a lot of Dr Thiele's patients because he did the abdominal aortic aneurism repairs or any vascular surgery, so they would come to ICU for a two-day stay post-operatively. So we had a bit - quite a bit to do with, like, Dr Thiele.

And contrasting that, you were telling us yesterday about the difficulty you had with Dr Patel not scheduling operations at a time that met the convenience of ICU, when, for example, you were already full with emergency patients and didn't have spare ventilators and so on, how does that compare with the way that a visiting medical officer or a private surgeon like Dr Thiele worked in with your staff at ICU?-- Well, they'd ask if you had a bed and if they didn't have a bed, then they would wait till you had a bed, or staff.

That's all you wanted Dr Patel to do?-- Yes.

You see, one of the things that I discussed with the other two Deputy Commissioners, there obviously is a shortage of appropriate specialists in Queensland, I don't think anyone is disputing that, and one figure we've seen is that there are 1200 foreign trained or overseas trained specialists in hospitals around the state and it just seems strange that Queensland Health isn't using up the available resource of private specialists who could work as visiting medical officers at hospitals like Bundaberg rather than putting off their salaries and paying them to Dr Patel?-- Mmm.

You don't have anything to add to that?-- No, I think you're correct in what you said. I mean, Bundaberg's regarded as an Area of Need, they say that they have a lot of trouble getting doctors there, but I think that they had trouble getting doctors there because of the way that they were treated by the executive rather than any other reason. It's, you know, it's certainly not Mount Isa or, you know, it's close to the coast and it's got, you know, a lot of redeeming features, but they, they would say all the time, you know, that they'd had such a hard time getting anybody there, but I think it was because of the way that they were treated, the young doctors were expected to, you know, work very long hours and under no supervision, and I hope that you speak to one of these doctors who actually arranged a petition before he left in, I think it was late 2002 about the way that the administration worked at the hospital.

Mr Andrews, we'll be following that up, won't we?

MR ANDREWS: Yes, Commissioner.

D COMMISSIONER EDWARDS: It would be fair to say there would be very few secrets relevant to the performance of medical practitioners and surgeons and other people in those areas. Obviously, if you made these reports as you did, and it seems as if many of them may be true or could be well and truly true, did other people raise with you, for example, the theatre sisters, other doctors, this man's competence or otherwise?-- Yes, Sir Llew, they did.

And were they reported on to the hospital administration, do you know?-- I don't - I don't know. I mean, I don't know about what was said in passing, you know. A lot of things in hospitals are said in passing. I mean, the anaesthetist was the one who labelled Dr Patel "Dr Death", I mean, that was our head anaesthetist who labelled him "Dr Death".

At a fairly early stage?-- A very early stage, and it was common knowledge even around the town that they also would call him Dr Ecoli and it was very well known about Dr Patel's abilities, the nursing staff in theatre would say - the nursing staff anywhere would say, you know, "If I have an accident on the weekend, you know, make sure you fly me out straight to Brisbane" you know, "Don't you let Dr Patel touch me.", like things like that, like, you're right, like, there were no secrets about Dr Patel's ability, but I don't know why executive thought one thing and other things were being said down on the floor, except they weren't being followed up with things like sentinel adverse event forms, incident forms and-----

Audit?-- -----proper audits and proper letters of complaint as well. I can't, I just can't answer that, and I wish I could because it would have made my job so much easier if I had had the support of the other people in this situation because, as I said, it was perpetuated for the longest time that it was a personality issue between him and myself.

COMMISSIONER: I'm starting to get the impression from your evidence, and I hope I'm not being unfair in suggesting this, that the glass wall that separated the hospital administration from the rest of the building was almost hermetically sealed?-- Mmm.

That no-one ever ventured out to hear what the gossip was on the hospital floor and to talk to the nurses and the doctors and even the patients to find out what problems there were?-- Mmm. And even when they did, like, I don't know if you can remember just after the - after Rob Messenger spoke in Parliament, how - I don't know if you saw the Bundaberg press, but the people that stood up for him were the people who were - knew very well what he was like, the GPs in town, one of the doctors at the hospital, Kees Nydam wrote this glowing editorial for the paper saying how wonderful Dr Patel was, and so after that - I'm just skipping ahead of myself here, but after that broke out in Parliament, there was never an attempt to try and find out whether any of this was true, the only attempt that was made was to further bully and intimidate us and to - and to threaten us with gaol and all sorts of other things and no attempt whatsoever to find out if any of this was true, and by this time they had letters from, not just me but I think from six other people in ICU at this point.

Anyway, we are jumping ahead a little?-- Yeah, we are.

And I know Mr Andrews is going to get cross with me for taking him out of his chronological order, so I'll let him get back to where he was at.

D COMMISSIONER VIDER: Well, Mr Andrews can get cross at me as well, to just ask a clarifying point: you mentioned the common impression was if I have a road accident, ship me out?-- Mmm.

Did Dr Patel work in the emergency department as well?-- Yes, he did.

As Director of Surgery, that was his right to go in there?-- Yes, if there was, like, if there was a trauma on or something like that, he would work down there, yep.

So that was another way that patients came under his care?-- Yes.

Thank you.

MR ANDREWS: Ms Hoffman, who was the doctor who organised the petition in 2002?-- It's Dr Hiro, H-I-R-O, and-----

Do you know where we'll find him?-- Yes, I do, yeah.

Perhaps you can tell me?-- The lawyers-----

Perhaps you can tell me afterwards?-- He's Japanese so I can't pronounce his last name.

COMMISSIONER: Mr Allen, perhaps you'll be able to assist us

with that?

MR ALLEN: We've communicated the name of the doctor and his current whereabouts to the Commission by way of letter, but if I could-----

COMMISSIONER: No-----

MR ALLEN: To Mr Morzone, counsel assisting.

COMMISSIONER: Yes, I assumed that it was given to one of the counsel assisting. I can see Mr Morzone's not present at the moment, but that's fine, so long as we've got those details.

MR ALLEN: Yes.

MR ANDREWS: And which anaesthetist coined the nickname for Dr Patel?-- Dr Carter.

Thank you. Perhaps you'll tell us about patient P11? And I see that P11 is discussed in a number of documents in your statement. Am I right in thinking that the annexure to TH20 contains the fullest description from your point of view of what you saw of the treatment of that patient?-- Yes. Yes, I believe so, we had to write several statements, that's why there's so many because I had to right one quickly for the sentinel event quickly and I had to write one for the Coroner, then I wrote another one when I had some more time, so that's why I had so many of them.

Am I right in thinking that this is one of the ones written when you had more time, this document annexed to your e-mail of the 17th of August?

COMMISSIONER: Mr Andrews, I think I'm right in understanding this: this is the gentlemam who was crushed under a caravan?

MR ANDREWS: Yes, Commissioner.

COMMISSIONER: I think his case has already been fairly wildly discussed in the media so I see no difficulty in using his real name on this occasion.

MR ANDREWS: In any event, I'll ask that the annexure to TH20 be put on the monitor; do you recognise that as the document that you wrote?-- Yes.

And Mr Bramich, he's a patient who came into the Bundaberg Hospital as a result of being crushed by a caravan?-- Yes, he did, yep.

He initially went into ICU but was transferred to the surgical ward the next day, that is, on the 26th of July?-- Yes.

Is that an indication that he was either - that he was stable or improving?-- He was quite stable at that point.

And were you rostered on as a member of ICU staff on the 27th

of July?-- Yes.

When he was returned at 1 p.m.?-- Yes. There's some conflicting time - some conflicting times about whether it was 1 o'clock or a bit later about what time he came back, but it was around, it was between one and two.

Now, Dr Carter at some stage said that if the patient's going to need blood products, he'll need to be flown out?-- Yes, that's right.

About when during the day did that happen? Soon after he came into ICU?-- Yeah, very soon after he came into ICU. He was - he came in, as you can see, in a very serious condition and there were quite a number of nurses and one - and basically just Dr Younis trying to stabilise the patient and Dr Carter walked in and heard them talking about that he needs platelets and said that, "If he needs blood products, he needs to go to Brisbane". That wasn't my overriding concern, my concern was that I knew how many fractured ribs the man had and I was worried that he would need - if he needed surgery, that he would need to be in a hospital that did thoracic surgery and that had access to cardiopulmonary by-pass. So he was actually not a patient of Dr Patel's, he was actually a patient of Dr Gaffield's and Dr Gaffield, we had arranged for a bed very quickly at the Princess Alexandra Hospital.

Now, does that mean sometime shortly after Mr Bramich came into ICU and shortly after Dr Carter's comment, a bed was obtained?-- Yes, yep.

And that's at the Prince Charles Hospital?-- Yes, no, it was at the PA Hospital.

Did a doctor from Prince Charles arrange it? I see that the statement says a doctor from Prince Charles called back?-- That's right, because they didn't have a bed at Prince Charles from my understanding, and so he was trying to find a bed for us and so he rang back to say that there was one at the PA and the issue then was that the surgeon at the PA wanted the surgeon at Bundaberg to speak with him, that was - that's how these things are done, the surgeons need to give a handover to the surgeon so that they know what was going on.

And you took the phone call?-- I took that phone call at that time because all the doctors were busy and there was nobody to speak with the coordinator.

And your recollection of the time of 2.30?-- That's my recollection of the time. I thought it was quite early in the piece but that's contraindicated - contradicted by another doctor later on.

Right. So you passed on the message to three doctors - four doctors?-- Yep.

And it seems, was there to be a short delay while a CT was done?-- Yeah, it was about that time that Dr Patel walked in

and he started saying that, "The patient didn't need to go to Brisbane, he wasn't sick enough. If we couldn't care for such simple things as fractured ribs, there was no point in doing any sort of trauma surgery at the hospital.", and basically he then started to override what Dr Gaffield was saying, and I think sort of pretty much took over the care of the patient from then on. They did want the patient to have a CT scan before he was transferred just to see how, how he - what was going on in his chest and I - and so they delayed the, they delayed the transfer, they delayed the transfer with the RFDS.

Was it while the CT scan was being arranged that Dr Patel interfered?-- It was before that.

Yes. And you're quite certain that Dr Patel's criticism was that this was an insignificant matter that didn't need to be transferred as opposed to a patient who was likely to die anyway?-- Very much so. He kept - he just kept reiterating that fact, that this man - he went into - he even went into the family and he said to the family initially, you know, "He doesn't need to be transferred, I've been a cardiothoracic surgeon for 15 years - 20 years" - something - "and if he needs anything, I can do it here."

That's something you've read in another person's statement, is it or did you hear that?-- No, I was present the whole time through all of this, so I heard most of what was going on.

D COMMISSIONER VIDER: Mr Andrews, could I just ask Ms Hoffman just the sequencing of this? This gentleman was admitted to ICU on the 25th of July; he was admitted to ICU?-- Yes, that's right.

Stayed for 24 hours?-- Yes.

He went to the surgical ward?-- And then went to the surgical ward and then came back.

And it was this patient the surgical ward notified you about his condition was deteriorating?-- Yes.

What was happening to Mr Bramich that made his condition deteriorate?-- He was becoming dyspnoeic - he was short of breath sorry, he was sweating, he was diaphoretic, he was sweating, his blood pressure was fluctuating, he was in extreme pain, he was going in and out of consciousness.

Did he have intercostal drainage in?-- He did have some intercostal catheters in at that time. When he came into the ward, he was obviously extremely ill and I remember going - when after Dr Patel started to interfere, as soon as I heard his voice, I thought he's going to stop this - try and stop this transfer. I went up to Dr Gaffield and I said, "Please Dr Gaffield, send this man through to Brisbane, even if you think he doesn't need a cardiothoracic surgeon, I'm really afraid that he's going to die.", and he just said to me, "No, that won't happen.", and-----

COMMISSIONER: "No, that won't happen, he won't die" or, "No, that won't happen, he won't be sent to Brisbane"?-- No, that won't happen, he won't die, and at that time Dr Younis was pretty much trying to resuscitate the patient, he ended up ventilating him and he was trying really hard by himself with the nursing staff and one of the other junior doctors to stabilise this man and he had a short period of cardiac arrest at that time from which he was resuscitated and the events went on and then Dr Patel disappeared for a while and he went back into theatre and he actually went back into theatre to do a colonoscopy. Time was getting on by then and he did the colonoscopy and perforated the person's bowel in theatre.

D COMMISSIONER VIDER: With the colonoscopy?-- With the colonoscopy, so we needed two anaesthetists, one outside to go with the man down to CT scan and another anaesthetist to go with - to repair the perforated bowel in theatre, and it was getting around to the time when the doctors were going home, and - but I was desperate to get this man out to Brisbane and-----

This man was ventilated?-- He was ventilated by this time so he needed a anaesthetist to go down to the CT scan.

Yes?-- And I couldn't get one so I asked Dr Carter, who was going to give a talk that evening, would he stay behind and take Mr Bramich down for the CT scan, which he did, and Dr - and then another doctor was in giving the anaesthetic for Dr Patel's perforated bowel. Then by that time, Mr Bramich was - continued to deteriorate and he came back to the ICU, they saw that he had about 3,000 mls of blood in his chest and Dr Gaffield said, "Yes, he does need to go to Brisbane.", so they reactivated the RFDS.

So Dr Patel had actually ceased the retrieval orders?-- He'd stopped the retrieval orders, so they reactivated that and then Dr Patel came back in and then in the course of probably the next hour, Dr Patel changed his mind from the patient not being ill enough to go to Brisbane and he could have done anything that was needed to be done, to being too ill to go to Brisbane and he was going to die anyhow. So but anyhow, in the meantime the RFDS kept coming, so the RFDS did arrive with a doctor from Royal Brisbane - I think it was Royal Brisbane or it must have been the PA or - yeah, emergency room so they came with a, you know, with a well qualified doctor, and they - I think they got there, I can't remember the exact time that they got there. They tried - they tried desperately to resuscitate him and then he bled, just bled out and died just after midnight. Certain things happened during that time. Once I - I was due to go off at 4.30 but I stayed until around 7.30 to make sure that he was being transferred out. And then once I thought that he was on his way, I had left the hospital and I fully expected him to have been retrieved and to have been okay at that point, and when I came to work the next morning, I met Martin Carter, the Director of Anaesthetics, in the - outside the lift and I said, "Oh, did Mr Bramich get off all right?", and he said, "No, he died.", and I just said - I just said to him at that time that, "We have to do something

about this, we cannot let this happen any longer, we cannot let this happen again because too many incidents of this had happened.", and he made a some sort of non-committal response to me and I went up to my office and one of the other doctors came in and asked me what was the matter with me, what was wrong with me and I told him and he said to me, "Okay, I'll go away and talk to some of his colleagues about Dr Patel" and he came back on the Friday and said, "There's widespread concern but nobody is willing to stick their neck out yet to do anything about Dr Patel to try and stop Dr Patel from operating." So about this time there were - all the nursing staff were just desperate to do anything to stop him from operating anymore.

This is the nursing staff in Intensive Care?-- In ICU, yes.

Were they united?-- They were united. Some people wouldn't put in a written complaint.

No, no?-- But they were united, the people who didn't put in a written complaint supported those who did.

Yes?-- And we were just - we just didn't know who to go to to get us to - to get someone to listen to us and the nurse - one of the primary nurses who was looking after him, I had gone home by this home, describes Dr Patel's using a stabbing motion - Dr Patel decided he was going to do a pericardiocentesis, which is to try to get some fluid out from around the heart, he'd done an ultrasound first and there was no fluid around the heart, there was no indication to do this but he decided he was going to do it anyhow, and the nurse who was caring for the patient described that Dr Patel used a stabbing motion into the man's heart around 50 times with a hard needle, not the normal type of thing that you use for pericardiocentesis and she was so disturbed about this - we all were obviously, we - all of us were so disturbed about this man's care that we all wrote letters, and we called the union, we called our union because we didn't know what to do and the union started to give us advice about what we could do and also how to formulate our statements and they also read our statements, they had their legal people read our statements before we handed them in. I was contacted by Dr Jane Truscott, who's a nurse with a PhD at the hospital who was acting in the quality control as a quality control coordinator and we wrote a sentinel event form and she took it up and gave it to Dr Keating and she - and I think she gave a copy of it to Linda Mulligan, I'm not sure, but they took it upon themselves to downgrade it from a sentinel event - a sentinel event form should go straight to the central manager and not by the hospital, by-pass the people at the hospital, but Darren Keating took it upon himself to downgrade it to a whatever the next level was, it's a severe occurrence or whatever the next level was, and so we wrote all these letters and we contacted the union and the union told us what to do and where to go to from there. I tried to make contact with Linda Mulligan and I couldn't - I was told I couldn't see her for two weeks. I called the Coroner myself and talked to him and he said to me, "That explains some of the things that's

been happening - that I think has been happening at the hospital, but I have no proof" or something like that, and I even called the police that night from my home because I was so concerned about what was going on, and I had a couple - I think maybe two conversations with this - an inspector and then he had to go to Brisbane for something to do with the Carolyn Stuttle murder and I - and we, you know, we didn't continue on the conversation, and that's when it was - once all the reports were in, took a while for everybody to write their reports and get them all checked by the union and that and the union came up and saw us and it was still the issue between Dr Patel, the issue with Dr Patel was still being perpetuated as being a personality thing between myself and him and Kim Barry, one of the professional officers from the QNU came to me and was talking to me and went up and saw Linda Mulligan and Linda Mulligan just said, you know, it's - I'm still only getting, you know, complaints from Toni Hoffman, but anyhow, in the meantime, these other complaints came up from the staff but still nobody came near the staff, nobody came down to talk to the staff and Linda happened to be in the - come down at one point and I asked - I sort of like cornered her, I got her into the office and I asked her would she talk to the staff because most of the - a few of the staff who were on duty with this incident were on that day and so they went in there and talked to her at some length about the incident, and but we still didn't receive any feedback or anything about that. So Dr Patel was - still continued to have patients come in with different complications and that and that's when the union people said to me, "You know Toni, you have to do something about this in writing with Peter Leck." So that's when I wrote that letter dated the 22nd of October, I think, and gave it - I talked to Linda first and tried to make her understand the significance of what - of what was going on and then she called me up to go and see Peter Leck and I did and he took sort of copious notes about that and then we waited and we waited and we still were having patients come in with complications and then I think it was in the February, we waited all that time before we find out that Dr Fitzgerald was going to come up and do a - it wasn't even an investigation, it was called a fact-finding mission to look into Dr Patel's activities.

COMMISSIONER: So that's seven months later?-- Seven months after the event.

Yes. A couple of things, I'd just like to clarify: you mentioned Dr Patel doing a colonoscopy while that was all happening?-- Yes.

Was that just a routine colonoscopy or was there some urgency or-----?-- No, it was routine.

All right. You mentioned that he pierced the bowel, I think, in the course of that colonoscopy?-- Yeah.

In your experience, is that a frequent consequence of a colonoscopy?-- It is a well known complication of a colonoscopy but it's not - it was very frequent with Dr Patel

but not so often with anybody else.

Mmm. In the circumstances, where Dr Patel had chosen to, as it were, take over responsibility for another doctor's patient, was there anything urgent that you know of about the colonoscopy that would have given that priority rather than the patient in ICU?-- Only when he'd - only at that point he was still saying the patient wasn't sick enough to go to Brisbane.

I see?-- And he wasn't that sick, he came in and said, "A perforated bowel takes precedence over a CT scan at all times."

Yes?-- So even, he was using, he wasn't - use those particular patients' conditions, he was just using something which was right, you know, a perforated bowel would take preference over a elective CT scan, but not an emergency CT scan of someone who was extremely ill.

Now, you've mentioned a few names that we haven't come across before. We have heard previously of Dr Younis who was one of the doctors in anaesthetics, wasn't he?-- Yes.

And he worked under Dr Carter?-- Yes.

The Head of Anaesthetics?-- Yeah.

All right. Dr Boyd?-- He was the - Dr Patel's, like, Registrar, PHO.

Yes?-- Yes.

Dr Gaffield?-- Dr Gaffield is the other attending surgeon at the hospital, the other consultant at the hospital.

He's on staff, isn't he?-- He's on staff, yes.

Right. Dr Warmington?-- He was the ICU junior resident who was on for that day.

Right, okay.

D COMMISSIONER EDWARDS: In your statements, and so forth, there are an enormous number of incidents relative to Dr Patel's performance. Were doctors in the hospital or visiting doctors to the hospital, did they ever mention to you their concern of his competence?-- Dr Miach did, Dr Keil, who is the Director Of Emergency Medicine, he did. Dr Behrens did.

Do you know if they at any time made any complaints to the medical superintendent or any other authority about this man's competence, and would it be fair to say that if somebody was not performing to accepted standards that the processes would be there for such complaints to be made?-- I believe that several of the doctors did make complaints about Dr Patel's ability. I understand that Dr Behrens did and some of the other - specially some of the junior doctors, as they were leaving the country, but I don't have any - you know, any information on that.

D COMMISSIONER VIDER: Just further to that, talking about the scope of practice, you said that Dr Patel said in the intensive care unit in relationship to Mr Bramich that he was a cardiothoracic surgeon?-- Yes.

We have heard he'd tell you he was a general surgeon?-- Yeah.

Did he have no boundaries to his specialisation?-- No, he had a different qualification every day.

Oh, good.

COMMISSIONER: It has been a fairly long and arduous morning for Ms Hoffman, I wonder whether you would prefer to have a break now for an hour or so and come back at, say, quarter to two?-- Yeah.

An hour and a quarter, would that suit everyone?

MR ANDREWS: That's convenient for me.

MR FARR: Yes, thank you.

COMMISSIONER: We will adjourn now.

THE COMMISSION ADJOURNED AT 12.35 P.M. TILL 1.45 P.M.

THE COMMISSION RESUMED AT 1.48 P.M.

COMMISSIONER: Mr Andrews?

MR ANDREWS: Could Ms Hoffman be recalled?

COMMISSIONER: Mr Andrews, while Ms Hoffman is coming, are you able to give us any indication, just for scheduling purposes, of how you think we are going with her evidence? Will we finish-----

MR ANDREWS: I expect her evidence-in-chief will be completed today.

COMMISSIONER: Yes.

MR ANDREWS: Yes.

COMMISSIONER: Thank you, that's-----

MR ANDREWS: It may be that Mr Allen will ask, as her counsel, questions of her. I have not really discussed that with him.

COMMISSIONER: Mr Allen, I think you have probably seen in the practice direction that, as the counsel representing this witness, you are entitled to ask any additional questions by way of evidence-in-chief. We have assured the Crime and Misconduct Commission we won't allow any cross-examination until their inquiry is finished, but if you have any additional matters Mr Andrews hasn't covered, you will, of course, have the opportunity to do so. Do you anticipate at this stage there will be much?

MR ALLEN: I anticipate there will be a few questions but it will not take long.

COMMISSIONER: So, one of the logistical things that has to be arranged is Ms Hoffman's flight back to Bundaberg. You don't think you will be holding us up beyond this afternoon?

MR ALLEN: Well, if the evidence-in-chief finishes this afternoon, I won't be adding much to it.

COMMISSIONER: Thank you very much for that indication. I won't hold you to it if things develop differently.

Yes, Mr Andrews?

TONI ELLEN HOFFMAN, CONTINUING EXAMINATION-IN-CHIEF:

MR ANDREWS: You mentioned sentinel events. Are they rare and extremely significant incidents in a hospital?-- Yes.

Such as, for example, if one took off the wrong leg, would that be a sentinel event?-- Yes. There is actually a Queensland Health definition now of what a sentinel event is, but it would be like that sort of thing, yeah.

COMMISSIONER: Was there a definition at the time?-- It was still in production.

Right?-- Yeah.

You told us, I think, that you wrote up an incident form as a sentinel event and someone chose to downgrade that?-- Yes.

Who would have authority to downgrade?-- Darren Keating downgraded it, apparently.

To your understanding was Dr Keating acting within the scope of his authority in, as it were, overruling your view that it was a sentinel event? Was that something he was entitled to do, as you saw it?-- I don't - I am not sure. I don't really think so. I think - I don't think - I think once - if it is written and it is correct, then it should stay as a sentinel event. I don't think he has that-----

Were you consulted before it was downgraded?-- No, I didn't know about it.

I would have thought that as the person taking responsibility for that report, it wasn't up to someone, to use what might be an appropriate term, to doctor your report?-- Yes. I didn't know about it.

Sorry, Mr Andrews.

MR ANDREWS: Sentinel events would normally, I think you said, go to regional-----?-- They go to the zonal office.

Zonal?-- And they actually bypass any internal investigation at the hospital because they are so serious.

Was the procedure for you to forward the sentinel event form to the zonal office?-- No.

And what were the indicia of this event that to your mind made it a sentinel event?-- The fact that the patient died whilst awaiting transfer or whilst nearly in the process of transfer.

But surely that must happen from time to time with seriously ill patients who need an intensive care unit in a tertiary hospital?-- It does happen very occasionally.

Does that make each of those a sentinel event?-- Probably should be, yes.

Now, after the death of Mr Bramich, Dr Carter wrote a note, didn't he, which has become an exhibit in your statement, exhibit 19?-- Yes.

I will put - I will have exhibit 19 placed on the monitor.

COMMISSIONER: While that's coming up, can you tell us on the third page of that exhibit, third page of TH19, there is some handwriting on the bottom of the page. Is that - do you know who made that handwriting?-- That's my writing.

All right. Can you interpret it for us? I know this is sort of a multigenerational photocopy, so it may not be clear enough?-- I have just written myself some notes - I do have the originals so I can get this for you.

Don't worry about it for the moment, anyway?-- Yeah.

MR ANDREWS: Now, did Dr Carter give you that note as a result of conversations you had with him following the death of Mr Bramich?-- I believe this report was written in response to a request from Dr Keating.

How-----?-- And Dr Carter gave me a copy of it.

I see. Now, on the bottom of that page the history - part of the history begins, "He was admitted to intensive care unit for overnight observation."?-- Yes.

"And on the following day, the 26th of July, he was sufficiently awake and comfortable to be discharged to the surgical ward." Now, further down on, I think, perhaps, that page, in the green section, Dr Carter writes that, "The Director of Anaesthetics was called to review on further management of the patient and his decision was to arrange for the patient to be transferred." Now, who do you understand the Director of Anaesthetics at the time to be?-- Dr Carter.

I see. Now, were you present when the abdominothoracic CT was performed or when its results were discussed?-- I was in the unit whilst the patient went down for the CT Scan, so I stayed in the unit while he went down for the CT Scan, and, yes, I was present when they came back and discussed the results.

And there is a note that there was "no evidence of pericardial fluid". Is that fluid around the heart?-- Yes.

Yet at the bottom of the page the note is that, "The Director of Surgery reviewed the patient" - is the Director of Surgery Dr Patel?-- Yes.

"And decided to do an ultrasound-guided pericardiocentesis despite the evidence of the CT"?-- Yes.

Is a pericardiocentesis an invasive procedure using a needle

to look for fluid?-- Yes.

According to the CT, there would have been no reason to do this procedure?-- That's right.

And is that the procedure that you graphically repeated another staff member's description of as the stabbing procedure to the heart area?-- Yes.

COMMISSIONER: And the outcome, as indicated in this report, was two or three mils of blood, which would be quite negligible-----?-- Yes.

-----in the context?-- Yes.

D COMMISSIONER VIDER: Did this patient have multiple stab wounds, injection sites around the area of-----?-- Yes.

-----the thorax?-- Yes.

So that would have been obvious?-- Yes.

Thank you.

MR ANDREWS: You have said the wrong needle was used. Did you see which needle was used?-- I didn't see the needle that was used. It - I just know that he used a different type of needle than the other doctors use when they do this procedure.

COMMISSIONER: Was that a larger needle?-- Yes, yeah.

MR ANDREWS: Now, areas of concern are noted. The first of them "the delay in the arrival of the retrieval team". Now, you comment upon these areas of concern at paragraph 94. Are you able to tell us what Dr Carter was trying to convey about that first area of concern? Was it a criticism of the retrieval team?-- No, I actually think Dr Carter's confused here because I - I - when I - I had already - I had left at 7.30 and I knew the retrieval team was already on the way, so I think he's got it muddled up there.

All right. The second area of concern, "lack of coordination of care. Two surgical teams involved", what were the two surgical teams?-- Dr Gaffield team, because that was his patient, and then Dr Patel becoming involved.

And "the pericardiocentesis being performed without any indication", I think you have explained it, and "the lack of radiology support, CTs not reported until 30 August '04"?-- That's just a comment about that. We don't have 24 hour radiology and we have to wait for reports to come back. So the doctors would have to read the ultrasounds and that themselves without the benefit of a specialist radiologist.

Thank you.

COMMISSIONER: But in this case Dr Patel did have the results of the CTs, he just didn't have a radiologist to interpret

them for him?-- Yeah, he could see it - it is like a portable ultrasound that you use and he could see it on that.

Just going back to Dr Carter's item 3, or item 3 of his areas of concern, I don't mean this as criticism of Dr Carter, but where it says "performed without any indication", it is really worse than that, isn't it; it is performed despite contraindication?-- Yes.

He wasn't simply doing an experiment which he had no reason to do, he was actually doing an experiment which he had good reason not to do?-- Yes.

Yes.

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

In relationship to area of concern number 2, "lack of coordination of care, two surgical teams involved", in that situation do you have a process system whereby you know who is the senior of the two surgical teams involved? So that, in other words, do you have virtually a principal admitting officer that the patient is directed - who is directly responsible for the patient's care, and anybody else who subsequently comes in might be a consultant unless the care is actually handed over-----?-- Mmm.

-----to that person?-- Well, it should, to my knowledge, be Dr Gaffield's patient because that's who he came in under, but at one point, because it was time for them to go home, Dr Gaffield actually left the hospital because he wasn't on call that night, so Dr Patel continued his care.

COMMISSIONER: Dr Patel took over before Dr Gaffield had left?-- He did take over before he left. That's what he - that is what he normally - not normally, he did that often, he would come in and take over someone else's care of a patient, interfere.

Presumably Dr Gaffield wouldn't have left if the patient was still under his care without arranging for someone else to stand in?-- Well, no, he shouldn't have left, no, without arranging for someone. So he was, I think, quite happy for. Dr Patel to continue with the care.

D COMMISSIONER VIDER: Was Dr Gaffield aware that Dr Patel was going to do that procedure on the pericardia?-- I don't think so, no.

Was this a problem that you had often?-- Which part?

The two surgical teams and not having someone then that was giving principal orders to you? I think you mentioned yesterday that you had situations where you were getting conflicting instructions?-- Yeah, it wasn't usually two surgeons, it was usually two different disciplines, like usually surgery and medicine or surgery and anaesthesia. It was unusual that it was two surgical teams.

Right.

COMMISSIONER: Just to interrupt the flow of things a little, I was wondering whether, trying to be very cooperative with the media, but with the still photographers could we limit it to, say, the first 15 minutes in each session, or something like that? It does get a bit distracting having the clicking going on. If, for example, a new witness starts and you want to come in, that's fine, but I think we should try and limit it to some extent, if that's all right. Thanks.

MR ANDREWS: You have told us you made contact with the police. You also spoke to the head of the Royal Flying Doctor Service, Dr Costello, about your concerns. Because of the effect of the incident on a number of members of staff, you attempted to contact the Employment Assistance Service of the hospital to debrief them. You had no success in trying to contact that group?-- No, I had - I had no success and consequently one of the staff members accessed a private psychologist.

Now, you talk about the effect of the P11 incident, that is Mr Bramich's incident, on the staff. Were they visibly distressed?-- Yes.

And did that distress continue after the evening of Mr Bramich's death?-- Yes, yes.

You sent a statement to Ms Mulligan on the 26th of August. Is that the first report that you made to Ms Mulligan, the Director of Nursing?-- Sorry-----

You would find it - it is exhibit 21, a document which is an email attaching another document that you have reviewed for us this morning?-- Yes. I think she was aware of this because of the sentinel event form. She would have been given a copy of the sentinel event form. She certainly didn't make any contact with me about the patient, about Mr Bramich, and so I was just informing her of the situation, and about another situation that was occurring as well.

COMMISSIONER: Just dealing with that other situation, what is a thoracotomy?-- A thoracotomy is when they put an opening into the chest to gain access to the thoracic cavity in the chest for some reason.

Right?-- My concern was that Dr Patel was booking these large-scale surgeries for late in the week, and this one particularly was booked for a Friday. A thoracotomy doesn't necessarily have to be a particularly big thing, like, they do do them in the Emergency Department in emergency, but my concern was that it shouldn't have been done on a Friday, it should have been done on a Monday when all the staff were there and radiology were there, pathology were there and all that sort of thing. But this was becoming a pattern for. Dr Patel, and so that was me trying to bring that concern to her.

Yes?-- And.

Dr Patel you note had assured you that the patient would not need ventilation. Do you recall how that turned out in fact?-- How it turned out in fact was that I got - I received an email back from Ms Mulligan.

MR ANDREWS: Would that be TH22?-- 22. And both her and Dr Keating tell me that "the case is not a thoracotomy, the case is a wedge resection, and the plan is for the patient to return to the surgical ward. Therefore advise suitable for this case to proceed", and then she goes on to talk about conflicting information, and communication issues that I have with other people.

COMMISSIONER: Was Dr Patel still not speaking to you at this time?-- No. And but what Linda - what Ms Mulligan and Dr Keating - I don't know if they didn't realise, or what was going on, but you can't do a wedge resection of a lung without doing a thoracotomy. You have to be able to open the chest to get there. So what they're telling me is just a complete insult to my intelligence, and TH23 is the booking list.

MR ANDREWS: Perhaps before you get to that, can you concentrate - it is just that TH22 is on the monitor?-- Sorry.

It will be very convenient if you complete it before you go on to the next exhibits. Ms Mulligan's response to your sending her a lengthy report about Mr Bramich is dealt with in the first sentence, isn't it?-- Yes.

Now, her response to your concern that a thoracotomy was booked is dealt with in the balance of the email?-- Yes.

And she appears to be attempting to correct your misapprehension?-- Yes.

Now, it is the case that should any nurse appreciate that if there is to be a wedge resection it involves a thoracotomy, or does it take a deal of expertise?-- No, any nurse should be able to realise that.

COMMISSIONER: Really, Mr Andrews, the second last sentence in that should go into a book of bureaucratic doublespeak. This highlights to me the issues/strategies with communication that you and I have discussed previously are not resolving and further action needs to occur. What on earth does that mean, that people aren't talking to one another?

MR ANDREWS: My head is spinning just listening to it.

COMMISSIONER: Yes.

D COMMISSIONER VIDER: Did Dr Patel speak to you ever before he left the hospital?-- No. No. He used to speak about me but he didn't speak to me.

That issue is still unresolved?-- Yes. Though 60 Minutes did want to fly me over there, so maybe it will be resolved one day. No, it is-----

COMMISSIONER: It does say "further action needs to occur".

MR ANDREWS: Ms Hoffman, I am going to have you look at exhibits TH23, 24 and 25 on the monitor in sequence. Are these documents which were all generated about the surgery which you thought might be a thoracotomy?-- Yes.

What's the TH23? What's that document?-- That's the theatre list that comes out every afternoon to tell you what's on for the next day in theatre.

Is that the document that made you believe it was a thoracotomy that was scheduled for the next day?-- Yes, that and the following two documents - well, following - yeah.

That's the surgeon's report. Is that a document compiled by Dr Patel?-- Yes.

In advance?-- That's - no, not in - that would - well, should have been done afterwards, after the surgery.

I see?-- But what I was trying to highlight was that he did refer to it as a thoracotomy over the 6th rib and so this thoracotomy that wasn't a thoracotomy to get to the lung, that you can't get to unless you do a thoracotomy, was in fact a thoracotomy.

The next document, 25?-- That was the booking - the theatre booking request where he details what he is going to do, and if you see, like, more than halfway down the page it says that he is going to do a left thoracotomy.

COMMISSIONER: Wedge resection?-- Yeah. The further issue which - that's my writing on TH23 - was that he made an assurance that the patient wouldn't come back to intensive care, and the patient - what happened to the patient was he was specialed in the ward where perhaps he should have come back to intensive care. He was specialed in the ward for some period of time. His drains blocked because the nurses weren't used to caring for a patient with a thoracotomy, or the equipment to care for the patient was actually accessed from the ICU, so it was almost like to prove a point. To prove a point the patient wasn't going to ICU, Dr Patel kept this patient in the surgical ward despite the fact that he perhaps should have been cared for in intensive care.

MR ANDREWS: Now, on the - your investigative work tells you that you had a meeting with Linda Mulligan on the 30th of August 2004 because of an e-mail that you received from Karen Fox and returned to Karen Fox?-- Yes.

Exhibit TH32. Now, would you look at the document on the monitor, please. Now, in sequence, is the first e-mail from Karen Fox to you at the bottom of the page and your response at the top?-- Yes.

Where was Karen Fox working, in the ICU or elsewhere?-- No, she was working in the ICU. She was the nurse who was basically caring for Mr Bramich that - you know, a few nights previously. So she was actually working in ICU. The comments that she's making about DEM are sarcastic comments.

From that document, you realised you spoke with Linda Mulligan that day, the 30th of August?-- Mmm-hmm.

And you spoke with her about Dr Patel and Mr Bramich?-- Yes, all of those issues, yes.

Now, you had a meeting on the 28th of August-----

COMMISSIONER: Sorry, Mr Andrews, while that's on the screen, in the second-last paragraph: "Are you aware that DEM is less than safe ICU." What does "DEM" stand for?-- Department of Emergency Medicine.

Why would that be less safe?-- She's actually being sarcastic here.

Oh, I see?-- Because it is less safe because they only have two staff on in the emergency department, which is very difficult to run a trauma with only two nursing staff, but what she is saying is that the after-hours nurse managers were not very helpful and when they'd come up to ICU, they'd say things like, "The emergency department is less safe than here. You don't need anymore staff, despite one patient arresting, one patient climbing out of bed, one patient close to needing a tube put down for ventilation." So she is being sarcastic to me. Not to me, you know; about the after-hours nurse managers and their response-----

Ms Hoffman, I don't want to embarrass you by asking you about this, and I hope you take it in the spirit in which it is intended; I have the impression that the ICU nurses are in effect the cream of the crop. They're often the most highly trained and skilful nurses found in a hospital. Is that an overstatement?-- I'll take that.

Thank you. I just wondered whether there was some jealousy from the other wards and departments of the hospital?-- I think that there - you're right, there's often a perception that IC nurses are elitist and that some - and that - because they think that we always only have one patient. They don't understand that that one patient may require two or three nurses to care for them. So that is a - that is sometimes an

assumption made by some people; if they haven't worked there, if they haven't worked in ICU, yeah.

MR ANDREWS: Please look at Exhibit TH33, which seemed to be - you can look at it on the monitor - notes of a meeting on the 25th of August, the minutes of a level 3, 5, 6 meeting. Ms Mulligan was the chairperson. You attended?-- Yes.

Was this a regular monthly meeting?-- Yes.

A couple of pages in there is something highlighted, you mentioning stress over a medical incident. Is this your mentioning at that meeting the stress of staff members over the Bramich incident?-- Yes.

And Mr Bramich wouldn't be the first person to pass away in intensive care, would he?-- No.

So if the staff were stressed, it would be about something unusual-----?-- Yes.

-----in respect of that patient?-- Yes.

COMMISSIONER: In the previous sentence there is a reference to possibly using an EN. What is an EN?-- Enrolled nurse.

I see. So that could be either a staff enrolled nurse or an agency nurse?-- No, an enrolled nurse is someone who is not registered - not a registered nurse.

I see?-- A nurse that just has done one or two years' training.

Would that be sensible for them to be using a person at that level of training?-- No.

To help out in ICU?-- No. In some big ICUs they do because they use the enrolled nurse to do-----

To empty bed pans-----?-- Yeah, well, I didn't want to say that. To do restocking and things like that and, you know, they're very good nurses too, very helpful as well. But our ICU is quite a small ICU so they may not have been busy all the time. We would need to have RNs in our ICU because we have so little staff.

Do you have any-----

D COMMISSIONER VIDER: No comment on that particular, but still staying with that, I'm curious, you've brought to the attention of Ms Mulligan on a number of occasions your concern about the stress levels of the ICU nurse and you specifically link it to episodes of patient care. The employee assistance scheme people were not available to you you stated. Were any other avenues of support open to you or suggested that you can access? For example, did the Director of Nursing herself come up and want to do a debriefing with the staff or talk through or listen to their concerns?-- No, never. Never. The only

time she came to talk was that time when she came into my office for some reason and I asked her would she stay there and talk to the three staff that were on and they went in there and spoke with her, but, no, never offered any support or any other suggestion to the staff or anything.

Because it's fairly apparent, you know, by the end of August, and Mr Bramich died end of July, if you've still got staff that are distressed about that incident, it must be said that the stress levels are unresolved for them?-- Mmm.

And it's an issue?-- It's a big issue and it actually still isn't resolved. The staff involved are still very, very upset about this incident. I think probably too, you know, and it is not - you know, yes, we have patients who die in intensive care on a daily basis but this was associated with a longstanding history of watching Dr Patel's patients with all these complications and us not being able to do anything about it and nobody assisting us in doing anything about it and I think that's - it was that frustration, that level of frustration as well and also the particular way that Dr Patel treated this man's family. He had a little eight-year-old girl who stood at the end of the bed and watched this whole thing and it was incredibly distressing for everybody involved, the way Dr Patel spoke to Mrs Bramich and told her she wasn't allowed to cry.

She wasn't allowed to cry?-- Yeah. And I think that the staff couldn't believe what was happening and didn't know what was - what to do. And we had no - no support from within our hospital. And when we - you know, we were trying all these other different people to try and get someone to listen and I can remember thinking, "Please, Mrs Bramich, just ask one question", you know, "Just ask one question of what's happened to your husband", you know, and - I mean, now they know but it could very well have happened that they would never have known.

COMMISSIONER: Mr Andrews, if we can move back to the first page of that same document. I just happened to notice on the way through that the second item refers to "medication incident management and adverse event reporting" and that was still under review. Ms Hoffman, does that bring to your mind any discussions that took place about, particularly, adverse event reporting and what was being reviewed?-- Yeah, we were having a lot of training about adverse event reporting and risk management and a few of us went to courses and things like that and I think one of the most ironic things was that Dr Keating was actually teaching the risk management within the hospital and how - and how it would be handled, like, in a no blame culture and all that sort of thing. So whilst theoretically we were receiving education about how to deal with risk management and adverse events and that sort of thing, in practice nothing that we were learning was happening.

If we can then go through to the third page-----

D COMMISSIONER VIDER: Can I just ask a question about risk management while that's happening?

COMMISSION: Yes, certainly.

D COMMISSIONER VIDER: Did you have a risk management committee? I notice in here earlier, somewhere in here earlier you mentioned a risk register?-- Yes, that was part of the development.

Yes?-- We had to develop a risk register for each area but that was still and is still in development, really. I think the person who was responsible for that had some extended leave and everything was sort of, like, put on the back-burner.

So you don't have a collective register at this stage?-- No, not yet.

That has clinical risks on it that you strategically work your way through?-- We have identified some on our separate forums but it hadn't developed any further than that.

D COMMISSIONER EDWARDS: Ms Hoffman, looking at all the matters that were discussed and so forth, what about outcomes? It doesn't seem as if there were many references to outcomes of the patient care in the intensive care units and so forth. How was that recorded so there is some mechanism by which competency and other matters could be considered?-- We didn't look at outcomes apart from we participated - I don't know if you have heard of it, the aortic database for intensive care, which should give us some benchmarking information back. So we do do that. I guess we would look at the number of re-admissions into theatre, re-admissions into ICU within 72 hours - that was one of our indicators, clinical indicators for the HSHS - and things like complications like pneumothoraces after intercostal catheters or after central line insertion, and then infection rates, they would be looked at, and - I just thought of something else but I have forgotten now.

Would you say these reports did not necessarily show up any problems relevant to Dr Patel's competency or management of patients?-- No, not in this one because this is a nursing meeting, so it sort of wouldn't have shown up there.

COMMISSIONER: I have got to tell you that the third page brought up, because I noticed the second-last item, I guess it's a typographical error, perhaps, or a Freudian slip which it says, "Surgical war and ICU needs to be reviewed". Was there some discussion about the issues going on between the surgical ward and the ICU?-- There was no war.

No?-- I'm not quite sure what they're referring to there. It's pertaining - Trendcare is a patient dependency system that we use.

Right?-- So it may just be referring to that. I can't

remember, and we certainly - I don't remember any follow-up about it. So I'm not quite sure what they're referring to.

I guess it just gives us a bit of an insight into the way in which these things were operating because it seems to be indicated that a new business rule is going to be issued and that that will in turn go into an overarching nursing policy?-- Mmm.

Is that the level of sort of red tape and documentation under which you operated?-- That was this - this was when Linda came in. This was the type of thing that she was perpetuating. That everything had to be done like right down to the minutest detail. And that's - you know-----

Except, you know, things like saving patients' lives and that sort of thing?-- Mmm.

Yes, Mr Andrews.

MR ANDREWS: You did seek advice from the Queensland Nurses Union of Employees?-- Mmm-hmm.

Spoke with their organiser and you arranged to have all staff involved in the Bramich incident complete a statement as a guide for the QNU?-- Yes. The QNU were the only people really that gave us any direction about what to do.

And two representatives of the union attended on the 3rd of September 2004 to speak to the intensive care unit?-- Yes.

They met six or eight staff; is that the case?-- Yes, yes.

To discuss the staff grievances in respect of Dr Patel?-- That and particularly the Mr Bramich case, because we were aware that the Mr Bramich case would be a Coroner's case and we were - we were very concerned about that and the ongoing issues with Dr Patel.

After the two union representatives spoke with you on the 3rd of September, did one of them, a Kim Barry, say that she was going to speak with the Director of Nursing, Linda Mulligan?-- Yes, she did.

And she came back and reported to you?-- Yes.

What did she tell you?-- She came-----

COMMISSIONER: Mr Andrews, I don't know that that sort of hearsay is going to be very helpful. It's a matter for you but it's a slightly serious allegation and it's not only hearsay but it's hearsay of an opinion. It's not very cogent evidence.

MR ANDREWS: I take the force of what you say. Thank you, Commissioner. You determined, after speaking with Kim Barry, that you would forward statements to Linda Mulligan that had been prepared from other persons affected by the Bramich

incident?-- Yes. I think some had already - some may have already been forwarded to Ms Mulligan.

Well, had you - you hadn't forwarded any to her before the 3rd of September, had you?-- I can't actually - because they were coming in in dribs and drabs according to when the staff were at work or-----

Okay. Would you look, please, at TH26. It's an e-mail from you to Linda Mulligan of the 3rd of September with an attachment that seems to be an e-mail from Karen Fox to you?-- Yes.

I will just put up on the monitor the e-mail from Karen Fox, which is part of TH26. It's the typed words I'm more interested in. Can you move it slightly so you can see the left-hand side of the page.

COMMISSIONER: You just don't want anyone seeing the handwriting, Mr Andrews.

MR ANDREWS: It's better than it sometimes is.

COMMISSIONER: Yes.

MR ANDREWS: Is that the statement provided to you by e-mail by Ms Fox?-- Yes.

And she was in the ICU on the occasion of-----?-- Yes, yes.

-----the Bramich incident?-- Yep.

Now, Ms Fox is able to record events that occurred from 7.30 p.m. Now, that was at about the time that you had in fact - you left, imagining that Mr Bramich was to be transferred to Brisbane?-- Yes, yes.

On the page on the monitor, Ms Hoffman, there's a question mark to the right of one of the paragraphs. Do you see it?-- Yes.

In which Ms Fox describes an instruction about using an introducer. Are you able to tell us whether introducers are generally used with such procedures?-- I've always seen an introducer used with this procedure. I've never not seen one.

Have you seen that procedure more than once?-- Oh, many times, yes.

COMMISSIONER: Mr Andrews, my impression is that the statements of these other witnesses really speak for themselves. Unless there are any particular points that you think that Ms Hoffman can highlight or comment on, it's perhaps slightly unfair to ask her to give evidence about what other people saw or heard.

MR ANDREWS: Yes, thank you, Mr Commissioner. There is one point. In TH28 I'd like you to look at the monitor, please.

Do you see the last line of that report which seems to deal with ICU on the 25th of July, which would have been the first day that Mr Bramich came into the ICU before being returned to the ward. It records that the patient "was not reviewed by a doctor overnight". Is that common at the Bundaberg Hospital, ICU?-- It would depend on the condition of the patient and there is no - the doctor that they will have to call is an on-call doctor that would be busy throughout the whole hospital. So unless the nurse would call the doctor or the doctor had had a hand-over from another doctor to say that there was a critically ill patient in there, they may not come and see them overnight.

And to upgrade the status of the ICU, would it be necessary to have an intensivist overnight?-- Yes.

Would you comment on one item in Exhibit TH29. On the second page, you will see it on the monitor in a moment - were you present in the ICU when there were any exchanges of conversation between Dr Gaffield and Dr Patel?-- Yes, I was.

Did you hear that exchange, the one indicated in the sixth paragraph?-- Yes, I did.

Aside from speaking with the union members, you also spoke with a registered nurse Jane Truscott, who was doing a cancer control project?-- Yes, because Queensland Health commenced a project and it was to do with cancer - cancer services throughout the state. My understanding of it, though, was different to what I thought it was about. I thought it was about not allowing doctors who weren't experienced in particular surgery to do certain surgery but what it was actually about was what sort of services the ICU or the hospital could provide to patients with cancer. Because I had seen this as a way of being able to stop - stop Dr Patel from doing certain types of surgery that was too big for our hospital.

Did you send an e-mail which is Exhibit TH35, to appear on the monitor now, about - 34, I beg your pardon, about a Whipple procedure?-- Yes.

COMMISSIONER: Is that the same one that we saw earlier, the same Whipple procedure?-- I'd have to check the dates, yes.

MR ANDREWS: It shouldn't be, Commissioner. Chronologically, it's later in time.

COMMISSIONER: Right.

MR ANDREWS: You were concerned to prevent the large scale operations occurring?-- Yes.

Yes. The ventilated hours in ICU, had you done a survey to determine or was there some way of recording how they'd increased during the year?-- We keep monthly stats on ventilator hours for ventilated patients, admissions, discharges, ICU patients, CCU patients. We keep monthly stats

on a lot of things, including ventilated hours, and our normal ventilated hours were around 100 hours per month and at some period towards the end of 2004 they were getting up into the eight and 900 hours per month.

What does that indicate?-- Well-----

Apart from meaning that there was a lot of work for the staff in ICU to do, does it say anything about the patients?-- That we were having a higher acuity, a high level of acuity of patients, and patients that were much sicker than normally. Plus, we were having or holding on to our patients longer than what we should have been.

Was it your consistent view that patients likely to be in intensive care for more than 48 hours should have been transferred?-- I didn't take stick to it. Like, if we only had one patient that's there, because it's very distressing for the family to - if the patient was going to be - you know, have the tube off the next day, have the ventilator off the next day, I wouldn't like insist that they'd be moved. If it looked like they were going to be ventilated for another five to seven days, then I would push for it, or if the patient needed to go for a different reason.

You e-mailed Linda Mulligan on the 28th of September; that's on the second page of Exhibit TH35, that second page will be put up on the monitor. Is your e-mail in response to the increasing hours and acuity?-- Of the patients and the fact we don't have any agency staff in Bundaberg, so the staff, to staff the unit for that many ventilated hours, I had to ask people to work overtime, to come in on their days off, on their holidays and they were exhausted. So I was asking Linda and Martin, I had asked Martin Carter to delay if possible any routine surgery that may require an ICU bed until our last ventilated patient is no longer ventilated.

And did Linda Mulligan respond to you about your request to Martin Carter?-- She didn't respond to that. She just responded about someone - a nurse whose resignation we were expecting.

Now, you made an appointment to see her, Linda Mulligan, I think you refer to it in paragraph 120 of your statement?-- Yes.

And was this the - well, you explain what you outline to her in paragraph 121. You mentioned being more forceful than before. Is it possible that Linda Mulligan might not have understood your concerns prior to this time? I mean, each of those concerns?-- I don't - I doubt it, I don't think so, no.

Well, to be fair to Ms Mulligan, had you ever said to her before you were concerned about the number of deaths?-- Yes.

Prior to this meeting?-- Yes.

Had you mentioned to her that you'd been concerned about Dr Patel's behaviour in the unit?-- Yes.

Had you reported to her that Dr Patel had indicated to the staff he was untouchable because he earned so much money for the hospital?-- Yes.

COMMISSIONER: So none of this really should have come as news to Mrs Mulligan?-- No.

Just while we have that document still on the screen, perhaps it's not on the part on here, but there was the suggestion that given that ICU was already over budget or at the limits of its budget, you shouldn't be paying for agency staff. Was this at the time when Mrs Mulligan still had the practice of when she went on leave, getting an external person to fill her position rather than using her deputy?-- I'm not actually sure how much leave she had during that time.

All right?-- Yeah.

But that happened throughout the time she was there as far as you knew?-- Yeah, because she's only been there since March 2004, she hadn't - she hadn't had that much leave, so.

Yeah?-- Yeah.

I'm just wondering why it is that there'd be funds to bring in someone external to be behind the glass wall in the office but no funds to bring in an agency nurse to help out intensive care?-- Mmm, and we also were only over budget because of the extra burden that Dr Patel's patients had placed upon the ICU.

Particularly the overtime?-- Particularly the overtime.

Yes?-- Yes.

D COMMISSIONER VIDER: Ms Hoffman, you mention in that e-mail your concern for the staff and you talk about the fact that they come in on days off?-- Yes.

They've come back from holidays?-- Yes.

I will put another aspect to that and say they must have the highest regard for you as the nurse manager and leader of their team if they have cooperated and come back on those occasions to keep that unit staffed.

COMMISSIONER: Mr Andrews, would this be a convenient point to take a five minute break?

MR ANDREWS: It would, thank you.

THE COMMISSION ADJOURNED AT 2.50 P.M.

THE COMMISSION RESUMED AT 3.00 P.M.

TONI ELLEN HOFFMAN, CONTINUING EXAMINATION-IN-CHIEF:

COMMISSIONER: Thank you Mr Andrews.

MR DIEHM: Mr Commissioner, if I may raise a housekeeping matter before we resume evidence with Ms Hoffman? Given Mr Andrews' indication earlier that he expected to finish Ms Hoffman's evidence-in-chief this afternoon, he presumably means that coming tomorrow we'll be moving on to some other witnesses.

COMMISSIONER: Yes.

MR DIEHM: And we've been given some indications, at least informally, as to who those witnesses are likely to be. What my request was to be was whether it was possible for the rest of us at the Bar table to be provided in advance with either witness statements or, indeed, in the case of one witness, I'm told there is a record of interview that the CMC undertook to

give us some idea in advance of the evidence.

COMMISSIONER: Mr Deihm, I'm very sensitive to that difficulty. The witness to whom you refer with the record of interview, my understanding is it's a CMC record of interview and inquiry staff are, as we speak, are contacting the CMC to see if we have their permission to make that available. If we get that permission, then that will overcome your problem, otherwise, the best we'll be able to do is we'll provide you with a draft statement which is yet to be approved and signed by the witness.

MR DIEHM: Yes.

COMMISSIONER: And that's, as I say, the best we can do in the circumstances.

MR DIEHM: Yes.

COMMISSIONER: But we are conscious of the problem and are trying to ensure that things are as convenient as possible for you.

MR DIEHM: Thank you, your Honour.

COMMISSIONER: Thank you Mr Deihm. A couple of other housekeeping things I wanted to mention. There have been some inquiries from the press about the use of the name of Mr Bramich. I think I indicated earlier that since Mr Bramich has already received considerable mention in the press, I don't see any point at all in suppressing his name and I will therefore delete him from the order I made earlier concerning patients' names.

The other thing I wanted to say, I guess particularly for people in the public gallery and the press and media as well, because this is an entirely new precedent of having television cameras in this room, people may have the wrong impression that comments made from the three of us on the bench suggest that we've already formed opinions or have concluded views about things.

Those who are experienced with the processes of our Courts throughout this country will realise that it's a common thing for people sitting on the bench to express themselves in language intended to excite comment, response, to identify areas of interest and to encourage witnesses to be forthcoming in expressing their views, and sometimes the words used may come across to other people in the room as if the people sitting on the bench already have a concluded view on that matter.

One example that comes to mind during the course of evidence today is that when the evidence is referred to Mrs Mulligan, I've made some comments and my colleagues have made some comments about the appearance that's emerging from the evidence today about the divide between the bureaucracy at the Bundaberg Hospital and the staff on the cutting edge of

providing medical services to the people of Bundaberg.

That's not to say that when we hear evidence from Mrs Mulligan, we may not form an entirely different view, and so I wouldn't want anyone walking away from here thinking that simply because of things we've said from the bench during the course of today, we no longer have an open mind and that we're not prepared to give Ms Mulligan her opportunity to be heard and to give appropriate weight to her evidence when it's received, and that's particularly why I've emphasised to the press and media that when they're reporting evidence and allegations concerning particular individuals, it's really only a matter of simple fairness to point out that those witnesses haven't yet had an opportunity to answer the allegations and to respond on their own behalf. Is there anything you wish to add to that, Mr Andrews?

MR ANDREWS: No, thank you, Mr Commissioner.

COMMISSIONER: Thank you. Well, we might proceed with the evidence. Ms Hoffman, I understand you have a flight black to Bundaberg around about 6.30 or so tonight?-- Not to my knowledge.

Not to your knowledge?-- No.

Okay. Well, if that's the situation, we'll try and make sure that you're in plenty of time to catch one. Were you expecting to stay in Brisbane overnight?-- Yeah. If it actually could be changed until tomorrow morning?

MR ALLEN: I raised that with the secretary with the Commission during the last adjournment.

COMMISSIONER: Thank you.

MR ALLEN: And I understand that he is to make inquiries to ensure travel arrangements and bookings for tomorrow.

COMMISSIONER: Predictably you're always ahead of me. Thank you for that.

MR ALLEN: Thank you, Commissioner.

MR ANDREWS: Ms Mulligan suggested to you after your meeting that you put your concerns in writing and she arranged for you to attend a meeting with her and the district manager, Mr Leck; do you recall that?-- Yes, yes.

Now, you repeated all of your concerns to Mr Leck on about the 20th of October?-- Yes.

Have you seen a file note supplied by Queensland Health which appears to be a note of Mr Leck's relating to a meeting between you, Ms Mulligan and Mr Leck on the 20th of October-----?-- I saw it yesterday.

-----2004? Would you have a look at a copy of that note

please?

COMMISSIONER: Do you have copies for the bench?

MR ANDREWS: I have two copies and one for the monitor.

COMMISSIONER: Thank you.

MR ANDREWS: Now, you read that note yesterday, didn't you?-- Yes.

And as a record of concerns that you raised, was there anything about it that appears inaccurate?-- The sentence where it begins, "I didn't want anyone to come and die in unit because he stops transferring patients".

Is that on page 2 shown on the monitor with the highlighter?-- Yes.

And what's inaccurate about that?-- Because - well, it just doesn't make sense, I think that sentence, and also we had already had patients who had died because he had stopped, because he had stopped the transfer of patients.

I see. So it's inaccurate in so far as it suggests a future tense instead of past?-- Yeah.

But in other respects, does the document accurately reflect things that you said?-- There may be some little things like where it said, "Heard second-hand that Dr Patel told you and your doctors not to use certain words." Well, I had actually heard the doctors themselves in the unit discussing that. But other than that, I think it is a fairly accurate document.

I tender it.

COMMISSIONER: Just before it goes in, at the top of the second page there's the dot point, "When approached Jenny Church but said won't fill in adverse event forms." Can you explain what that refers to? Do you see the first dot point on the second page?-- Yes. Actually, that mightn't be correct either. Jenny Church is also referred to as Jenny White, she was the nurse unit manager of the theatre, and I don't believe that she said she wouldn't fill in adverse events forms, even though they weren't being done, I don't believe that she actually ever said that.

And the next dot point then says, "Saw Di Jenkin"; is this a record by Mr Leck of something you told him or is he saying that he himself saw Di Jenkin?-- No, I think he's saying that this is what I said when I went to see him.

Yes?-- Mmm.

And did you tell him that you'd seen Di Jenkin?-- Yes.

Who is Di Jenkin?-- She is the nurse unit manager of the surgical ward.

All right. And again, the comments attributed to her that she wasn't filling in the forms but asked what is the point; is that accurate?-- My recollection of when I saw Di and asked her about it, she's just said she did have problems with Dr Patel and she was dealing with them in her own way, that's my recollection of.

The next point refers to a person called Dieter?-- Yep.

Who's that?-- Dieter Berens, the doctor.

Right, okay, and you've already given evidence about your discussions with him?-- Yeah, and actually that's not correct either because he said he would support and tell the truth even if it did cause him to lose his job, he was afraid that he would lose his job and Dr Patel wouldn't, so that's not correct either.

The next one, David Risson; who is that?-- David Risson was one of the junior doctors in - doing surgery plus he worked in ICU for a while and he had grave concerns about Dr Patel's work and he actually did approach me at one point because he knew that I did also.

Yes.

D COMMISSIONER EDWARDS: He'd be a resident medical officer?-- Yes.

COMMISSIONER: Okay. Oh, sorry, on the previous page, there's a couple of names, just to fill in the picture, about five points from the bottom there's a reference to a Dr Strahan or Strahan?-- Strahan, yes.

Was he someone from Queensland Health or how did he become involved?-- He, Dr Strahan is a visiting medical officer and a physician and he was the Director of Medicine at one point and he does visiting sessions at the hospital. He became involved when he came to talk to me one day after a round in ICU and I voiced my concerns with Dr Patel to him then.

All right. We've heard already about Dr Miach, the - he was the renal expert, wasn't he?-- Yes.

Jon Joyner's mentioned; Gail Aylmer was your - nursing colleague of yours?-- Yes, she's infection control coordinator.

And there's a reference to Robin Pollock; who's she?-- She's the nurse unit manager of the renal unit.

All right, and they're the ones who've complained to the medical superintendent about the lack of handwashing?-- Yes.

Okay. Yes, that will be marked as an exhibit when the secretary returns. I think that will be Exhibit 7.

MR ALLEN: I think Exhibit 8.

COMMISSIONER: All right. Mr Farr, this appears to be a document provided to us by Queensland Health. Can you confirm that this is what, a type-up of the handwritten notes provided by Mr Leck?

MR FARR: That's my understanding but can I confirm that as well that that is correct.

COMMISSIONER: Certainly. And what are we to make of the bar codes at the bottom of the page? Is that some Queensland Health system?

MR FARR: It is, that's been placed on there for the assistance of the Commission for ease of reference electronically, but how that is going to work I don't know yet because they're yet to explain it to us.

COMMISSIONER: All right. Well, I'm pleased to hear the word "assistance" used anyway. Thank you Mr Farr. So Exhibit 8 will be the file note of the meeting between Toni Hoffman, Linda Mulligan and Peter Leck of the 20th of October 2004.

ADMITTED AND MARKED "EXHIBIT 8"

COMMISSIONER: Thank you Mr Andrews.

MR DIEHM: Mr Commissioner, could I ask if copies of that exhibit could be made available to the parties?

COMMISSIONER: I'm happy for you to have mine and-----

MR DIEHM: Simply in due course, I mean.

COMMISSIONER: Certainly copies will be available in due course and at any stage if you need copies, just speak to the secretary and it will be attended to.

MR DIEHM: Thank you, Commissioner.

COMMISSIONER: Thank you Mr Andrews.

MR ANDREWS: Mr Leck asked you to put his concerns in writing at that meeting and you e-mailed him things?-- Yes.

You say in paragraph 125, you e-mailed the various statements of ICU nurses. Now, will they be the statements that you have referred to in evidence that have been put up on the monitor, Exhibits TH27, 28, 29, 30 and 31? Perhaps you should look at them to determine what's been shown to Mr Leck?-- Can I just - can you - I'm sorry, but can you repeat that? I'm just confused.

At paragraph 125 of your statement, you say, "I e-mailed this through to him together with various statements of ICU nurses on 22 October 2004."?-- Yes.

It's the various statements of ICU nurses that I'm initially concerned to identify?-- Okay.

And within your document, your statement, appear some exhibits that we've seen today, Exhibit TH30?-- Yep.

So, yep, there's one from Karen Fox, one from Karen Jenner.

Do you have the exhibit numbers that were-----?-- Yep, TH26, TH27.

26, 27, yes?-- 28, 29.

COMMISSIONER: 29's Sharon Cree?-- Sharon Cree.

TH30?-- TH30.

And you mention in your statement that the name doesn't appear on the document itself but you understand it's a registered nurse by the name of Dan Atkin?-- Yes.

And then 31 is Kay Boisen?-- Yes, that was about a different incident. That was actually attached as well, yep.

So the position then is perfectly clear, as at the 20th October 2004, Mr Leck had your verbal complaints to him that are set out in the document we were just looking at that he reported, plus all of these statements from other nursing staff?-- I believe so. I am just trying to check the dates, because some of the e-mails came - some of the reports came in late, so I am just trying to ascertain the dates are correct.

So, for example, Sharon Cree's is dated the 1st of November, so presumably you handed that over as soon as you got it?-- Yes, as they came. And because they should have gone to Linda first, some of them went to Ms Mulligan first and she forwarded them on to Mr Leck.

Right.

MR ANDREWS: Now, exhibit TH37 is a document you forwarded to Mr Leck on the 22nd?-- Yes.

It seems to have considerably more detail than some of your earlier documents. Would you please look at the document on the monitor at some of the highlighted passages? I can't be sure, did you tell us yesterday about the patient UR063164, whose death certificate said he died of malnutrition?-- No, I didn't.

Are you able to give me any details of that patient?-- The patient's name was Mr-----

Is he on your patient key?-- He should be. Patient 22.

COMMISSIONER: All right, patient 22.

MR ANDREWS: Are you able to give any details of that patient and his care?-- Yep.

How old was he?-- He was - he was 94, and his diagnosis, when he came in, was sigmoid-volvulus with impending perforation.

COMMISSIONER: What does that mean?-- His bowel had sort of twisted on itself and it was about to perforate.

Yes?-- He was operated on and transferred to the ICU, probably because of his age and he would have - I am sure he was ventilated. And he died in hospital on the 17/08/04, and his death certificate stated that he died of malnutrition, my concern being that in hospital, really, you shouldn't die of malnutrition. It is very unusual that you would, unless you came in with malnutrition, that you would have that on your death certificate as a cause of death because if you can't be fed one way, you can be fed another way. So malnutrition would to me be not a cause - not a normal cause of death to write on a death certificate.

D COMMISSIONER EDWARDS: Was that death certificate signed by Dr Patel?-- I can't remember whether it was signed by Dr Patel or one of his junior doctors. I can't remember.

COMMISSIONER: Was he an apparently malnourished man?-- Not at all.

What did he look like?-- He was - you know, a well nourished, quite - he looked quite good for his age. I remember him quite vividly, yeah.

D COMMISSIONER VIDER: What in your opinion would have been a more accurate notation on the death certificate?-- Well, I don't - I don't know what he died from. Probably should have been, you know, a Coroner's case, so they could have determined that.

COMMISSIONER: From your description of him it certainly wasn't malnourishment?-- No, I don't believe it was malnourishment.

MR ANDREWS: At the bottom of the page you write to Mr Leck of "Dr Strahan expressing widespread concern". Is that an accurate statement?-- That was when Dr Strahan came - went away to talk to other doctors in town and he came back and said to me that there is widespread concern but no-one is willing to stick their neck out yet.

D COMMISSIONER EDWARDS: What is Dr Strahan's specialty?-- He is a physician. He has got - he has got an interest in gastroenterology, he has got a lot of qualifications.

Okay, specialist?-- Yes, he is a specialist physician.

COMMISSIONER: I think you told us he had been on the staff at the hospital at one time?-- Yes, he had, as a Director of Medicine.

Yes, and he was still a visiting medical officer?-- Yes, he is, yes.

MR ANDREWS: These - this email which was sent on the 22nd of October, your statement also shows that two other exhibits were attached?-- Yes.

Shortly after that or some time after that there was a seminar conducted by three Queensland Health Department officers. Can you say how long after you sent these documents to Mr Leck on the 22nd of October that the seminar occurred?-- I think it was in - I think it was in - I think it was probably a month to six weeks after that.

And what was the seminar about?-- It was about - it was from the Ethical Standards branch of Queensland Health, from what I can remember, and it was about what was ethical behaviour for a nurse, or someone working in a hospital, and what wasn't. And they talked a lot about whether or not nurses could have - could give information to the Nurses' Union.

And could they?-- From what I can remember, that we were told no, that we weren't allowed to.

COMMISSIONER: Your statement goes further. It says that you were told that it was illegal even to speak to your union and that if you did that you could go to gaol and lose your job?-- Sorry, where are you reading-----

I am reading from paragraph 131 in your statement?-- Yes, that's right. We were specifically told that it was impermissible for us to tell our union anything about what goes on in the hospital or any hospital-related business. We were told this was illegal and if we spoke about anything that happened we would go to gaol and lose our jobs, yes. That's right.

MR ANDREWS: How did that make you feel at the time?-- Well, I was - I was really frightened, I was very scared because I had had contact with the union at that point about what to do in this - in our situation, and so had the staff in ICU - so had the other staff in ICU. And I remember that I was supposed to be meeting with Kim Barry down here in Brisbane and we were going to go and see Dr David Kerslake, the Health Rights Commission, because the union had told me to - not to take my concerns about Dr Patel through Peter Leck and Linda Mulligan. They had advised me to go straight to the CMC, or the D-G, or the Health Rights Commission because of previous experiences they had had with Mr Leck. But instead I was - I thought that I should at least give them a chance, them being my line managers, to do what's regarded as being the right thing, and also I was very well aware that by making this complaint, even just to Peter Leck and Linda Mulligan at that particular time, that I would never get a chance to progress my career in Queensland Health.

What was your belief about this?-- My belief was that I would never get an opportunity to act up into a higher position, I would never be given the opportunity to go to conferences or any of the things that enable you to progress in your profession. I knew that my making this complaint, that that would be the end of my career and it may even be the end of my career at that hospital.

COMMISSIONER: Mr Farr, you will be aware one of our obligations under the Terms of Reference is to advise the Premier of any possible cases of official misconduct or criminality. In that context, I wonder if I could ask you to assist the inquiry by identifying the names of the people who provided this seminar at Bundaberg in, it would seem, about November 2004, and any script or documents relating to what was said on that occasion.

MR FARR: I certainly will.

COMMISSIONER: Thank you.

D COMMISSIONER VIDER: Ms Hoffman, those statements that you just made, are you aware of anybody else - any of your colleagues whom you believe have not been able to progress professionally because of action they might have taken?--

Yes, I am. And I think that the reluctance of most of my colleagues to help me in this situation was based on that, that assumption that, you know, if you make a complaint you - you're ostracized and-----

And you are aware of people who have been ostracized?-- Yes.

Thank you.

D COMMISSIONER EDWARDS: Outside the Bundaberg Hospital?-- Yes.

MR ANDREWS: Ms Hoffman, are you able to give any details so that the Commission can assess whether your theory is correct, that historically there have been people ostracized for complaining?-- Yes, I can. Would it be possible that I give them later? I can give - one comes to mind now but I would just like to be able to think a bit clearer - or not?

COMMISSIONER: Well, unfortunately, for reasons we're all aware of, you will have to give evidence at a later stage, perhaps in the Bundaberg sittings of the inquiry. So perhaps you would like to think about that over the next couple of weeks, and it may be that you would prefer not to name names without at least telling the people concerned that you intend to mention their name. I think that's perfectly reasonable. So we will perhaps leave that matter in abeyance until we come back.

Is that satisfactory, Mr Andrews?

MR ANDREWS: Yes, thank you, Commissioner. In late 2004 you were asked by - separately by Ms Mulligan and Dr Keating to look at statistics for patients in intensive care?-- Yes.

Did you respond with an email, TH40?-- Yes.

Had you been asked to address each of these topics by Ms Mulligan and Dr Keating?-- Yes, a lot - even a lot more than those from Ms Mulligan. But they were - they were the sort of - the things that I had made a note of. There was one other thing that happened in the town that impacted upon our ICU, and that was a private coronary care unit opened at one of the private hospitals and took up a percentage of our coronary care patients that would have come to us.

COMMISSIONER: What are the other hospitals in Bundaberg? Is there a Mater Hospital?-- Yes, there is a Mater Hospital and there is one that's called The Friendly Society Private Hospital.

Right. And the Mater, I assume, is a fully equipped surgical hospital, is it?-- It is not a very big hospital but they do do quite major surgery there. They do hemicolectomies.

What about the other private hospital you mentioned?-- It is actual - it has actually got a coronary care unit and a high dependency unit, a new one attached to it, and Dr Strahan is

attached to that. So he works over there a lot of the time. They actually have a cardiologist now, too.

Both of those hospitals have, to your knowledge, an adequate supply of appropriate specialists?-- Yes, I believe they do.

And that's from the - generally speaking from private specialists practising in Bundaberg?-- Yes.

I am sorry if I am leading us astray from the evidence you were giving but it is one of the things that I just don't understand about all of this. We keep getting told how difficult it is to attract specialists in places like Bundaberg, but it sounds like you already have in Bundaberg a good resource of well-respected specialists who would be available to perform services at the hospital as visiting medical officers?-- Yes, it was difficult to get doctors for Bundaberg Base Hospital.

Yes?-- And, as I said, I think it was because of the way that - news travels fast around the place and it was the way that doctors were, you know, being treated by the executive. That's - that's the information that I am aware of.

Thank you, Ms Hoffman.

MR ANDREWS: Vivian Tapiolas emailed you on the 20th of January 2005. Were you her line manager?-- Yes, I am, yes.

And in that email did she discuss the treatment of some patients with which you were not involved? Is that the position?-- Yes.

Would you look at this document on the monitor, which is in fact exhibit TH41? Indeed, the attachments are probably more significant. The first of the two patients discussed seems to concern an issue of withdrawing support. Does that mean turning off a ventilator?-- Yes, it does.

And is there anything unorthodox about the incident that's reported there?-- Yes, there is. Dr Patel - this was not Dr Patel's patient. Dr Patel wanted a bed the next day for an oesophagectomy. There was no bed because this lady was taking a bed. He left instructions when he left that Dr Joyner was to turn the ventilator off - I understand at midnight. Dr Joyner refused to turn the ventilator off without brain death tests being done, and Dr Patel came in in the morning and was furious that the lady - the patient was still on a ventilator and asked why it hadn't been turned off.

Is there a procedure or a protocol before a ventilator is turned off?-- There is a very strict procedure regarding brain death that must be followed when someone - when someone is suspected of being brain dead, and this lady had not had any brain death tests done at all. Apparently Dr Patel continued to speak within the intensive care unit with Dr Carter about Mrs - sorry, patient 44's treatment and

Dr Carter, to my knowledge, went in behind the curtain and turned the ventilator off and Dr Patel went ahead and did his oesophagectomy.

COMMISSIONER: At the time when Dr Carter, as you say, turned off the ventilator, had any brain function tests come back?-- No.

MR ANDREWS: Were you there to see Dr Carter turn it off, or is this something you have been informed?-- This is something I have been informed.

The source of your information was?-- Vivian Tapiolas RN.

And is that something you deduced from this document, or is it something that Ms Tapiolas has told you?-- It is what she has told me.

Now, the next patient described on that page, there are some events identified. Is there anything unorthodox about them?-- Yes.

And what's the feature of that which is unusual?-- P21's had been brought in to - into the intensive care unit whilst he was still bleeding. He had gone in for an oesophagectomy and he was still - he was bleeding. He was actively bleeding when they brought him into the intensive care unit. This was pointed out to the theatre staff.

Is it usual to stop the bleeding before a person is transferred from theatre to-----?-- Yeah.

-----the ICU?-- Yes. The nurse was informed that the patient was bleeding internally and would need to go back to theatre at a later stage and - can you move the-----

Perhaps you should - it might be easier for you to follow it on your own exhibit?-- Yep.

Exhibit 41, if there is something in particular-----?-- I don't understand the logic for what happened - has happened because they spent four hours trying to stabilise the patient instead of just taking him back to theatre. This particular patient, from what I have been told, Dr Patel actually nicked his aorta, whether he nicked - nicked the aorta or actually was more than nicked, it was quite an extensive cut in the aorta, from what I understand, and this is the patient that very quickly was taken out of the mortuary and transferred to the funeral home and consequently buried without a Coroner's Inquest, and I believe Dr Carter wrote a death certificate for this patient.

COMMISSIONER: There is a mention here of a doctor, whose name I am going to have trouble pronouncing, Anthioziov (?)?-- Yeah, he is actually still there.

What part of the hospital is he in?-- He is like a Registrar for - Surgical Registrar, PHO Registrar.

D COMMISSIONER VIDER: So if the aorta had been nicked, that would then give rise to that statement towards the bottom of the page - it refers to the patient's abdomen was now distended with bright blood flowing through the bellovac drains?-- Yes.

So this patient was actually exsanguination?-- Yes.

COMMISSIONER: What was the last word?-- Exsanguination, bleeding to death.

D COMMISSIONER EDWARDS: Nothing was done surgically?-- He returned to theatre at 6.30, and I don't know what was done in theatre at that particular time, and he either came back to the ICU and died there or died in theatre. I can't exactly recall now.

D COMMISSIONER VIDER: If this patient died in the operating theatre?-- Yes.

That automatically involves the Coroner?-- Yes.

And notification?-- Yes.

That didn't happen?-- No, it didn't happen.

And even so, the patient had come back to the intensive care unit, ventilated and died?-- It still would have been.

Within 24 hours it still-----?-- Yes, whatever way you look at it, this patient was still a Coroner's case, and from my understanding of this, I think even the Coroner - not the Coroner, but the forensic pathologist was actually on her way in to do this autopsy, and when she went to do it the body had been released. That's my understanding of that situation.

So then the patient must have had a death certificate?-- Yes, and I believe Dr Carter wrote the death certificate for this patient.

And this patient was buried?-- Apparently.

D COMMISSIONER EDWARDS: Buried or cremated?-- Apparently buried.

MR ANDREWS: Ms Hoffman, how certain are you that the patient died in theatre rather than in the intensive care unit?-- I am not certain. I think he died in the intensive care unit, but I am not exactly certain.

COMMISSIONER: As you say, that doesn't matter in the sense that there had to be a coronial report?-- It doesn't matter, no.

Within 24 hours-----?-- I received that documentation and I forwarded it straight on to Linda who forwarded, as she said, to Peter Leck and this - this was also - this was the last -

this was the last straw. This is when we just thought it doesn't matter what we do, we have to stop this man from operating and this behaviour, because what was going on now was just totally and utterly illegal. And this is when I went to Mr Messenger with my concerns and then we all know what's happened after that.

D COMMISSIONER EDWARDS: Did you ever get any emotion from the operating theatre staff at any time as to his performance?-- To Dr Patel's performance? Oh, verbally all the time. They would talk about him all the time. When they handed over, they would talk about it all the time. It is just that they weren't putting anything in writing, and even up until-----

Not in the nurses notes?-- No, not - no. Even up until - even right up until the end, a lot of them were still supporting Dr Patel.

But would you expect somebody who saw such occurrences to record them in the nurses' notes?-- I don't - yeah, in theatre, I don't actually think the nurses actually write nurses notes in the theatre. They do in recovery once they leave and go to recovery, but I - but in theatre I don't think they actually specifically write anything in the nurses notes. When the complaint - when the theatre nurses made the complaint, they left - it was the three most - apart from the nurse unit manager who did make a complaint at the end, it was three of the most junior nurses in the intense - in the theatre who made the complaint, including an enrolled nurse. They were just so scared about doing it and there was such - at that point such a lot of support for Dr Patel in the unit that they were really worried that, you know, about working in the unit. So at that point I think, you know, we had counted how many people - I had gone to to try and get assistance to try and stop Dr Patel from operating and I think we had - I think we counted sort of around 12 - 12 people or so that I had actually been to. And to add a little bit more perspective to it as well, we had had the audit or the fact-finding mission by the Chief Health Officer in the February and we kept having more patients with more complications, including a young boy who lost his leg, this episode with P21, turning off a ventilator on someone to get a bed for someone else, it was almost as if we were working within - for us it was we were working within a nightmare.

COMMISSIONER: I think we should probably ask you, and I know it's a bit painful, to give us some details on some of these other cases. If you go to page 48 of your statement, the case of the 15-year-old boy is dealt with and I would appreciate you telling us more about that?-- It was a little boy who got on a motorbike when his mother told him not to at Woodgate, I think, and came off the bike and a stick went through his iliac region and perforated his iliac artery, and Dr Patel operated on him at the time and ligated - ligated the artery, and he should have then been sent on to Brisbane to have a graft put in but he ended up going back to theatre that night to have fasciotomies, because he had no pulse in his legs. Fasciotomies is where they make big cuts up your leg to relieve the pressure on your leg so you have got some venus return and arterial flow so your leg wouldn't become gangrenous. Instead, Dr Patel kept him in Bundaberg Hospital instead of transferring him and he was transferred to I think - I think to Royal Brisbane, and I believe that there is a letter that came back to the hospital from one of the doctors at that hospital talking about the concerns with this particular patient. This - this young boy - I'm not sure whether still with this young boy, and to my knowledge he may not even to this day know that he lost his leg because of the surgeon rather than that he may have lost his leg anyhow. So that - I think that's a very sensitive subject.

I'm sure it is. On page 48 you list a number of other patients. Obviously we can read those for ourselves but is there any particular information you have to provide us with in relation to those patients in addition to what we already know?-- On page 40-----

Page 48.

MR ANDREWS: Page 48 of your statement, paragraph 142?-- Okay. This - I was looking at the patients that - with complications that we had post that fact-finding mission by Dr Fitzgerald who we would continue to look after. So the patient by the name - P46 was the patient with a ruptured spleen that underwent went splenectomy and was transferred to Brisbane. A patient P15-----

But-----?-- Sorry.

We can read these for ourselves?-- Yes.

About patient P46, is there any additional information that we should know because I expect that - can it commonly happen that a patient undergoing a splenectomy suffers complications?-- I've just - I've written in my notes that he was a motor vehicle accident with a ruptured spleen and had an acute abdomen and went to theatre and had a splenectomy and then I've just written, "Complications. Transferred to Brisbane".

COMMISSIONER: I think, Ms Hoffman, you understand what Mr Andrews is driving at?-- Yes, I do.

There are adverse outcomes in a lot of medical procedures which are nobody's fault?-- Mmm-hmm.

But are there any of these that are particularly important from the point of view of this inquiry?-- Well-----

Perhaps the answer is you don't know?-- No, the answer is I do - the answer is I do know and I think that all of them - all of them have suffered complications because of Dr Patel's operating technique. The next patient-----

MR ANDREWS: Well, you can take your time?-- Mmm-hmm.

But patient P46?-- Yep.

The first on the list?-- Yep.

Is there anything about the technique that you're aware in this particular patient or are you simply deducing from the fact of complications that it was probably Dr Patel's faulty technique?-- No, I think it's something that we should refer to the notes properly to have a look at.

I see. And you don't have - I see. These are things that you - well, P46, is that a patient you regard as one who ought to be investigated by reading the notes?-- Yes, yes.

All right.

COMMISSIONER: So you're not coming here to give, as it were, medical evidence as to why this was - why these were the results of, shall we say, incompetence on the part of Dr Patel. You're just telling us that you're concerned about each of them and they should be looked at more closely?-- That I'm - yes, that I'm - that's exactly what I'm saying. These complications and re-admissions, like the next patient, they need to be looked at in a great - much greater detail.

Well, item 3 for example, the nicking of a spleen during a colectomy?-- Yes.

Would seem to be - from my little knowledge of anatomy, that would seen to be a pretty serious mistake?-- Yes, and a splenectomy as well in a patient. And the patient, which is patient - I have just got to refer to back to my - patient number 29.

The apronectomy?-- Yes. That was again - I had referred to that earlier, about that being done on a weekend.

D COMMISSIONER VIDER: Yes?-- Patient number 20, he - he was admitted for a laparoscopic cholecystectomy and developed a subphrenic abscess and pancreatic abscess and had many complications and re-admissions and actually, when he was transferred, he was very close to death actually, on transfer, to the Royal Brisbane.

MR ANDREWS: Well, is there anything about patient P20s

treatment that suggests it was not delivered to the proper standard?-- The complications that he suffered afterwards, once again, I think we need to look at the notes, examine the notes in greater detail. And then that's - that's that patient. And patient 21 I have already discussed. And then the 15-year-old boy.

When giving your answers in respect of the 15-year-old boy, you mentioned that he should have been transferred after his surgery at Bundaberg?-- Mmm-hmm.

To Brisbane?-- Yes.

And you also described some surgery by Dr Patel. What is it about that patient that you think may have jeopardised him? Was it the surgery Dr Patel or was it the failure to transfer him to Brisbane in a timely way?-- I think it was probably a combination of both.

Now, the next on the list is patient P38?-- Yes. That was a patient who was admitted following a colectomy and developed plural effusions and other complications as well.

I see. Now, you discussed again with Linda Mulligan Dr Patel on the 13th of January 2005?-- Yes.

And I gather you don't recall precisely what you discussed about him?-- No, it was - it was a discussion regarding concerns about Dr Patel and I think that someone from theatre had actually complained at that point about the oesophagectomy that I have just previously spoke about that the bed was needed for, and so I think it might have been at that point where they were assured that they weren't going to do anymore oesophagectomies at the hospital anymore.

I'm not sure which oesophagectomy you think you have just spoken about. Is it one of the patients in the list-----?-- Patient 21.

So your - you had achieved something. You had persuaded Ms Mulligan that there should be no further oesophagectomies?-- Well, I don't think it was me that achieved it. It was the nurse from theatre who achieved it. And this was two years down the line, nearly, and - since we first made - nearly two years since we first made the complaint and I think five to six deaths later of oesophagectomies.

Now, you met with Dr Gerald Fitzgerald in February 2005?-- Yes, I did.

Dr Fitzgerald was on a fact-finding mission, or so he told you?-- Yes.

It seems that you deduced that he didn't have all of the notes that you'd provided to Mr Leck and Ms Mulligan relating to Dr Patel?-- I asked them did they have copies of it and they had - they said no.

Who is "they"?-- Gerry Fitzgerald was accompanied by Judy Simpson, the legal officer from the QNU. And so, I gave them copies.

COMMISSIONER: Was Mr Simpson there at your request?-- Yes

MR ANDREWS: You have told Dr Fitzgerald what you thought should be done with Dr Patel - namely, that he should be stood down?-- I thought he should be stood down whilst an investigation was carried out, yes.

What did Dr Fitzgerald respond?-- Dr Fitzgerald said that - said that what would we do without a surgeon at all, if Bundaberg didn't have a surgeon, and what solution could I offer to the hospital if Dr Patel didn't - wasn't there. So I suggested that Dr Gaffield took over as Director of Surgery during that time.

Was that a reasonable suggestion?-- Well, I thought - I thought it was, but as Dr Fitzgerald said, none of the things that I had said had been proven yet and Dr Patel was - he had - it had to be proven, basically, before they would accept that these things that I was saying were true.

COMMISSIONER: Sorry, this is in about March of this year?-- Yes - February this year was the fact-finding mission.

Okay. And the truth of the matter, as you knew it, was that Mr Leck had had full details since at least October of the previous year?-- Yes, yes. And he gave - he gave the letter to the audit and operational branch of Queensland Health on the 16th of December. So there was a delay from when I handed that to him on the 22nd to the 16th of December.

So it took two months for Mr Leck to do something after you told him the problems?-- Yes, yes.

Then it took another two months for Queensland Health to do something?-- Yes.

After Mr Leck referred it up the line?-- Yes, yep.

Then by the time Dr Fitzgerald came to see you, his response was to say, "Well, we can't do anything because nothing's been proved at this stage"?-- That was - that was his response. And, please, in saying that, Dr Fitzgerald was extremely pleasant and kind to us.

Yes, yes?-- And I don't want that to sound derogatory in any way.

No, no, he obviously has to operate within a system?-- Mmm.

He does his best?-- But meanwhile, all the nurses in intensive care were seeing these patients dying every day and we couldn't - we could not do anything. It came to a point where we had discussed all of the things we'd done, all of the

people we'd been to and we just thought, "What on earth can we possibly do to stop this man?" We'd taken to hiding patients. We'd taken to telling patients that, you know, they should be - they should ask to be transferred to Brisbane. We had - we were doing all sorts of things which, really, we shouldn't have been doing.

MR ANDREWS: Ms Hoffman, on the topic of hiding patients, you do seem to deal with it in your statement from paragraph 149. Let me remind you of an incident that you've described there. On the 4th of March 2005 there's an incident relating to a patient P33?-- Yes. Yes.

Do you remember that patient?-- Yes, vividly, yes.

Is it the case that a principal house officer, when inserting a dialysis Vascath, nicked the carotid artery?-- Yes.

Is that something that needs corrective surgery?-- Yes. Straightaway, because the man was also on Warfarin, which thinned his blood, so he was bleeding a lot more, and he was a Jehovah's Witness, so he couldn't have any blood products. So he needed surgery quite urgently and he was a patient of Dr Miach's, and Dr Patel walked into the theatre and came up to the bed and asked what was going on and asked whose patient it was and they said it was Miach's and he said, "Okay, I won't touch him then", and walked away. But after saying that, he walked straight into theatre and told the theatre nurses to get a theatre ready because he was going to operate on this man's artery and Dr Miach said, no, he's transferring him to Brisbane and refused to let him operate on him and all day - not all day, for probably about six hours Dr Patel kept hanging around, which is what he would do. He would sort of, like, actively seek out patients to operate on and he was hanging around this patient, hanging around the junior doctor, the PHO - the PHO who had put the Vascath in who already felt really bad enough that he had done this and he was - he was hanging around him and Dr Miach said to me, "Don't you leave" - "Don't you leave this man alone. Don't you let Dr Patel go near him. If there's any further interference" - you know, "If there's any interference, please call me", and we arranged an RFDS transfer and transferred the patient to - to Brisbane to my knowledge.

And did - how long did it take for that transfer to be arranged?-- Oh, once - if they've got a bed and they can get the plane, it only - it's only a 55-minute flight.

Yes, but-----?-- Two hours.

I'm wondering how long it was that - after the nick that it had been determined that a flight transfer to Brisbane was a possibility?-- Well, he was - he was in the ICU for about six hours, so it was probably just later on that evening that he went.

Now, you telephoned Linda Mulligan about this incident?-- Yes I did, because at one point it looked like the patient was

going to die. He had started to go bradycardic and lose his blood pressure and I thought he was going to die, so I wanted to let her know that this was going on in the ICU.

Why did you call this a sentinel event?-- Because it was heading for what I thought was a death caused by a surgical procedure.

But in this case, not a procedure performed by Dr Patel?-- No.

Now, you subsequently received an e-mail from Ms Mulligan in response to your telephone called advising her of the sentinel event?-- Yes.

Is that TH44? Would you - you will be able to see it on the monitor?-- Yes.

Had there been a definition of "sentinel event" created by Queensland Health by this stage?-- Yes, there had been, yep.

COMMISSIONER: Where can we find that definition?-- It's on all of the risk management and sentinel event forms that - at all of the Queensland hospitals.

I wouldn't-----?-- Should be on the G drive. I can get you a copy if you want.

I wouldn't expect you to remember the precise words but can you tell us what the general effect of it is?-- Of what a sentinel event is?

Yes?-- It's like a - a suicide of a patient in hospital or a death whilst under anaesthesia, or amputation of the wrong limb, wrong blood products being given, death of an infant in hospital, there's several things.

What category did you think that this one fell into that made you think that it was a sentinel event?-- I thought he was going to die.

Right?-- So I thought it would be a death, you know, whilst undergoing a procedure.

Yes?-- And - so when I actually called Ms Mulligan, I was - that's - he was so serious that I thought he was going to die then, he was bleeding so severely. And I said, you know, "This would probably be a sentinel event", and then she sent me back that other e-mail saying that I was obviously - "It appears, however, that you're unfamiliar with the current Queensland Health definitions for this as this is not the case at the moment." Well, it wasn't the case at the moment because the patient hadn't yet died but I thought he would die. But anyhow, thankfully he didn't die and he stabilised out a bit and we transferred him or according to my e-mail at round 4 o'clock that day.

Now, you speak of another patient at paragraph 153, a patient

who was to have an oesophagectomy?-- Yes.

Were you simply informed of this?-- This patient-----

Do you have personal knowledge of it or was it something-----?-- Yes, no, I have personal knowledge of it. It was a patient who was supposed to have an oesophagectomy done. It was - and then for some reason or another, Dr Strahan was involved in the patient. She was an elderly lady and he must have been called in on consult to see her and he didn't - he wanted her to go to Brisbane to be operated on. He didn't want Dr Patel to operate on her. So he admitted her to the ICU medically instead of surgically and then arranged a medical transfer, medical to medical to Brisbane so that Dr Patel couldn't operate on - on her.

COMMISSIONER: Was he the only doctor to your knowledge actively trying to keep his patients out of the reach of Dr Patel?-- Apart from Dr Miach who had done it very early on in piece, he was with the renal patients.

Yes.

D COMMISSIONER EDWARDS: Did the medical superintendent express to you or the nurse - senior nursing staff concern at any time?-- No, he did not, and this, this was one of - something else that happened prior, prior to us going to Dr - Mr Messenger, was that Dr Patel received employee of the month, after we'd put in our complaint, Dr Patel received employee of the month - an employee of the month award in November for his contribution to the tilt drain disaster. He also came and told us that he'd received a $10,000 bonus and his contract was extended by four months, so we had put in all of these complaints and this just came back just like a big huge slap in the face to us that none of us - that it didn't, like, the seriousness of these complaints to me was like, like a bad book that had been written and I couldn't understand why anybody wasn't acting upon them, but instead, he was getting rewarded and we were getting ignored.

D COMMISSIONER VIDER: Is there a policy with appropriate characteristics so that, you know, to be nominated for the employee of the month award?-- I don't know.

COMMISSIONER: Who decides the award?-- Peter Leck.

Yes?-- It can - other people can nominate them, but it's his ultimate-----

D COMMISSIONER VIDER: So there is some criteria?-- I think so.

COMMISSIONER: Mr Andrews, I understand the next area of evidence is the complaint to the - Mr Messenger, the member of Parliament. I wonder whether it's better for us to hear that directly from Mr Messenger rather than in a sort of second-hand way and whether we shouldn't therefore be moving on to about paragraph 167?

MR ANDREWS: Paragraph 167?

COMMISSIONER: Yes.

MR ANDREWS: That seems most practical, thank you.

COMMISSIONER: Just while I think of it now, may I raise something else? I - during the course of this afternoon's evidence, a number of patient names have been mentioned, obviously the members of the press and media will be aware of the direction that's already been given about that, but we might - someone might make a note to check that before the transcript goes on the internet that those names are covered up, particularly the names of patients 22, 44 and 21, I think, have been mentioned in whole or in part during the afternoon.

MR ANDREWS: The 23rd of March 2005, Linda Mulligan on holidays, there was an Acting Director of Nursing, Dianne Walls, and a Mr Peter Leck who met you and assembled staff. Had you in fact called in some ICU staff who were not rostered on that day so that they could be at the meeting?-- Well, I was just told that Linda was coming down to talk to us and I thought she was coming down to debrief us about the media, you know, the events and what had happened.

The events in the media?-- Well, the events that, yeah, the events in the media, you know, that, that had been reported in the media by Rob Messenger, and so I called in all of the staff that were involved in the complaint because I actually thought we were going to be, like, commended, so they came in on their days off and when and - when Deanne came down, she came down with Peter Leck and he, we went into the ICU tea room and he was furious with us and he just told us that he - that this was appalling, that this doctor of such good high standing should be not accorded natural justice and how - and he was visibly furious with us and it - he was so angry and he brought down, he bought down photocopied copies of the Code of Conduct for Queensland Health and an IRM about what happens to whistleblowers.

Is an IRM an Industrial Relations Manual?-- Either that or an internal - I can't remember what exactly it stands for at the moment, but it's part of our - we've got sort of an IRM that we go by, I don't think it's industrial relations manual, it's more internal - I forget at this moment, I forget.

And what did that IRM reveal?-- That we could go to gaol for two years for releasing this information to an unauthorised person, and they also had, I think they had the photocopy copies from the - from the Ethical Standards Group, I think they had the photocopies of the PowerPoints from that and they went on to just say that this was the most appalling thing that could ever happen, that it would - that there would be no, that there'd be this terrible rift between the doctors and the nurses in the ICU, that no patients in Bundaberg Hospital would ever come back to the hospital because of what had happened, that this was so unfair, unfair to this man to do this and he probably berated us for about 20 minutes.

COMMISSIONER: Did he make any mention of what he'd been doing for the past over five months since you'd originally brought these complaints to your attention?-- No, he didn't allow us to speak at all.

MR ANDREWS: Did he tell you what processes he'd put in train to investigate Dr Patel's fitness to practice?-- No, only about the Gerry Fitzgerald fact-finding mission.

Did he mention the Gerry Fitzgerald fact-finding mission at this meeting?-- He may have, I - he may have. I mean, all I remember is being, is just being screamed at and being threatened with gaol and-----

The IRM document that Mr Leck brought with him, did you read it or did he tell you the effect of it?-- I think he told us the effect of it.

D COMMISSIONER VIDER: So you'd gone to Mr Leck with issues of concern, clearly outlining these case studies of these clinical matters and then when Mr Leck came to the unit following the release that was then publicly mentioned, the facts of that matter were ignored?-- There was no attempt-----

And the attempt that - the point of the conversation was to say that you had no business to speak out?-- Yes.

And that the consequences of speaking out was a possibility of a gaol sentence for two years?-- Yes, I'd lose my job and I would get put in gaol, yep.

COMMISSIONER: Mr Andrews, I'm anxious to give an opportunity to Mr Allen to ask anything additional he wants to if-----

MR ANDREWS: In the circumstances, I'll let the statements speak for itself.

COMMISSIONER: Thank you Mr Andrews. Mr Allen, is there anything you wish to raise at this stage?

MR ALLEN: Very briefly please, Commissioner.

COMMISSIONER: Thank you indeed.

EXAMINATION-IN-CHIEF:

MR ALLEN: Ms Hoffman, yesterday in response to a question from the Deputy Commissioner Sir Llew, you said, and this is at page 66 of the transcript for the benefit of the lawyers here, that you understood that there was some type of published admission and discharge policy?-- Yes.

For the intensive care unit?-- Yes.

If you could have a look at this document please? And I'll hand Madam Bailiff three copies for the Commissioners. Did you take steps to try and locate a copy of such policy?-- Yes, last night I rang the ICU and asked to fax it.

All right. And this is the document that you received by way of fax?-- Yes, to Gavin's office, yep.

And it's entitled an "Intensive Care Unit Protocol" and in particular, intensive care unit admission and discharge policy?-- Yes.

It's dated the 1st of July 2003, so it would have applied

during the majority of time that you were at the Bundaberg Base Hospital?-- Yes.

And it's under the hand of Dr Martin Carter?-- Yes.

Now, in relation to the contents of that, it appears to provide for the criteria for persons to be admitted to the Intensive Care Unit?-- That's right.

And under the subheading on the first page, "Description of Services Offered", it's stated, "The intensive care coronary care units are Level 1 facilities."?-- Yep.

That's consistent with the understanding you stated in evidence that the Bundaberg Base Hospital Intensive Care Unit is a Level 1 ICU?-- Yes, that's right.

At any time prior to recently seeing a Queensland Health submission to this inquiry describing the ICU at Bundaberg as a Level 2 facility, had you ever heard it described as such?-- No.

I'll tender that Intensive Care Unit Admission and Discharge Policy.

COMMISSIONER: Yes, the admission and discharge policy will be Exhibit 9.

ADMITTED AND MARKED "EXHIBIT 9"

MR ALLEN: And just before leaving that, on the last page of the document, at the end under the heading "Bibliography", there's reference to the Australian and New Zealand College of Anaesthetists, 1994 Guidelines; would that seem to be an earlier form of document to that which you were asked to look at yesterday which was a publication of the Joint Faculty of Intensive Care which set out the criteria for Level 1, 2 and 3 intensive care units?-- Yes.

Exhibit 6 for the record?-- Yes.

Thank you. You told us today about the circumstances surrounding the care or lack thereof of the patient Mr Bramich, and you mentioned the distress that was caused to nursing staff who were present in relation to Mr Bramich. That included, to your knowledge, a nurse who was present during the attempted pericardiopericentesis which you've described as leaving Mr Bramich with multiple stab wounds. You mention one of those staff actually seeking the help of a private psychologist?-- Yes.

Was that the nurse who witnessed those events?-- Yes.

Is that - you've continued as nursing unit manager at the

Intensive Care Unit and would, of course, be live to all staffing issues in that unit. Is that nurse working at the moment?-- No.

Do you know why?-- Because she's so upset.

Was she one of the nurses for whom you sought assistance from the Employee Assistance Scheme unsuccessfully?-- Yes.

Was she a nurse who therefore had to go to a private psychologist?-- Yes.

And as you understand it, one of the reasons why she is currently unfit to work is experiencing those events?-- Yes.

Given your involvement in what occurred afterwards, do you know whether there are any other factors that contributed to her current condition?-- Apart from?

Mr Bramich?-- Well, all of the issues surrounding this whole situation.

Was she present during any of these occasions you've described in your statement where staff were, for example, yelled at by Mr Leck?-- Yes.

And told that they could be liable to imprisonment?-- Yes.

And when you said in answer to a question from the Deputy Commissioner Ms Vider that there are still staffing issues flowing from that that remain to be resolved?-- Yes.

Are you aware of any other nursing staff at the Bundaberg Hospital who are still suffering the effects of Dr Patel and Queensland Health's response to it?-- Yes.

Are you able to say how many?-- I think everybody in the Intensive Care Unit is affected?-- To different degrees, and there's another girl who had to go and work in another hospital but I think everybody-----

Has Queensland Health offered you yourself personally and other staff under you some type of counselling or assistance to try and address these issues?-- Yes, they have.

All right, and what has that consisted of?-- That consisted of them supplying us with counsellors that came up after all of the issues came out, but as I pointed out to them, they sent all these people up there but they didn't relieve any, they didn't relieve the staff in ICU so the ICU staff could attend the sessions, so ICU staff continued to care for the patients while all of the other staff at the hospital could access these services.

And what can you tell us about the intensity of ICU during the last couple of months since these issues have all arisen?-- Well, it's been, it's been, it's still been busy, we've still had, you know, a lot of patients but obviously not the same

types of patients, and I think there's just been a huge sigh of relief that we're not having to try and protect every patient that comes in from Dr Patel, but we've also had to continue working there on a day-to-day basis plus at the beginning when we were totally vilified by the people, other people in the hospital and doctors in town and so everybody's continued to work under that sort of atmosphere and care for the patients.

Do you think that there's anything else that could usefully be done now or in the immediate near future to try and assist staff who are still suffering the effects of these circumstances?-- I arranged for them to have some time off by giving them some TOIL.

That's time off in lieu?-- Time off in lieu because a lot of them were coming in to attend all of these things in their own time.

And when you say "attend these things" what are you talking about there?-- Oh, we had to go and be interviewed by Homicide, by CMC, by - or the lawyers, not that that was traumatic, meet - often lots of meetings.

And are staff having to do those things as well as try and do all their normal duties?-- Yeah.

So you are saying one of the things that could possibly be done to assist staff is to recognise the commitments being placed upon them by assisting inquiries and give them some time off?-- Yes.

All right. And you have endeavoured to do that with your own staff?-- Yes, I have, yeah. I did ask - I did ask officially Queensland Health through - through our Director of Nursing, through Nita Cunningham, and I think even Steve Buckland was present, for some - if we could get some agency staff so that we could actually release some of our staff for a while, but the acting district manager just said the staff could only use the time they had available to them, their holidays. They weren't allowed to have any other time off.

COMMISSIONER: Mr Allen, I am sorry to interrupt this evidence but let's see if I am more successful than everyone else has been.

Mr Farr, will you get instructions overnight and be in a position to tell the inquiry tomorrow morning whether, consistently with the assurances of cooperation that have been provided by the Director-General, he will provide paid leave for any staff of Queensland Health anywhere in the State who are involved in either this inquiry or the CMC inquiry, and whether he will make funds available to provide agency nurses or other appropriate relieving staff so that staff can deal with those matters.

MR FARR: I will take some instructions.

COMMISSIONER: Thank you, Mr Farr.

MR ALLEN: If I could just take you lastly to page 48 of your statement?

COMMISSIONER: Which paragraph, Mr Allen?

MR ALLEN: Page 48, paragraph 142, Mr Commissioner.

WITNESS: Yes.

MR ALLEN: I may have heard wrongly, or it may have been a slip of the tongue, but my recollection is that you mentioned that this exercise you describe in paragraph 142 was an attempt to identify those patients who had suffered complications after the fact-finding mission by Dr Fitzgerald commenced?-- Yes, that's right.

So you were attempting to identify so as to inform Dr Fitzgerald of prior cases of complications?-- No, I had my list of prior ones that I asked for them to look at and then after Dr Fitzgerald came up, these were the ones that we had after that fact-finding mission. What I was trying to, I

think, look at was if Dr Patel had been suspended or stood down whilst the investigation carried on, that these patients wouldn't have suffered these complications. That's what I was trying to look at.

I see.

COMMISSIONER: So is there - for example, P26, if Dr Patel had been stood down, the patient P26, the 15 year old boy, might still have two legs?-- Yes.

MR ALLEN: So in your letter to Mr Leck, dated the 22nd of October 2004, you had listed certain specific cases up until that date?-- Yes.

And then before speaking to Dr Fitzgerald in February 2005, you went back and looked at those cases that had occurred between late October 2004 and February 2005?-- Yes.

And that included, for example, patients P21 and P26 who we know both suffered at the hands of Dr Patel shortly before Christmas 2004?-- Yes, that's right.

I see. So the cases set out in paragraph 142 are really those which occurred between late October '04 and February '05?-- Yes.

Thank you. Thank you, Commissioner.

COMMISSIONER: Thank you, Mr Allen. I know it is a little after 4.30 but I would like to raise a couple of matters of my own interest. You will appreciate that we have two functions. One is to examine what's gone wrong in the past, the other is to make recommendations for the future. And I would ask your assistance, if it is possible, just to provide your comments on a number of the suggestions that have been made to us in various submissions and other means. Firstly, can I ask were you working for Queensland Health at the time when regional hospitals were under the autonomous control of local hospital boards rather than the present regional and zonal structure?-- Yes, I was.

All right. Are you able to make any comparison between the administrative efficiency as you observed it under the old system as compared with the present system?-- To me it seemed - it worked better then but I don't know if we're at a different time and age now. So there has to be a better system than the one we work under now.

One of the things that has been suggested to us is that, for example in your case at Bundaberg, if the hospital was being run by a hospital board consisting of local people, the local solicitor, the local accountant, the local shopkeeper, they would have been a lot more proactive in dealing with your concerns than possibly Charlotte Street was?-- Yeah.

Do you have any thoughts on that?-- Oh, no, I think that's - I think that's true and I think one of the things that I feel

really strongly about is that I think for all - there is all of these things that exist, there is the Health Rights Commission, there is the CMC, there is all of these people that exist in their own entirety, but we need nurses and other people in the hospital, need someone who is independent of the government at the time and the hospital to be able to go to to take concerns to that can be investigated.

Well, that was another thing I was going to ask you. One of the other suggestions that's been made to us is the establishment of a stand-alone body, a Commission, I guess a bit like the CMC that is specifically dedicated to health issues which, not only nurses and doctors and other medical professionals, but also patients and patients' families can go to with their complaints knowing that it stands completely outside Queensland Health and is entirely independent of Queensland Health?-- Yes.

Is that the sort of thing-----?-- Yes.

-----you are hoping for?-- Very much so. And also the ability to feel that in a country like Australia, that we should be able to - if we have got an issue, that we should be able to bring it up, if it is appropriate, to the Member of Parliament, and even to the media, even though perhaps that's not the best way to do it, and I hope that the way that this has happened never has to happen again, but - but I just think that we should have - we should be able to be heard somehow.

Well, one of the precedents that we have been looking at is the law in New South Wales where a whistleblower is expected to go through the proper channels first, but if, after a period of time, the whistleblower has no success going through the administrative structure of their own department or to other autonomous government bodies, then they have the legal right to go to either a Member of Parliament or to the press to make their complaints known?-- Yeah.

Is that the sort of thing that you-----?-- That's what I - that's what I think. I think that if we had had that ability or we felt comfortable in doing so early on, perhaps we would have acted much earlier than what we did.

Yes?-- Because it got to the - I mean, you know, when we did what we did, we were desperate, absolutely desperate.

Another suggestion that's been made to us is that a lot of the problems at the operational level within Queensland Health hospitals have arisen because each year a larger share of the total health budget is going on administration?-- Yes.

Rather than doctors and nurses?-- Yes.

What has been your experience of - I think it is 25 years or so that you have been in the health system? Have you observed any changes in the way in which these things operate?-- Yes. There is - I mean, I don't even remember recalling such a thing as corporate office when I started nursing and I don't

know how many people corporate office now employs, but there must be an awful lot of money that's spent in those areas. And the other big issue is accessibility. When - like, people from corporate office would come around but you would never bring up with them an issue or tell them an issue of what was going on in the hospital. I mean, we had difficulty even telling our district manager or our Director of Medicine an issue. The people in charge of the hospitals have to be accessible, they have to be - they have - they have to see their staff and their patients. Doesn't matter who they are, really.

Indeed, one of the suggestions that's been made to us is that no hospital in Queensland should be managed by someone who isn't a clinician, either a doctor or a nurse or some sort of medical professional who is able to be active in the operational parts of the hospital and speak to medical and nursing staff about the issues that they are dealing with?-- Yes, that's right.

How do you feel about that?-- Yep, I think that's very true. If we - if we had had some - you know, if we had had somebody to take our concerns to early on, I think - and who took our concerns seriously, I think that this would never have happened, and we have to tighten all of our procedures, from when we recruit staff, and reference checking and things like that. A nurse can't get a job without having three references, so how can a Director of Surgery get a job without a reference? I mean, just basic things, absolutely basic things. We have to be so much more tighter in the things that we do.

Sir Llew?

D COMMISSIONER EDWARDS: Many years ago there was a trial program on what was called The Patient's Friend in Queensland hospitals which was thrown out because of many reasons, according to what information I have had. That person was totally independent of the system but could accept reports on his own, and so forth, not to mention other matters. But do you think there should be some independent person/group who is not bound by the health department to which concerns such as you have had over the years would be referred and be independently considered?-- Yes, I do. Something like a clinical ethics committee or something like that where people could take their issues to and be examined, yeah. I mean, I am sure that, you know, the majority of complaints that, you know, that they got, they probably wouldn't be necessarily valid, but just the one that happens to be might be the one that saves some people's lives.

D COMMISSIONER VIDER: A comment. The Australian Council on Healthcare Standards now has been in existence for nearly 30 years in Australia, and its national, that system?-- Yes.

It is based on the principles of peer review. I presume the Bundaberg Hospital is part of that process with ACHS?-- It is an accredited hospital, yes.

That process has a framework that could be used that would stop duplication of everything. You know, it has got a national standard for clinical indicators and those sorts of things that would provide avenues for clinical auditing, review, new proactive ways of clinical practice and all that. Would you see that, if that was promoted nationally, as being feasible to go with that as some sort of review and quality assurance tool that we could all adopt?-- Yes, I do. That would be good, too.

Yeah?-- Yeah. And I think, too, that all hospitals should have a morbidity and mortality meeting that everybody attends, not just the doctors, but the nurses need to be a part of it as well, you know, because you need to be looking at process, and where processes fall down, what you can do to fix them.

Yes, and all that is part of the ACHS framework?-- Yeah.

It is all there. Perhaps at times we're not best at implementing the elements of that, but the framework is there. We don't need to go duplicating something?-- Yeah.

Thank you.

COMMISSIONER: Thank you very much for coming to give your evidence over the past two days. I understand that if you wait around, the Secretary will be able to inform you of travel arrangements. You have the option of either going back to Bundaberg tonight or staying overnight, whichever you are more comfortable about. You realise, of course, that after you give evidence to the Crime and Misconduct Commission in a couple of weeks' time, we will be wanting to see you again, as I say, hopefully in Bundaberg in about a month's time. But for the present, may I convey, on behalf of the Deputy Commissioners and myself, our thanks for making yourself available, and I didn't realise it was at your own expense, in the sense you are not even being compensated for your time here, but we appreciate very much your coming to give your evidence and the way in which you have given your evidence, the thoughtful and careful and helpful way in which you responded to all of the questions asked of you. We appreciate it very much?-- Thank you.

Thank you. We will adjourn now until 9.30 tomorrow.

MR ALLEN: Could I raise a matter?

COMMISSIONER: I am sorry, Mr Allen?

MR ALLEN: It really does arise from Ms Hoffman's evidence, and it is the evidence she gave regarding nurses being told by Queensland Health that they could face disciplinary or, indeed, criminal action if they spoke to people outside the department, including their union.

COMMISSIONER: Yes.

MR ALLEN: It has become clear in recent weeks that the position of the Director-General of Queensland Health remains that, absent a written authority from the Director-General, employees of Queensland Health who disclose matters concerning patients accept to those specifically authorised by the Health Services Act - and that doesn't include the union, for example - are, indeed, in breach of the confidentiality provisions of section - of the Health Services Act. Now, that position became clear in correspondence between my instructing solicitors and Queensland Health. That position has been maintained, but to address the concerns of my instructing solicitors in being able to take instructions from QNU members, the Director-General eventually, on the 16th of May 2005, signed an authority pursuant to section 62F of the Health Services Act authorising QNU members only to provide information relevant to the various inquiries into the Bundaberg Base Hospital, but to certain specified persons, being my instructing solicitors, any counsel engaged by them for any official inquiry, and to the QNU itself for the purposes of official inquiries into the Bundaberg Hospital matter.

Whilst that might address the situation regarding members of the QNU, it would certainly not address the position of other Queensland Health employees, be they nurses or otherwise, and I ask the Commission to consider whether in fact there should be - the Director-General should be invited to make a public statement that Queensland Health employees can communicate concerns regarding the matters the subject of this inquiry without fear of any type of repercussions.

COMMISSIONER: Mr Allen, I would invite you to take this up again in the morning and at that time provide me with copies of the relevant correspondence and then I will invite Mr Farr or Mr Boddice, if they're back, to respond and I can foreshadow that unless there is some very persuasive argument that I hear from those here representing Queensland Health, I will personally be outraged if it is the case that the Director-General has prevented any employee of Queensland Health anywhere in the state from communicating freely with any of the parties or the legal representatives who have been given leave to appear here, whether its your client and its organisation, Mr Tait's client, the AMA or any of the other parties involved here. At our end, we have done everything humanly possible to make this an open inquiry and I just can't understand a mentality that would suggest that any employee of Queensland Health should not have the opportunity to speak freely to anyone involved in this inquiry to air their concerns and grievances but I will hear what is said on behalf of the Commissioner of Health.

MR HARPER: Commissioner, I may just say on that point on behalf of the patients, it obviously would be a matter of concern were the patient information, which I understand was the purpose of the direction, be able to be freely given to any party who has expressed some interest in it. Obviously the Commission is able to obtain that information under its powers but without having specific instructions from my client, I can't take it any further but I should foreshadow we may have some interest in that debate tomorrow.

COMMISSIONER: Yes, I understand entirely there may be needs to maintain confidentiality and, indeed, Ms Hoffman has given us all the example of how it can be done properly by providing code names for patients so that individual names don't have to be mentioned. But my concern is not issues of patient confidentiality, which of course do have to be protected, but any attempt to maintain confidentiality in relation to either real or perceived flaws in the administration of Queensland Health. But if anyone has information on that subject, which being a doctor they'd like to provide to the AMA or being a nurse they want to provide to the nurses unit or being otherwise involved in the health industry, whether as wardsmen or as administrative assistants or anything else, if they want to make available either directly to this Commission or through one of the parties, I think they should be given every opportunity to do that in the way that they feel most comfortable about doing it.

MR HARPER: Thank you, Commissioner.

COMMISSIONER: Anything else? 9.30 tomorrow.

THE COMMISSION ADJOURNED AT 4.55 P.M. TILL 9.30 P.M.