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Transcript of Proceedings

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IN THE MATTER OF THE COMMISSIONS OF INQUIRY ACT 1950

BUNDABERG HOSPITAL COMMISSION OF INQUIRY

COMMISSIONS OF INQUIRY (No. 1) 2005

BUNDABERG

..DATE 21/06/2005

..DAY 11

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THE COMMISSION RESUMED AT 10.01 A.M.

COMMISSIONER: Just before we get started, I mention that we have had some discussions and it has probably become apparent to those at the bar here anyway that yesterday's evidence didn't progress quite as quickly as had been expected. I make no criticism for that because it is important evidence and the time taken, I think, was extremely useful, but one of the possibilities that we are looking into is extending the Bundaberg sittings to a fourth week. I just mention that now so you all have an opportunity to check your diaries and accommodation arrangements and so on. No decision has yet been made, but it may give you an opportunity to put further logistics in place if necessary.

MR DIEHM: A fourth consecutive week?

COMMISSIONER: Yes. Anyone wish to raise anything before we start the next witness? Mr Andrews?

MR ANDREWS: In the circumstances, I call Lindsay Druce.

LINDSAY SIGRID DRUCE, SWORN AND EXAMINED:

MR ALLEN: If it please the Commission, I appear for Ms Druce.

COMMISSIONER: Thank you. Ms Druce, do you have any objection to your evidence being filmed or photographed?-- No.

Thank you.

MR ANDREWS: Ms Druce, would you tell us your full name, please?-- Lindsay Sigrid Druce.

You are a registered nurse?-- Yes, I'm a clinical nurse at the Bundaberg Base Hospital.

COMMISSIONER: We can contact you through the Nurses' Union?-- Yes.

MR ANDREWS: Ms Druce, you are a Nurse Officer 2; is that it?-- That's correct, yes.

In the Renal Unit?-- Yes.

And have been for eight years?-- Yes, that's correct.

Have you prepared a statement in writing?-- Yes, I have.

And subject to some corrections that you are going to draw our attention to at paragraphs 7 and 15, is that statement true to the best of your knowledge?-- Yes, it is.

And the opinions you express in it, you hold them honestly?-- Yes, I do.

I tender that statement.

COMMISSIONER: The statement of Lindsay Sigrid Druce will be received into evidence and marked as Exhibit 67.

ADMITTED AND MARKED "EXHIBIT 67"

MR ANDREWS: Thank you, Commissioner. I'm informed that people up the back can't hear the witness. Perhaps if the microphone is adjusted. Ms Druce, you were on maternity leave for a year and came back to the Renal Unit in November 2003; that's the position?-- That's right, yes.

And you did a handover with nurse Mandy McDonald?-- On my return, yes.

You then discovered that there were problems with patients peritoneal catheters?-- That's correct.

It caused you to review the charts?-- Yes.

And as patients came in, you physically reviewed their catheter exit sites for infections and you checked the external position of their peritoneal catheters?-- That's correct.

As they came in, you noticed acute and chronic infections and complications?-- Yes, I did.

Can you tell me from your experience in other years earlier in the Renal Unit how commonly it was that patients coming in would come with acute and chronic infections?-- We keep records within the Renal Unit and we have a database called POET that we input data into - how many times patients experience infections, but what we found in reviewing POET that in the years of 2003, infection rates had certainly increased, and I felt it was in direct relation to the external positioning of the peritoneal catheters.

As patients attended, you would observe the position of the - or the external position of the peritoneal catheters?-- Yes.

You mentioned you saw migration of catheters; that means the movement of them?-- Yes, that's the internal movement of the distal end of the peritoneal catheter. Patients usually presented, though, with drainage problems. The peritoneal fluid could not drain out. We do certain tests to see if the catheter is blocked, and then we proceed to X-ray the abdomen to have a look at the internal position of the catheter and in the cases that I have outlined where migration has occurred,

on X-ray you could see that the distal tip of the catheter was up high inside the peritoneal cavity.

Now, you were - you eventually did a review that you turned into something looking like Exhibit LD1?-- Yes.

I have a copy of LD1 with patient names blacked out. I'll ask that you look at it on the monitor before you.

COMMISSIONER: Whilst that's being placed on the monitor, I'll just remind those members of the press and media who weren't with us in Brisbane that I've given a general direction that names of patients are not to be disclosed without the permission of the patient or, in the case of a deceased patient, without the permission of their next of kin or family. Now, obviously during the course of the evidence, some names will be mentioned, either accidentally or otherwise, or they will be apparent from the exhibits. We are really leaving it to the judgment and discretion of the journalists present to make sure that those names are not revealed any more than is necessary outside these proceedings. Some names, of course, have already become well known and there's no difficulty in using those names that already appeared in the press and media, but we trust your judgment not to embarrass people and their families by mentioning names that come up incidentally during these proceedings if the people are concerned merely as patients.

MR ANDREWS: I see that the columns in LD1 run vertically and horizontally. Please look at the vertical column second from the right headed catheter position. You describe three types of positions: upways, side-upwards, and sideways?-- Yes.

Are they the positions of the catheter at the time that you saw them or the positions of the catheter when it was first inserted?-- Well, no, I wasn't there when they were first inserted because I was away on maternity leave, but they were the positions when I started reviewing all of the exit sites, but let me say the positions don't change because they are surgically implanted catheters, so that would have also been the position at the time of insertion.

So, the migration that can occur doesn't change the catheter position?-- No. Migration just - is dependent on that distal tip of the catheter internally. This is the external positioning of the catheter.

You raised your concerns with Dr Miach in December and began to do a survey?-- Yes, basically. I was directed by Dr Miach to maybe look at positionings and infection rates and so forth and started to compile these findings.

And when you began to see disturbing conclusions emerge, you went to Dr Patel?-- Yes, Dr Patel came into the Renal Unit to review a patient and when he was about to leave the Renal Unit, I caught up with him and I introduced myself and told him I was the peritoneal dialysis nurse and that I would like to take the opportunity to talk to him about the placement of

the Tenckhoff catheters or peritoneal dialysis catheters.

And was an approach by a peritoneal dialysis nurse to a surgeon a normal thing to do?-- Well, the previous surgeons I had had contact with - for instance, one of the previous surgeons, Dr Nankivell, would discuss catheter placements with me. I have also spoken to other surgeons, so I didn't feel that I was out of my place by talking to him directly.

Did you raise your concerns with Dr Patel?-- I tried to, yes.

What did he say?-- He was dismissive of me and I think he told me that he was the surgeon and he just walked away.

You continued to compile your findings?-- Yes.

You were particularly distressed by an event on 17 December-----?-- Yes.

-----2003?-- Yes, I was.

COMMISSIONER: Just before we come to that event, Mr Andrews, you will understand that I'm a lawyer, not a medical person, so I don't entirely understand these things. If you can help me by explaining what exactly it was with the placement of the catheters that caused you concern that you wanted to explain to Dr Patel?-- Well, the catheters that we use are called swan neck catheters. They have a double cuff and a coiled end, so basically the catheter - the catheter is simply a tube that allows dialysis fluid to flow in and out of the peritoneal cavity. The catheters we use have a pre-formed bend along the shape - or halfway along the shape of the catheter, so they are actually a bent catheter. When they are placed internally, if the distal end or the coiled end is placed low into the peritoneal cavity, the external part of the catheter should exit the subcutaneous tissue and skin in a downward facing action, reflective of the catheter's shape. If the catheter is inserted, in my view, correctly, this is what happens: the catheter exits the skin in a downward-facing direction. The concern was that these catheters were facing sidewards or upwards and allowed, for instance, when the patient showered, fluid and secretion to pool inside the tunnel that was created for the catheter's exit, and giving rise to infections - acute and chronic infections. Patients actually could express fluid and in some cases pus out of the tunnel of that catheter, which should normally drain away, not pool within the tunnel itself.

When you then talk about catheters migrating, I think you said earlier that they don't actually move internally once they are placed?-- No, the - no, the internal tail-end of the catheter can move, but the external positioning is fixed because the catheter has two Dacron cuffs that embed into the tissue, so the external portion of the catheter coming out of the skin doesn't move, but certainly the internal section of the catheter can move, especially if it is not sutured down.

And how do you tell, looking at the patient from the outside,

whether the internal end has moved?-- Okay, the patient would present to me with problems of drainage - that their peritoneal fluid that they normally drain in and out of the peritoneal cavity to allow dialysis to occur, they are unable to get that fluid out, and maybe if you think of the catheter as a straw in a cup, if you don't have the tip of the catheter in the base of the peritoneal cavity and it is sitting up outside the cup, you are not going to be able to drain that fluid out, so it is the internal positioning of the catheter that has moved, so they will present with a drainage problem. So, what I would do is connect them to a dialysis solution bag and I would see if I could get the fluid to drain out by moving the patient - making sure that the catheter wasn't blocked by instilling some fluid into the catheter to look at the patency of the catheter. If all of those interventions failed, I would then contact either Dr Miach or one of his doctors and ask that a plain abdominal X-ray was performed, so that the catheter has a radio-opaque stripe along the length of the catheter, so on the X-ray we could clearly see where the distal end of the catheter was lying, the internal portion of the catheter and, in some cases, the patients presented and the catheter - the internal end of the catheter was sitting up, say, for instance, up under the liver, so then the peritoneal fluid couldn't drain out.

On the document that's on the screen at the moment, where it mentions catheter problem migration, is that something established through X-ray in each case, or-----?-- Yes.

Okay?-- So, the migration is looking at the internal portion of the catheter.

D COMMISSIONER EDWARDS: The migration would be around amongst bowel and other organs?-- Yes. Sometimes the catheter migrated sort of up - up to, say, the hip area and the iliac area, but sometimes it was as high as up under the liver.

Would it be fair to say the migration would not be a problem unless an obstruction occurred in the drainage?-- Catheters can migrate for a variety of reasons; sometimes, you know, if a patient is extremely constipated, the catheter can move inside just with the pressure of the bowel, but normally it is not a problem, but it does cause outflow drainage problems, certainly.

MR ANDREWS: With the schedule that's on screen at the moment, there are six instances, each of them the surgeon was Dr Patel?-- That's correct.

Is that six out of six catheters placed by him, or have you only listed those that resulted in-----?-- No, I reviewed every catheter placed by him in 2003 and they are the catheters placed.

So, it was 100 per cent - you might not say failure rate, but 100 per cent complication rate?-- Certainly.

How would that compare, in your experience, with other

surgeons - what sort of complication rate would you normally expect?-- The time that I was there, I don't believe - I think Dr Nankivell may have had one catheter migration. Another surgeon had a problem with omentum wrapping around the distal end of the catheter, but this certainly alarmed me because it was so significant that every patient was presenting with problems. I can't give you the facts. I would have to go back and review to see exactly how many complications, but as evidenced by our peritoneal dialysis peritonitis rates and infection rates, certainly Dr Patel had - we had a high rate of infection between 2003 and 2004 based on these catheters.

COMMISSIONER: I'm just thinking in statistical terms, we have got here a 100 per cent complication rate for-----?-- Mmm, patients do - sorry.

Is it possible to say that there is some benchmark that anything over 10 per cent or 20 per cent or whatever the figure is is a matter of concern?-- What we tend to look at - we do look at infection rates and peritonitis rates for catheters. We don't necessarily look at migration rates because migration is not a common complication of the catheters. So, what I had looked at in the past was infection rates by systems using the catheters and the fluids and I could draw you back to maybe 2000. We had - for peritonitis rates that we reviewed we had - we look at total patient months per peritonitis episode, so that's the statistics you are looking for. In 2000, we had a rate of, say, 20.4 patient episodes total patient months per episode of peritonitis. In 2001, we had - 36.1 was the rating. Then in 2002, the peritonitis rates dropped to 23.2, and the average, if you benchmark against other units, is about 20 to 22 rates.

Yes?-- In 2003, it dropped to 12.2 and in 2004 it dropped to 11.9. For 2005, it is climbing back up to 38.9.

One other thing: in relation to the migration, to your understanding, is there some procedure that should be undertaken to prevent the distal end of the catheter from migrating? Is it stitched in place or is there some-----?-- Usually with the swan neck catheters, they need to be tunnelled correctly. The tunnel needs to accurately represent the shape of the catheter when it is being inserted and there's been lots of studies to suggest, you know, different catheter configuration and catheter design, and the swan neck catheter is one of the best catheters to use to prevent complications such as migration. So, if it is placed correctly - and this is - the literature suggests that the tunnel needs to accurately reflect the shape of the catheter, then problems like migration tend not to occur.

In respect of the infection which is also shown on this schedule, are you able to identify what the causes of that infection are? I guess what I'm saying is that from my general understanding, infection can happen to any surgical patient through bad luck or bad management?-- Mmm.

Were you able to identify any particular causes of the instances of infection we see here?-- The patients presented with different types of infection, but certainly the fact that the catheter exited the skin in an upward fashion caused fluid to pool around the catheter creating the dark, moist, warm environment that organisms thrive in. So, I felt that purely the position of the catheter led to these patients experiencing increased infections.

Thank you.

D COMMISSIONER VIDER: You indicated that the distal end of the Tenckhoff catheter on X-ray - and you described it here as being upwards, you have also said some of them ended up in near the liver?-- In the column that says catheter position, that purely refers to the position exiting the skin, not the migrated - not the position of the catheters when they have migrated.

No, no, is that - is this the first time you have had this experience of the catheter position being as high in the abdominal cavity as that?-- I have had experience with maybe two other patients that the catheters have migrated, but they were with different surgeons - two different surgeons - but they are the only experiences I have had.

Thank you.

MR ANDREWS: Now, looking at that diagram, I see that migration is noted for three catheters for three patients only, and other problems noted in the "catheter problem" column for the other three patients?-- Yes.

When I look at the "catheter position" column, second from the right, and it describes upwards and other positions, I would like you to cast your mind back and tell me over your eight years in the Renal Unit, for how many of those years prior to your return from maternity leave were swan neck Tenckhoff catheters being used?-- We have always used them since I started in the Renal Unit back in 1998.

And on - how commonly would you find catheter positions upwards, side-upwards or sideways prior to your return?-- Never. They were always downwards.

COMMISSIONER: Mr Andrews, at some stage, would it be possible for us to get - we have a copy of this schedule as LD1, but, of course, the patient names are blocked out, and we don't have the patient code numbers, either.

MR ANDREWS: Would you look at my copy of the confidentiality key and tell me if I'm correct that the first patient in the left hand column would be P8 - P for Paul, 8?-- Yes, that's correct.

The second one would be P19?-- Yes, that's correct.

The third, P24?-- Yes, that's correct.

The fourth, P21 - sorry, P31?-- Yes, that's correct.

The fifth, P30?-- Yes, that's correct.

And the sixth, P45?-- Yes, that's correct.

Thank you. It was P30 who died on the 17th of December 2003?-- What number did you say? P31?

Well, your statement at page 2 says P30?-- Yes, P30. Sorry, that's correct.

Can you explain, please, why it is you attribute the death of that patient to the care or the intervention of Dr Patel?-- The patient had a peritoneal dialysis catheter placed by Dr Patel and we had - we usually leave the catheter in place for a month, so that the incision can heal, the Dacron cuffs can embed. After a month, there is less likelihood of dialysate leaking out around the tunnel. We started up his peritoneal dialysis, and we experienced - and we started training both him and his wife and we started experiencing outflow drainage problems. So, again, we tried - we checked the patency of the catheter, we then also then had the catheter X-rayed and the catheter clearly showed that the internal portion had migrated. This then required the patient to go back to theatre to have the catheter repositioned internally back down into the peritoneal cavity.

Can you suggest the reason the patient had to return to theatre was because of the - because of something that Dr Patel had done when surgically inserting the catheter to begin with?-- Well, I didn't feel the catheter had been tunnelled correctly internally, and the exit sites showed that it was a sidewards-facing catheter. The catheters tend to have what we call shape memory, so if you bend them out of their shape, they tend to want to return to their shape. So, if it is a shaped catheter and one part is on an angle, you will often find the internal section may move as a result of this shape memory. So, I just felt that if the catheter had been placed correctly and tunnelled and exited correctly, then the catheter would not have migrated. It was just my opinion.

Well, when you saw P30's catheter, it appeared sideways to you, did it?-- Yes. It was.

And that would have been the position in which it was when it was first inserted?-- Yes.

And do I understand it that it should never have been inserted so that it was sideways?-- In my belief, it should have been facing downwards.

And the fact that it needed surgical intervention, was it because of the migration or because it was sideways?-- No, it was simply because of the migration. There was nothing else we could do with the external tunnelling of the catheter to create - that catheter would have had to have been removed and

a new catheter placed. So, it was purely to address the migration of the catheter.

And are you able to say whether the migration was caused by Dr Patel's initial placement of the catheter or by some other cause?-- I can't really say if there was any other causes, but I still believe-----

Are you able to say what the probable cause was?-- I still believe it was tunnelled incorrectly and it should have been tunnelled in a downward direction.

And is the person who tunnels it the surgeon, Dr Patel?-- Yes.

D COMMISSIONER EDWARDS: Could I ask, was an autopsy done on the patient?-- Yes, there was.

MR ANDREWS: Now, you observed that the patient died as a result of a haemopericardium due to perforated thoracic veins during the insertion of a PermCath?-- That's-----

Was this during the - the insertion of this PermCath, the corrective procedure?-- The PermCath was inserted at the same time that the patient was having the repositioning of the Tenckhoff catheter. If we couldn't get good dialysis occurring with the peritoneal catheter, I believe that the PermCath was inserted so that the patient then could have access for haemodialysis.

Now, the process that resulted in the haemopericardium and the perforation of the thoracic veins, was that process carried out appropriately?-- I'm not sure. I wasn't in theatre at the time, so I don't feel I can comment.

COMMISSIONER: Your evidence is that it wouldn't have been necessary if the swan neck catheter had been placed appropriately in the first place?-- Yes, that the patient wouldn't have required the PermCath had the catheter not migrated and, yeah.

In your experience though, are you able to say whether the - what occurred on this occasion with the insertion of the PermCath, resulting in perforation of the thoracic veins, is that in itself one of the normal risks with inserting a PermCath?-- I have not experienced the death of a patient because of the insertion of PermCath in my renal experience.

Okay.

MR ANDREWS: Now, we come to paragraph 7 and you've a correction to make?-- Yes. In my original statement, I thought I presented the - I certainly presented my findings of this report to Dr Miach but it wasn't actually in this format. I created this document in February and left a copy for Dr Miach, but I certainly had just a pencil scribbled copy in this report and showed that to Dr Miach, so it was actually in February that I presented that report.

And, indeed, at paragraph 15 you've another correction. You observed that you completed the report and Dr Miach received a copy of it in January. As I understand it, you completed the report and put a copy of it in his in-tray in February 2004; is that the position?-- I'm sorry, that phone distracted me.

Did you put a copy of it into his in-tray in February 2004?-- Yes, I did.

Dr Miach, in January 2004, when you spoke to him about the death of patient P30 told you that Dr Patel was not to operate again on any of Dr Miach's patients?-- Yes, that's correct.

As a result of that you felt the Executive should know?-- Yes. I was very disturbed about patient P30's death, even more so when his wife presented to the Renal Unit to ask questions and have some understanding of what happened. So, at the time Mandy and I were in the Renal Unit and spoke to her and we went and got Dr Patel to speak to her - sorry, Dr Miach to speak directly to her and it was after that that, yes, he indicated that Dr Patel would no longer operate on his patients. My concern about that statement though was what was going to happen to the patients that were coming onto the Peritoneal Dialysis Program and what alternatives could be offered for them, because the district that we cover is quite large and people who, say, live in Gayndah that may want to choose peritoneal dialysis as their choice of therapy for their renal failure, if we did have a surgeon who could place the catheters, I felt that some type of preparation needed to

be put into place for those patients so that they didn't have to relocate to Bundaberg and that they didn't have to maybe pursue haemodialysis as their choice of treatment for their renal failure.

COMMISSIONER: Is there another hospital in the closer region where that sort of surgery could have been done, Maryborough, for example, or Hervey Bay?-- No, no. Dr Miach's patients in Hervey Bay, I think, I'm not sure about now, but had been referred to the Royal Brisbane and the plan was then that our patients would maybe be referred to the Royal Brisbane for placements of peritoneal catheters.

That involved going on waiting lists?-- Yes.

And just the geographical inconvenience of patients having to go to Brisbane?-- Yes. With the amount of time lapse between then, usually patients would require dialysis, so they would have haemodialysis initiated.

Do you know what the usual waiting list is at the moment in Brisbane for insertion of a catheter?-- No, I don't.

D COMMISSIONER VIDER: Once a Tenckhoff catheter is inserted, how long does that catheter remain in situ? In other words, does it stay there for what length of time before it needs to be replaced?-- It can stay there for a number of years.

Can it?-- Yes.

The same catheter?-- The same catheter. It's a silicon catheter so it can stay there for a number of years. I think with the ANZ Data Register, I think the average length of life of a catheter is about five years and that usually means that a patient has been transferred to haemodialysis unless they have problems with the catheter that it would need to be replaced, but usually if there's no problem they're not replaced.

COMMISSIONER: And I assume replacing a catheter is a somewhat simpler procedure than inserting the first one?-- No, it's the same procedure. The patient would have to have the catheter removed, the original catheter removed. Usually then they will place the catheter on the other side of the abdomen and, again, it's the same procedure. The patient would then have to wait about another month for that catheter and the tunnel to heal before we can initiate dialysis and during that month the patient would have to be placed on haemodialysis so they could receive treatment for their renal failure.

You don't reuse the existing tunnel, you place it on the opposite side?-- Yeah.

MR ANDREWS: Before I ask you to tell us about your constructive negotiations with the Baxter Group, you did refer us to some statistics that you had with you and as I recall they were expressed as the number of patient months?-- Total patient months per episode.

Per episode of what?-- Peritonitis or exit site infection.

And as I recall, for the Year 2003, they fell by a drastic amount and they remained low; that is, there were too short a period between patient episodes also in 2004?-- Mmm.

Was that for the Bundaberg Hospital or the district?-- Only for the Bundaberg Hospital.

And can you explain why the results would have been so poor in 2004 also?-- Because the patients that had the catheters inserted in 2003 still had those same catheters in 2004 and were continuing to experience problems.

And can you say - well, are you talking about the patients on your chart or those patients and others as well?-- The patients and others as well. The entire population of patients on peritoneal dialysis in the Bundaberg Renal Unit in 2004 of which it stands to about seven patients.

You spoke with the representative for Baxter, Mr Brian Graham, and your statement sets out what you achieved from about paragraph 19. Now, I won't ask you to repeat everything within it, but I notice that on the 15th of June 2004, you attended a meeting at the Friendly Society Hospital at Bundaberg and the attendees included Dr Keating, Dr Miach, Robyn Pollock and yourself and some representatives of Baxter and others. Can you say whether it ever occurred in your presence, either then or at any other time - well, let's say on this time, on the 15th of June, was there any discussion about Dr Patel's poor catheter placement as being the reason that this occurred?-- No, there was never that discussion.

And when you went in on the 10th of February 2004 to Acting Director of Nursing Patrick Martin, as you describe in paragraph 17, and you took your report, is there any prospect that Patrick Martin wasn't told by you that this was six out of six?-- No, because I presented that report to him.

But I noticed when looking at that report it doesn't say, for example, that these are the only six patients-----?-- At the-----

-----in whom Dr Patel placed catheters in 2003?-- At the bottom line I just put "x6 Peritoneal Dialysis Catheters Placed 2003". That was the total number of catheters placed in 2003.

Now, you know that was the total number, is there any chance Patrick Martin didn't know it was the total number?-- He may not have understood that, but I felt it was clear the way I presented it.

Well, do you remember whether Patrick asked what proportion of the total patients this amounted to, was there any such discussion?-- No, I don't remember. I don't recall, I'm sorry.

And you didn't ever speak to Dr Keating directly about this, did you?-- No. Patrick said that he would take the concerns and the audit to Dr Keating and to Peter Leck and I believe he did that on that day.

And you did never speak with Mr Leck about it either, did you?-- No.

COMMISSIONER: The fact is that in June of 2004, the 15th of June 2004, you were at the meeting which was also attended by Dr Keating and that was really for the purposes of these discussions with Baxter to put in place a new system?-- Yes.

That, as I understand it, was quite a novel initiative for Queensland Health to have an arrangement with a supplier of medical equipment that they would actually pay for private specialists to insert the equipment?-- Yes, I believe it was the - it would have been - or is the only arrangement in Queensland. I do believe that another hospital is looking at a similar arrangement now, but at the time it was the only arrangement in Queensland.

All right. So would it be fair to say that no-one present at that meeting could have been in any doubt whatsoever that the need to put in place this unique arrangement was the result of some problem that happened at Bundaberg Hospital?-- Well, I was aware of it, Robyn Pollock, Brian Graham and the Baxter representatives were aware. I'm not sure what any other parties thought. I'm not sure what Dr Miach discussed with, say, for instance, the Executive, with Darren Keating about why he wanted this program up and running, but certainly we knew, I knew.

Yes. There were also representatives of the Friendly Hospital, Friendly Society Hospital, Dr Thiele and Dr Merefield, they're both local specialists, aren't they?-- Yes, they are. One is a surgeon and one's an anaesthetist.

They're the local specialists who have, in fact, been inserting the catheters under the Baxter arrangement?-- Yes.

There's also a reference to Allan Cooper?-- He is the CEO of the Friendly's Hospital.

Right. Also there was a representative from Hervey Bay Hospital because Dr Miach was interested in extending this Baxter Program into Hervey Bay as well?-- Yes. He is the Director of Medical Services at Hervey Bay. He was involved.

All right. Prior to this time, was it the practice for Hervey Bay or Maryborough patients to come to Bundaberg to have catheters to place at the BBH?-- No.

This was again an entirely normal idea?-- Some of the patients did have catheters inserted in Bundaberg, but those patients were acutely ill and dialysised as acute dialysis patients and while they were there Dr Miach may have had the

catheters placed in the past but it wasn't a routine arrangement.

Thank you.

MR ANDREWS: Would you look, please, at LD3? I will put a copy of it up on the screen. If a Tenckhoff catheter needed repositioning after it had been inserted at the Friendly's Hospital under the Baxter Program, it might have been repositioned in any hospital so long as there was a surgeon, wouldn't that be the case?-- Yes.

But as you understand it, there was agreement reached that the repositioning would be - where would it occur?-- Within the Access Program it would reoccur at the Friendly's Hospital by Dr Thiele, the surgeon responsible for placing the catheters.

And since the catheters have been placed at the Friendly's Hospital, do the patients still come to your Renal Unit?-- Yes, the only arrangement with the Friendly's is that it's - it's a day procedure. The patients remain in hospital overnight. But prior to going to the Friendly's, they come and see me in the Renal Unit and I mark their exit site. I stencil the abdomen with a stencil kit to show the shape of the swan neck catheter and where the cuffs are placed so we determine where the exit sites are going to occur and we stencil the position on the abdomen to give the surgeon a guide as to where he's going to be tunneling the catheter and exiting that catheter.

Let me understand. So the patient comes to you at the Bundaberg Hospital?-- Yes.

To the Renal Unit?-- Yes.

You draw the position where you would like the catheter placed. The patient then travels to the Friendly's Hospital?-- Yes.

Where a surgeon, such as Dr Thiele, places the catheter and then the patient thereafter gets treatment in your Renal Unit?-- The patient remains an inpatient at Friendly's overnight following the surgery. They are discharged the following morning, but prior to their discharge I visit with them at Friendly's just to ensure that the dressing is secure and just quickly review the patient. On their discharge the following day, if I was happy with the dressing I might get them to come back and see me two or three days later and I review the dressing, that's correct.

COMMISSIONER: Ms Druce, you will probably think this is a very stupid question and I'm very embarrassed to ask stupid questions. This whole Baxter arrangement that was put in place involved Baxter paying for, as I understand it, accommodation at the Friendly's Society Hospital; is that right?-- Yes.

And paying for the gap between the private specialist's

Medicare fee and what the private specialist charged?-- That's correct.

And presumably put the patient to some inconvenience and put you to some inconvenience to have to relocate to another hospital to have this procedure performed and so on?-- I certainly didn't mind going over there because we had just good patient outcomes, so.

Yes. And also presumably Baxter had to pay for the use of the theatrette in the a private hospital?-- Yes, and they also paid - patients had to have a consultation with Dr Thiele prior to them becoming an inpatient, so they also paid for the gap for that initial consultation, and should they require further consultation Baxter would pay for that as well.

Here comes my stupid question then. Wouldn't it have been very much simpler if surgeons and anaesthetists of the standard of Dr Thiele and Dr Merefield could be made available as visiting medical officers at the Bundaberg Hospital so that a private hospital didn't have to become involved at all?-- Certainly, and I think Dr Miach at one point tried to pursue that but I don't think he was successful.

I see. Thank you, Mr Andrews.

MR ANDREWS: Since you began having this process done at the Friendly's Hospital, about how many catheter placements have occurred - well, subject to your care?-- At least four, maybe five. It might be up to five now. I'm not sure.

And what has been the complication rate or the adverse outcome rate in respect of those?-- There has been one patient that experienced infection within the first day of start up but it was a no growth peritonitis. We couldn't determine exactly what happened, so there was that one complication.

No migrations?-- No migrations.

Now-----

COMMISSIONER: Sorry, Mr Andrews. Just following on from my earlier question. I tend to think aloud a bit, for which I apologise, but do you happen to know from your own knowledge - perhaps it's not a fair question to ask you - whether people like Dr Thiele and Dr Merefield would have been prepared to do this work as visiting medical officers at Bundaberg Base Hospital if they had been offered that opportunity?-- I think Dr Thiele would have, yes.

MR ANDREWS: Were you aware in December 2003 when patient P30 died of any forms that you might fill in or were obliged to fill in to bring this outcome to the attention of the Executive?-- I just presumed because - I'm not sure if he died in theatre or in intensive care, but I would have thought an Adverse Event Form would have been generated from one of those two areas in relation to this patient. I mean, I saw the patient right up until the doors opened and he was wheeled

off to theatre and I never saw him again after that.

Would you tell us, please, about - or direct your attention to the Dr Qureshi's portion of your statement? You speak at paragraph 33 about Dr Trek Karesh, could that be Dr Tariq - T-A-R-I-Q - Quershi - Q-U-E-R-E-S-H-I?-- Yes, that would be correct. I wasn't sure how to spell his name at the time of preparing this statement.

I can't say I am either. I have seen it spelt both ways?-- Okay.

Now, you assisted the patient who alleged she'd been sexually assaulted by the doctor and you understand that an incident report was written and signed by patient P23?-- That's correct, that's what she told me and another nurse told me that as well that the incident form had been completed.

Now, she asked you to find out which doctor it was because he hadn't identified himself so far as you know?-- She was unsure of his name and she asked me if I could access her clinical notes and to provide her with that information.

And were you able to do that?-- I told her that I wasn't able to do that with regard to patient confidentiality and I instructed her of the method involved as to how she could obtain the information by signing a Release of Freedom of Information.

Is it the case that you are not able to access any patient's clinical notes?-- I could have walked into the room and got her chart and provided that information, but I felt that the allegation was so significant that the correct channels would have to be followed for her to obtain that information.

In any event, you went through the correct channels?-- Yep.

So that she could obtain a copy of that?-- Yes, I took her and her partner down to the administrative area and I said to P23 - sorry, I said the name, but I said to the patient that - that she would need to ask for the notes in relation to her admission back in October and she would also need to ask to obtain a copy of that incident report.

Now, at paragraph 33 you observe that you asked P23 what feedback she'd received from the hospital and P23 said there was none; when did you ask her that? How long after it was that she had filled in the paperwork that you asked her whether she had any feedback?-- It was probably the next time I saw her. I saw her on a regular basis because she was a peritoneal dialysis patient, so it was after-----

Does that mean weeks? Days? Months?-- Even months later I still asked her, up until probably a month ago, and she said she had never seen no information.

COMMISSIONER: Would you excuse me a moment, Mr Andrews? Mr Mullins, I assume this patient isn't one of those whom you

represent? She is not connected with Dr Patel?

MR MULLINS: No. My initial view is no. I will just seek confirmation of that from my instructing solicitor.

COMMISSIONER: Yes. I mean, I certainly don't want to create unnecessary complications and I would be very reluctant to ask this lady to come forward and give evidence in these proceedings, but I think it's important that we have her version of events and I was going to ask whether some arrangement could be put in place that that is done in private and in a non-intrusive way with the representatives of any of the other parties who wish to be present, but that it isn't held in a public forum. Perhaps I can leave that to you, gentlemen, to work out something that's appropriately sensitive.

MR MULLINS: I have been handed a note that indicates that Dr Qureshi's situation has been dealt with or canvassed by the Patient Support Group and the Premier, so I will follow that up through that avenue and make the necessary and appropriate contact.

COMMISSIONER: I appreciate that, because when it comes to matters of this nature I don't think it's in anyone's interests to put the patient through the trauma of having to give public evidence about that sort of thing.

MR MULLINS: Thank you.

COMMISSIONER: Can I leave you to sort that out with Mr Andrews and Mr Atkinson and Mr Morzone that will enable us to have a statement from that witness without putting her in the box and giving evidence.

MR MULLINS: Thank you.

COMMISSIONER: Needless to say, if anyone else feels they would be disadvantaged by that sort of procedure, I will review the situation. But I'm sure everyone shares my view that we should do that as sensitively as possible.

MR FARR: Commissioner, can I indicate that any material that is required, because I have material in my records relating to this matter that would probably need to be shown to that patient to assist her, I'm happy to provide that.

COMMISSIONER: Thank you, Mr Farr, I appreciate that very much. Yes, Mr Andrews?

MR ANDREWS: I have no further questions. I would like the documents returned and I wonder whether - I no longer recall whether I have left anything on the table for tendering.

COMMISSIONER: I don't think you have, but I was going to ask Ms Druce. You read to us earlier those statistics about the break in the number of months without infection and-----?-- Mmm.

And I wondered if you would be able to during the break provide that to someone here to get photocopied so we can have copies of that in evidence?-- Certainly.

Mr Allen?

MR ALLEN: I have nothing, Commissioner.

COMMISSIONER: We might take the morning break then before any cross-examination. I assume, Mr Mullins, you will be going first?

MR MULLINS: I will be 15 minutes

COMMISSIONER: 15 minutes. All right. We will take the break.

THE COURT ADJOURNED AT 11.00 A.M.

THE COMMISSION RESUMED AT 11.17 A.M.

LINDSAY SIGRID DRUCE, CONTINUING:

COMMISSIONER: Yes, Mr Mullins?

MR ANDREWS: Commissioner, before Mr Mullins is invited, there's a matter I should raise. I expect that from the evidence of Dr Keating when ultimately Dr Keating is called there will be evidence relating to the topic of Dr Qureshi and the complaint made by the patient, and part of that evidence will be to the effect that Dr Keating spoke with the patient on the 21st of October and explained that the matter should be referred to the Medical Board because it was so serious and asked if the patient was content to speak to the Medical Board. The patient said yes. Dr Keating on her behalf wrote - I beg your pardon, Dr Keating wrote the next day to the Complaints Unit of the Medical Board outlining in detail the patient's complaint and, indeed, a complaint relating to another person, and-----

COMMISSIONER: Involving the same doctor?

MR ANDREWS: Yes.

COMMISSIONER: Yes.

MR ANDREWS: And wrote that the incidents were brought to the attention of the Complaints Unit because of the significance of the allegations and a possible pattern in order that an appropriate form of investigation by the Medical Board of Queensland can occur, and continued, "I have explained to Dr Qureshi that these incidents would be forwarded to the Medical Board.", and in the same context the Audit and Operational Review Division of Queensland Health by its director wrote on the 29th of January 2004 to the patient in respect of this complaint observing that they - that the complaint had been referred to that branch for assessment as to whether further investigation was required. They wrote to the patient, "We have attempted to contact you by telephone but the number recorded on your file is disconnected.", and then they went on to talk of two avenues through which she would be able to pursue a complaint of this nature.

COMMISSIONER: Thank you for that, Mr Andrews. Mr Devlin, you will be able to take it from there?

MR DEVLIN: Yes. The Commission has the files in relation to the Board's files-----

COMMISSIONER: Yes.

MR DEVLIN: -----in relation to the investigation of Qureshi and they were supplied, I think, during one of the Brisbane sitting weeks.

COMMISSIONER: And my recollection is that we were told by one of your witnesses, and I'm not sure which one-----

MR DEVLIN: Mr O'Dempsey, I suspect.

COMMISSIONER: That that investigation was underway but then terminated when Dr Qureshi was found to have left Australia.

MR DEVLIN: Correct.

COMMISSIONER: Thank you. Mr Mullins?

CROSS-EXAMINATION:

MR MULLINS: Thank you, Commissioner. Ms Druce, my name is Mullins. I appear on behalf of the patients. I would like to ask you a series of questions about your peritoneal dialysis catheter placement assessment in 2003. Do you have a copy of that document with you?-- Yes, I do

Does that document have the patient numbers next to the blacked out names?-- No, I don't believe it does.

Can I put this copy on the screen? It has the patient numbers. I have copied it as Mr Andrews has read the numbers out. I can't guarantee its accuracy. Now, you prepared this document from reviewing the patients' files in conjunction with your own contact and examination of the patients?-- That's correct.

So it's not a situation where any of these patients have been assessed solely on the file alone, you have actually had physical contact with each of those patients?-- That's correct.

Now, the date range is 15 August 2003 and this is for the date of the catheter placements themselves, 15 August 2003 which is patient 8, through to 3 December 2003 which is patient 19?-- Yes.

Now, there is one later surgery which is the second surgery of patient 30, which is under the column, "Date of Catheter Problem.", and that's 16 December 2003. That's correct?-- Yes.

Now, who carried out the surgery on 16 December 2003?-- Dr Patel.

Running down the line of the, "Date of Catheter Problem Surgeries.", we see that for patient 45 the subsequent surgery was undertaken by another surgeon privately?-- That's correct.

We know that patient 30, the correction was carried out by Dr Patel. Patient 24, was there any further surgery undertaken there?-- No, I don't believe there was. The date of the catheter problem was when the patient, I think, presented there with the infection and the infection required treatment.

The remaining is patient 8 which is on the first line. The surgical intervention was on 19 September 2003. Can you recollect who carried out that surgery?-- No, I can't. I presume it was Dr Patel but I can't be sure.

You have been in the Renal Unit at the Bundaberg Hospital since 1988?-- '98, yes.

Do I understand your evidence correctly, that between 1998 and when you went on maternity leave in November 2003 to your recollection there had been only two incidents of infection on migration?-- There's more incidents of infection but migration had only been in limited numbers.

Between the end of 2003 - I should ask this question first. There was some evidence before the Commission that Dr Patel indicated that he had had enough of the Renal Unit toward the end of 2003 and wasn't going to perform the surgery there. Can you recollect him performing surgery in the renal unit during the course of 2004?-- No. He didn't operate any further on any more of Dr Miach's patients that I can recall after Dr Miach made that statement in about January of 2004.

Can you recollect him treating or attending upon any patients in the renal unit after January 2004?-- No. We had had an incident with patients who may have been referred - not through Dr Miach but, say, through their GPs that may have required surgery, for instance. One springs to mind, a patient who needed a gall bladder removed and had been referred by the GP and just so happened to mention to us that he had an appointment that week with Dr Patel, and we advised the patient not to pursue, and the patient was eventually transferred through to the PA for that surgery.

Between 15 August 2003 and 16 December 2003, which on your chart is the first and last surgical procedure of Dr Patel, is a period of about, on my calculation, about 16 or 17 weeks?-- That's right.

Do you know whether any other surgeon operated during that period within the Renal Unit?-- I don't know, no. I wasn't there until November of 2003 so I - I'm not sure.

Your evidence is that Dr Patel was the only surgeon who placed catheters in the Renal Unit during the course of 2003?-- That's right, yes.

So no-one placed catheters before 15 August 2003?-- That's right. There probably was no patient that required a peritoneal catheter up until that point and with - sometimes with renal failure we have our peaks and our troughs in the unit where we suddenly will be presented with a lot of patients who require dialysis and then we may go for some months without anyone coming on to the dialysis program. So, it was just a very - a peak period of activity during that time that these patients presented and were going to be placed on the peritoneal dialysis program.

So, it's your understanding that there was no need in the early half of 2003, rather that these patients were being referred elsewhere or being dealt with privately?-- There was probably no need. The patients, Dr Miach hadn't started them on dialysis yet and this is obviously when they presented to require - you know, initiation of dialysis.

Could I just take you briefly to each of the patients,

starting with P8. The initial catheter placement was 15 August 2003. I should ask you first, is it - do you have a table with the names-----?-- Yes.

-----for your own benefit?-- Yes.

And you have got a reasonable recollection of each of these cases?-- Yes.

Patient P8, surgeon Dr Patel, catheter placed 15 August 2003 and the date of the catheter problem was 19 September 2003. Is that the date of the surgical intervention?-- The 19th?

Yes?-- Yes, that was the date of the surgical intervention with the catheter migration.

When you say that there was a catheter - your chart says that the catheter problem was 19 September 2003. How soon prior to that was that diagnosed? Are you able to say?-- Probably within a couple of days.

Months?-- It would have been at the initiation of the dialysis. The catheter was placed back in the August and we leave the catheter for one month before we access that catheter and start the peritoneal dialysis process. When we initiate peritoneal dialysis, there would have been obvious outflow drainage problem. The catheter - as I said earlier, there would have been X-rays to determine that the catheter had migrated and that's why it wasn't working. So it would have been within a month.

Is an X-ray taken of the position of the catheter immediately after its placement?-- No.

Could it be the case that the catheter was simply placed in the wrong place?-- Well, usually the surgeon has - is able to directly visualise the cavity when they are placing the catheter, so usually it's just a direct visualisation. It's not necessarily an X-ray at the time in theatre.

COMMISSIONER: From what you said earlier, if it was pointing upwards in September that's where it must have been placed when it was inserted by Dr Patel a month earlier?-- The - if the external position is facing upwards it would still be upwards a month later.

Yes?-- But in theatre when you place the catheter, the catheter should have - the distal tip of the catheter internally should have been sitting down low in the peritoneal cavity.

Yes?-- So it must have moved in that month and migrated up.

Right.

MR MULLINS: When you say it must have moved, it could also theoretically be the case that the surgeon simply placed it in the wrong place at the time?-- Yes, that could have happened,

yes.

Is it common, in your experience, when there has been migration for migration to be identified as soon as a month after the surgery?-- Usually you identify the migration because there's no drainage inflow and outflow of the drainage. We don't identify it any earlier than that because we leave the catheter intact. We don't touch the catheter until it's healed and firmly embedded and the tunnel has healed. So, we don't identify migration before start-up of their dialysis usually.

But is that the most common time to identify it is at start-up?-- At start-up, yes, or may be, you know, a month or two down the track that you are using the catheter and it had migrated. So-----

COMMISSIONER: I think, if I'm not mistaken, what Mr Mullins might be driving at is this, that if only a month after the catheter has been inserted it's found to be in the wrong position, you have listed it as migration but it's equally possible that it may just have been inserted wrongly?-- That's correct, it may have been inserted incorrectly, yes.

MR MULLINS: Thank you. In respect of P8, the catheter position is suggested as being upwards and that's at the, as I understand it, entry point or the exit site?-- The exit site.

That would be, in your experience, completely the wrong way?-- Yes.

Moving on to P19, you will see Dr Patel placed the catheter on 3 December 2003. That patient passed away prior to catheter repair. Do you know approximately how soon after that patient passed away?-- From the second surgery?

Well-----?-- The patient - the patient went back to theatre, I think it was the 16th or 17th of December, for repositioning of that Tenckhoff catheter and died during that procedure.

Excuse me one moment. The patient you identified in the body of your statement is P30?-- I'm sorry, I was looking at the wrong patient.

That patient died prior - yes, you're right - to going to theatre. He had other complications and died as a result of those.

COMMISSIONER: So in relation to P19, the misplacement of the catheter was not necessarily connected with the death?-- No, no. Migration had occurred, but prior - between the time that migration was identified and him going to theatre, he died before he ever got back to theatre a second time of other complications.

Non-renal complications?-- I can't be sure. I can't remember.

MR MULLINS: Was the migration of the catheter in that case identified after his death?-- No, it was identified before death, again at start-up of dialysis, but I think he was too unwell with other complications to proceed to surgery.

So at start-up of dial would have been around about January 2004 - early January 2004?-- Dr Miach may have initiated his dialysis earlier because of access. I just can't recall when he initiated. The best time to start-up is one month after, but Dr Miach has started a patient up a week or two weeks after insertion of the catheter simply because we don't have any other access for dialysis. So very occasionally they will be started up earlier.

P24, Dr Patel placed the catheter on 30 September 2003, and that was the patient you've identified who had the exit site infection, the MRSA?-- Yes.

Patient 31, Dr Patel placed his catheter on - his or her catheter on 19 September 2003, and that was another case of chronic infection?-- It certainly was. That patient experienced a lot of exit site infection.

Do you still have contact with that patient?-- I do.

And has the infection cleared up?-- The catheter had to be removed and the patient was transferred to haemodialysis based on other complications of his renal failure, but he suffered chronic infection as a result of the catheter placement, whereas he was able to express wound exudation from the catheter site on a daily basis, I believe.

We've dealt with patient 30. Moving to patient 45, Dr Patel placed the catheter on 6 October 2003. Now, the date of catheter problem you've got as 18 November 2003. That patient had the corrective surgery done privately?-- Yes, Dr Patel refused to operate on that patient. The patient needed a hernia repair. I think Dr Miach may have given evidence about that patient, but he had outflow drainage problems and it was as a result of a hernia, inguinal hernia, and he needed to have that hernia repaired. He was referred to Dr Patel, Dr Patel couldn't identify a hernia and just said that we could continue, where we couldn't continue on peritoneal dialysis because we had impaired outflow drainage. The

patient lived out of town and had to then travel three times a week - he was an elderly man - for dialysis in Bundaberg. He wanted to pursue peritoneal dialysis as the choice of the treatment for his renal failure, so because he had private cover he sought a second opinion and was treated successfully at the Friendly's Hospital and continues on peritoneal dialysis to this day.

He continues treatment through the Bundaberg Base Hospital?-- Yes.

Thank you. Nothing further.

COMMISSIONER: Thank you, Mr Mullins. Mr Devlin?

CROSS-EXAMINATION:

MR DEVLIN: My name is Ralph Devlin, Ms Druce, and I represent the Medical Board of Queensland. I've only got a couple of questions about the complaint process in relation to the complaint of a sexual nature, and nothing I'm asking you is intended to be in any way critical. I'm just trying to get some understanding of your mindset about the complaint process at that point. First of all, your first response seemed to have been to see to it that an incident report was created?-- I asked the patient had an incident form been completed in relation to this matter. She told me that one was completed when she was an inpatient in the medical ward. So yes, she told me that one had been created.

And in a practical sense then as to where that complaint would be dealt with, for example by the Medical Board or internally, your view of it would have been that that was for others to decide. Would that be a fair way to put it? I'll go back a step. Was it at all in your mind to say to the patient, "Well, you can complain internally or I'm aware that the Medical Board takes complaints of this nature"? Was that part of your set of knowledge at that point?-- I was under the impression that the complaint would be generated internally.

Yes?-- I was unaware that the patient could seek direction elsewhere, and the patient told me that she had actually been to the police about this incident when it was first raised with me.

In terms of another method of complaint being either to the Medical Board or to the Health Rights Commission, they were not things that were in your mind at that point?-- No.

So your first response and only response - and I'm not being critical at all - was to initiate or see to it that an internal complaint was on record?-- Yes.

And as to what was to become of that, that was a matter for others to determine?-- Well, I spoke to the Nurse Unit Manager of the medical ward. The patient was an inpatient in the medical ward when this incident occurred and the incident occurred prior to my returning from maternity leave.

Yes?-- So it had been some months before she told me about an incident.

I understand. I understand why you want to make the answer in that way. I'm really looking at it in a general sense, that as a general proposition your first and only response as a relatively senior nurse in the system would be to see to it that something was done internally to create a record for others to deal with?-- Well, yes.

Thank you.

COMMISSIONER: Thank you indeed, Mr Devlin. Amongst the others is there any consensus as to who should go first?

MR MORRISON: Nothing from me, if that helps.

COMMISSIONER: Thank you.

MR ASHTON: Nothing, Commissioner.

MR DIEHM: I think that leaves me.

CROSS-EXAMINATION:

MR DIEHM: Ms Druce, my name is Geoffrey Diehm, and I appear for Dr Keating. Can I ask you some questions about the catheter document that you've been giving evidence about today. Ms Druce, you've told us that that document was one that you started working on, as I understand it, from December 2003, and that it was ultimately produced in its form as we see it here in February 2004?-- Yes.

Is that right?-- In that format, yes.

And you've told us that the patients that are dealt with in it are all of the patients who had these catheters inserted at the Bundaberg Hospital in 2003?-- Yes.

Now, for most of that time you were on leave?-- That's right.

How did you know that they were all of the patients that had such catheters inserted in that time?-- Because we keep a register of the patients that come on to the peritoneal dialysis program and have data back until about 1997, I think, clearly detailing what patients are coming on to the program.

With respect to the document itself, I wonder if the one that Mr Mullins provided might still be on the document reader, if that can be turned on. Now, again, as I understand your evidence, you say that you gleaned the information that appears in the document by reference to two particular sources. One is what you observed for yourself as these patients came back through the ward, and the second is by looking at their records?-- That's correct.

Clearly enough the patient names would be known to you by either of those sources. The information about who the surgeon was, where did that come from?-- The operating notes.

The thing that would have made it obvious to you as well that it was Dr Patel was that in your understanding he was the only surgeon at the Bundaberg Hospital who placed these catheters in the renal patients in that year. Is that right?-- That's correct.

The date of the catheter placement came from the record, I assume?-- The operating notes.

Thank you. The date of the catheter problem would have also come from the patient record?-- Yes, from the - we keep separate peritoneal dialysis records within the Renal Unit that are separate from the patient's clinical notes, and that information came from when they presented to us.

What sort of information is kept on that record source?-- We have inpatient notes. When the patient presents, if they just come into the unit they might be concerned about their stock, at home they may come in because they think their exit site looks a little bit red, they might want me to have a look at it. Sometimes patients present to the Renal Unit to just simply perform a dialysis exchange, especially the patients that come from other areas that are in town to do their shopping. They need a clean area to do a dialysis exchange, so they'll just present. Sometimes they present for line changes. So there's a variety of reasons why a patient may present. Sometimes they present to us rather than going through the Emergency Department, if they have, say for instance, peritonitis, so that we can immediately start the protocol for the treatment of peritonitis. So there's a variety of reasons, and we keep notes for when the patient presents. There's also a flowsheet on adequacy of dialysis. There's details in relation to POET, which I discussed earlier. POET is the database that we use. It's a Baxter software program. We keep information in the notes in relation to all infections, notes in relation to the current medications the patient may be on.

Now, those notes, apart from being stored elsewhere, that information would also be recorded in the individual patient records. Would that be right?-- No, it's recorded in the separate peritoneal dialysis notes.

I see?-- And, for instance, if then a patient is transferred to haemodialysis, those notes then are placed in the clinical chart and it's documented that these are the peritoneal dialysis notes.

The nature of the catheter problem is something that comes from one of two sources, either the patient records, or in some instances, depending on the nature of the problem, your own observations. Is that right?-- Yes.

And the observations that you can make, as you've explained to us, are the position of the catheter externally as shown in the column under "Catheter Position", and also presumably whether or not there's signs of infection externally?-- Yes.

Migration problem, as you've explained to us, is one that is detectable by x-ray and not by your own observations?-- No. The only observation is that if there's a problem with the inflow or outflow, so you're looking at a drainage problem. But to confirm that you'd need to do an x-ray.

A drainage problem is what gives you the suspicion, the x-ray is what allows the diagnosis?-- Yes.

Now, the x-rays that are taken, that would demonstrate a problem with the catheter with respect to migration, information about that x-ray would be kept on the patient file. Would that be right?-- It would be kept, yes, on the patient file, and also the hard copy of the x-ray would be kept in x-ray as well.

When you were compiling this list did you look at the original x-rays or did you just look at the file to see what information was there?-- I looked at the file.

Thank you. The outcome, that's something that you gleaned from the patient files, I gather?-- Yes.

The catheter position, that's something that you detected by your own observation. Is that right?-- That's right.

Was there information about the catheter position recorded in the patient files?-- No, I don't believe at all times that information was there.

So, for instance, if you were to see a patient as part of the routine follow-up after you came back from maternity leave and note a problem with the catheter position such as that it was pointed upwards, with the link in your statement you describe as giving rise to a high risk of infection, you would make no note about that in a patient record?-- I may have made a note. I'm not sure on every case, but I may have made a note.

With respect then to the issue of infection, again the source of the information, presumably, is what you see in the patient records?-- Yes.

As well as perhaps in some instances by your own observation?-- Yes.

Were any of these by your own observation or were they all placed on the records?-- They would be on record because the patient that has chronic infection would have had swabs taken, they would have - there would be pathology results available, and the infection then would have been treated based on those results.

This document, once completed in February 2004, you distributed it to a number of sources, did you?-- After Dr Miach made the statement that Dr Patel was no longer going to perform any surgeries, I really felt that nursing administration needed to be aware of that statement because of the impact that it would have on the patients that were coming on to the Peritoneal Dialysis Program. We keep a record of all patients in the pre-dialysis phase, so I knew there was patients pending that wanted to pursue peritoneal dialysis. So I felt the impact - that that statement had great ramifications for patients. So I really felt that Executive needed to know. I compiled this, I made an appointment with the Nurse Unit Manager, Robyn Pollock, and I went and spoke to her about my concerns about the Peritoneal Dialysis Program being ceased at the Bundaberg Base Hospital by Dr Miach's statement. We then - based on the information that I provided to Robyn, she had concerns as well, so she made an appointment for us to go and see the Acting Director of Nursing at the time and to talk to them about our concerns for the Peritoneal Dialysis Program.

Okay. When you went to see Ms Pollock, was the document that is on the screen now in existence by then?-- I had it in rough format.

In rough form?-- With notes. It was just in a pencilled format, but I didn't create this until we were going to see the Acting Director of Nursing.

When you say "a pencilled format", you'd just written something out on a piece of paper?-- No, it was similar to this and I had columns, but it was all in pencil. I hadn't had time to sit at the computer and put it into a format that could be presented, so I specifically put it into that format on the 10th of February when we went to the Acting Director of Nursing, and I left a copy of that then for Dr Miach, but I'd already discussed all these findings with him.

So the document we see here you gave to Dr Miach by putting it in his intray?-- Yes.

And you gave a copy of it to Mr Martin?-- Yes.

And perhaps a copy of it to Ms Pollock as well. Is that right?-- Yes.

That was the limit of your own personal distribution of this document?-- At that time?

At that time?-- Yes.

All right. What became of the other document, the pencilled document?-- I just threw it in the bin once I created it into this format.

Did you ever give it to anybody else?-- No.

Did it contain the same information as is in the document on the screen?-- Yes.

Can I ask you to - perhaps the most convenient thing will be for that document to be taken off the screen and for those following evidence to refer to the document in the witness's statement. If I can ask for this document to be put on the screen, please. Can I ask you whether you are able to recognise that document?-- Yes, it's, I think, a draft format of the original document that I presented.

I just wonder whether it's possible to, by reducing the size of it without hopefully compromising the legibility, get the whole of it in on the screen. Thank you. We'll do our best. Let me know if you're struggling to read anything there. Your eyesight might be better than mine.

COMMISSIONER: Journalists will observe that this version has the patients names, but I remind you of what I said earlier about not including those names in any reports without the consent of the patient or family of a deceased patient.

MR DIEHM: Thank you, Commissioner. I'll start by putting this in context for you. You will see in a scribbled note in the top right-hand corner of the document - I'm not expecting you to be able to read that, but my questions that will follow work on the basis that what that notes records is that this was a document that was provided to Dr Keating on 15 June 2004, the date of the meeting with the Baxter people at the Friendly's Hospital. Do you recall the meeting I'm talking about?-- Yes.

That's the context of where the questions are coming from, that that is when this document was provided to Dr Keating. Now, with respect to it, you can see in terms of differences, in the column under "Surgeon", for only one of the patients, the last one, is there a reference to the doctor being Dr Patel. Can you explain why that is?-- No, I recall having versions and updating the information, but no, I can't give an answer to that.

You see, the easiest piece of information would have been, on what you've told us, to fill out for this sort of a document, would have been who the surgeon was because, as you've told us, Dr Patel was the only surgeon in 2003 inserting these catheters. Was it at some point in time your understanding that there may have been other doctors involved?-- No, I was told it was only Dr Patel, and from the notes it was only Dr Patel operating.

So you've got no explanation for us as to why you were unable to complete the columns for the first five patients with the name of Patel as the surgeon?-- No. It's possible that I hadn't reviewed the operation notes at that point and had only relied on the peritoneal dialysis notes that we had in the Renal Unit at the time.

However, your understanding independent of the notes is Dr Patel was the only surgeon?-- Yes, yes.

So that wouldn't really be likely as the explanation, would it?-- Until I checked for sure I wasn't probably prepared to write Dr Patel's name there.

Okay. With respect to the date of catheter placement, the fourth patient we don't have a date there for the catheter placement. Are you able to say why that might be?-- Again maybe I hadn't referred to the patient's notes, the clinical notes, and was only relying on the peritoneal notes.

With respect to catheter problems for the third and fourth patients in this document the problem is described as "nil"?-- Yes.

Are you able to say why, by the time the next document was created, it described it as "infection - catheter position"?-- I think I had "nil" there because I was looking at maybe catheter migration and wasn't focusing on all the other problems, and it's clearly evident that the patient has infection, as detailed there in the outcome.

With respect to the column describing catheter position, for the first patient in the document on the screen the position is described as "side upwards"?-- Mmm.

Whereas by the time of the second document it's described as being the more serious position of "upwards"?-- It was definitely upwards.

Well, can you tell us why in the first document it's described as "side upwards"?-- I may have been relying on handover from Mandy at that time, but on reviewing the patient it was definitely an upwards facing catheter, so I've corrected the notes there.

I'm sorry, the first document was one that was created, as I understood your evidence - I'm sorry, the information that you collated was, as you've told us, based on your observations of the patients and what was in the file?-- Yes, my observation. Yes, my observation.

COMMISSIONER: Whereas this earlier draft may have had in it material that was provided to you by someone else and which you then later checked, verified and put into the final version?-- Yes, but that patient in particular had an upward facing exit site.

MR DIEHM: The entry for the fourth patient also describes the catheter position as side-upwards?-- Mmm, that patient-----

Versus upwards in the second document?-- That patient definitely has an upwards-facing exit site, and the notes then were amended.

Sorry?-- And I have obviously amended the document.

Mmm, all right. And for completeness, with respect to the last patient on the list, the catheter position is described - shown as a question mark on the first document?-- Mmm.

And is described as sideways on the second document. Any reason that you can tell us as to why that change appears?-- I have obviously reviewed the exit site and determined that it was a sidewards-facing exit, so I have changed the record.

Did you give this document which appears on the screen to any person?-- I must have.

Might it be the case that the document that's on the screen is the one which you, in fact, supplied to the other people, such as Dr Miach, Mr Martin, and so on?-- It must - it might have been the document - the original document that I supplied and then have since kept amending the document as further information has come to light.

All right. And it may be that the document that is attached to your statement, your complete document, is a document that did not come into existence until after 15 June 2004 in that form?-- Yes.

Thank you.

D COMMISSIONER VIDER: But it would have been known in the hospital that the only person - the only surgeon that was implanting peritoneal catheters was Dr Patel?-- Yes.

MR DIEHM: Is it at all possible that in 2003, Dr Thiele was still doing some placements of catheters?-- I was on maternity leave so I'm not aware of that.

You are not sure.

COMMISSIONER: But you have since been through the records and-----?-- The records, yes.

And you have been able to confirm that six out of six were done by Dr Patel?-- Those patients were all done by Dr Patel.

MR DIEHM: The other thing that's different, with respect, to this document, compared to the one that's in your statement, is that in the document that is in your statement, there is at the foot of it the note that you referred to in your evidence earlier?-- Mmm.

About six peritoneal dialysis catheter placements, 2003?-- Yes.

That's the note that was in your evidence intended to convey that these were the total of the catheter placements done in 2003. So, that note was not on that document-----?-- Not on that document.

-----evidently enough. Thank you. Can I just ask you a couple of questions about the patients - or some of the patients mentioned? Firstly, with respect to the second patient on the list known as P19, if I were to suggest to you that the cause of his death was myocardial infarction; does that ring a bell for you?-- No, I can't recall.

But in any event, as you have said, it was due to something that was unrelated?-- Other complications, yes.

With respect to the patient known as P45, the - you have made reference to Dr Patel not being able to find the hernia that Dr Miach was concerned about; is that your understanding of what occurred?-- From memory, Dr Miach referred the patient for assessment of a hernia, and Dr Patel wasn't prepared to operate on that hernia. That hernia caused us to have problems with his peritoneal dialysis and caused drainage problems.

As I understood your evidence earlier, you said that - and you were relating then what Dr Miach had said in evidence was that Dr Patel was unable to find the hernia?-----

COMMISSIONER: I think to be fair, this witness hasn't adopted that. We did hear from Dr Miach a couple of weeks ago that Dr Miach's version was that Dr Patel couldn't find the hernia. This witness, as I understand her evidence this morning, has simply said that she was told that Dr Patel was not prepared to operate on the patient?-- Yes.

Without assigning any reasoning; is that right?-- Yes.

MR DIEHM: Well, I suggest to you, and tell me if you need to look at the patient records, because I can take you to it, that it was on the 5th of December 2003 that an RMO referred the patient to Dr Patel, saying that the patient was APD ambulatory peritoneal dialysis. Can you explain what that phrase means?-- The patient at the time would have been on CAPD, continuous ambulatory peritoneal dialysis. That's the form of dialysis whereby the patient would exchange peritoneal fluid four to five times a day for the dialysis to occur.

Yes, all right. And the referral went on to describe that the patient had an inguinal hernia?-- Yes.

All of that fits with your recollection about the progress of this matter?-- Mmm.

Dr Patel saw the patient then on 9 December 2003 at which time he identified what he described as a small right inguinal

hernia?-- Mmm.

Does that fit with your recollection?-- Yes.

But that he recorded in the notes that the patient was tolerating peritoneal dialysis in the supine position; do you recall that?-- Well, the patient wasn't tolerating his peritoneal dialysis. That may have been the record in the notes, but certainly the patient wasn't, um-----

Do you make that observation regardless of whether the patient was in the supine position or not?-- Yes. I say that, though, because with this patient in particular, we tried different forms of peritoneal dialysis. We tried automated peritoneal dialysis, whereby he would just dialyse lying on his back overnight attached to a machine. The patient still experienced severe outflow drainage. The machine alarmed continuously overnight. His quality of life was being affected. We had put him back on CAPD, continuous ambulatory peritoneal dialysis, and that still caused outflow drainage problems.

All right. Now, those problems were not referable to the hernia, though, were they - the ones that you have described?-- The drainage problems?

Yes?-- Yes, they were.

All right?-- The hernia caused the patient to have a scrotal leak, from memory, and caused the patient significant discomfort, which continuing him on peritoneal dialysis wasn't in the best interests of the patient because of the discomfort that he was experiencing in relation to that hernia.

The hernia is an incidental finding as well; would you agree with that, or is it something you are unable to comment on? It is not caused by the original catheter placement?-- The hernia could have been caused because of the increased pressure in the abdominal cavity as a result of three litres of dialysate fluid residing in that cavity, so he may have had a weakness in that area and the hernia became more apparent because of the increased intra-abdominal pressure.

So, that's as a result of the dialysis, rather than the placement of the catheter?-- Yes, it could be as a result of the dialysis.

Thank you.

COMMISSIONER: Sorry, so that I understand that, it could have been a result of the dialysis in the sense that if the catheter had been draining properly, there wouldn't have been such pressure, but as a result of the catheter not draining properly, there was pressure-----?-- There was going to be pressure inside the abdominal cavity as a result of the volume of fluid that we had instilled into the cavity, so that could have been the - the dialysis volume could have been the cause for that hernia to occur, so it may not have been the catheter

placement.

Had the catheter been working properly, would you have had the same amount of pressure?-- Yes, we could have had the same amount of pressure and the outcome could have been the same anyway.

MR DIEHM: Just completing what I suggest to you the record shows, is that Dr Patel thought that there was no need to proceed to a hernia repair at that point in time, having regard to the fact that the patient was a 77 year old patient and was, in that sense, someone for whom you would avoid surgery if you could; is that your understanding of the turn of events?-- Well, without the hernia repair, the patient would have continued to have problems as with-----

Sorry, if I can just stop you? I'm not trying, by asking you these questions at this moment, to challenge what you say was the appropriate method or cause, I'm simply talking about the history of it?-- Dr Patel may have had concerns that he was a 77 year old man.

And what he related was that he didn't think that there was a need for the surgery at that point in time?-- Well, that's - yeah, that's what happened. He didn't agree with it.

The patient was referred then to see Dr Anderson?-- Yes.

A local private surgeon?-- Mmm.

For a second opinion, and Dr Anderson proceeded to operate on the 17th of December 2003 and repair the hernia?-- Mmm.

I assume, rightly or wrongly, that the positioning of the catheter would have been something that was obvious to Dr Anderson at the time of that surgery?-- I can't comment. I'm not sure.

If he examined this patient prior to proceeding to surgery, he would have had to have seen-----?-- He would have seen the catheter. He would have seen the catheter, yes, certainly.

All right. And in that circumstance - sorry, I withdraw that. I will ask you this: is it your understanding that Dr Anderson left the catheter in the same position as what it was from the original placement?-- Yes, certainly.

All right. And the catheter remains in that position to this day?-- Yes.

Now, I'm sorry, I just want to go back to a question about the second patient on the list, P19. You have described him as having a catheter problem of migration?-- Mmm.

I suggest to you that the records with respect to that patient do not contain a reference to any X-ray having been taken of that patient that would show - or does show a problem with respect to migration?-- I would have to check my notes. I

just can't - I can't remember at the time. I review so many of the charts at the time, I can't recall.

COMMISSIONER: This was the patient who had other serious complications at the time?-- Yes.

And is it conceivable that he would not have been subjected to an X-ray, given the other conditions?-- I just can't recall.

MR DIEHM: If he was not subjected to an X-ray, it would be impossible to make a diagnosis, as it were, of migration of the catheter as the problem; is that right?-- Yes, that's right.

Commissioner, I don't want to take up a lot of everybody's time having the witness look through a record that might take some considerable time whilst in the witness-box.

COMMISSIONER: Yes.

MR DIEHM: The records are here, and I wonder if, at a convenient time, after the witness has finished her evidence, she might conduct that search and, through Mr Allen, she can inform us whether or not as to whether she has found the reference.

COMMISSIONER: I would actually prefer to get this dealt with, and let me explain why, Mr Diehm: when we heard the evidence from Dr Miach back in Brisbane, my recollection is that your client, Dr Keating, was given a version of this schedule in June of 2004 - I think it was the 15th of June 2004 - I'm not sure if I have got that precisely right, but that's my recollection. Is that roughly correct?

MR DIEHM: My recollection is that Dr Miach was unsure as to when he first gave it to Dr Keating. He felt that it was soon after - he thought it was possible that it was before he went on leave in February but more likely when he returned from leave, which was in May. He could be no more precise than that. What he said was that Dr Keating later projected that he had been given the schedule that Dr Miach then gave him in October.

COMMISSIONER: In October, yes.

MR DIEHM: Yes.

COMMISSIONER: And we don't know whether the further copy was the same as the one that's on the screen at the moment.

MR DIEHM: The further copy that Dr Miach referred to as having given to Dr Keating was the same as the document that is in the witness' statement.

COMMISSIONER: Yes. Now that raises, in my mind, a number of questions that ultimately Dr Keating will be needing to address: firstly, whether there was any reason on either occasion to doubt the accuracy of figures shown - that there

was a 100 per cent complication rate, and even if it was less than 100 per cent, a significant complication rate with the catheters. If there was no reason to doubt that the - there was a significant complication rate, what steps he took to address that problem, and why, on its face, it wasn't dealt with with the level of seriousness that one would think would be attributed to that. Thirdly, according to Dr Miach, Dr Keating's response was that he wanted further statistics or benchmarks to compare against. That has always struck us as being a rather unusual reaction when you have got a 100 per cent complication rate. Fourthly, why, then, something wasn't done about Dr Patel by way of further examination and investigation to see why he was producing this 100 per cent complication rate. Fifthly, why it is that he allowed a situation to continue when his Director of Surgery was not prepared to allow his own patients to be treated - sorry, as Director of Medicine, wasn't prepared to allow his own patients to be treated by his Director of Surgery, which candidly strikes us as an utterly bizarre situation. Again, what steps he took about that. Finally, in relation to the Baxter arrangements, why this unique precedent was adopted of having public hospital patients transferred to a private hospital to be operated on by private surgeon in a private operating hospital theatre when, from all the evidence we have heard, the simple solution would have been to get a competent surgeon to come to Bundaberg Base Hospital to treat these patients without causing them or the nursing staff, like our current witness, any greater inconvenience. Now, on the face of the evidence, without making any findings or any final conclusions, those are all things that will need to be addressed, and if you have any questions of this witness relevant to those questions, I think it is better that we get them dealt with now, rather than coming back. Would it then be convenient to stand down for 15 minutes to let the witness go through those medical records with yourself and Mr Allen and identify anything you wanted to ask her about.

MR DIEHM: Commissioner, a couple of things. All of those matters that you raised will be addressed.

COMMISSIONER: Of course.

MR DIEHM: And I might pause to say that there is no evidence before this Commission to date that Dr Miach ever told Dr Keating of his position with respect to Dr Patel not operating on any of his patients.

COMMISSIONER: I accept that that's so, and again that makes you wonder why a medical superintendent at a hospital isn't sufficiently in touch with what's going on in a hospital to know that there's that situation between his Director of Surgery and Director of Medicine, but we will hear that explanation when it is forthcoming.

MR DIEHM: Indeed, it will be explored at a number of levels, no doubt. Commissioner, the other aspect is that I wasn't proposing, by my suggestion, that there be any delay in this witness' evidence. I was proposing to continue on with my

questions.

COMMISSIONER: Yes.

MR DIEHM: Simply, that the question that I raised about there not being any note in the file concerning the existence of an X-ray in the patient P19 that would demonstrate migration involves the witness looking through a rather large bundle of documents for a negative proposition.

COMMISSIONER: I think given the seriousness of these issues, we should ensure that the witness has had an opportunity to find anything appropriate in response to your questions, rather than simply assuming that if she was given that opportunity, it would change her answer.

MR DIEHM: What I was proposing, Commissioner, was after she finished her evidence before she leaves here today, she could look at her leisure at the bundle of documents, go through the file. If she can locate a source of information, it would be able to be tagged and Mr Allen can simply provide the document to the Commission.

COMMISSIONER: I think it is preferable that that issue be exhausted now so that, for example, if Mr Allen or Mr Andrews has any re-examination on that point, it may be, for example - I don't know - it may be that they will want to suggest that in the absence of an X-ray, there were other indicia that was sufficient to indicate a misplacement of catheter. I don't know what the answer to that is and that's why I want to know what the witness will say about it before she goes, so if that's convenient, we will stand down, and I'll say at the moment for 15 minutes, but you let us know if you are ready to go before that, and, Mr Diehm, I'll leave it to you and Mr Allen to make available the documents to the witness and direct your attention to anything that you think would assist her.

MR DIEHM: Thank you.

MR MORRISON: Mr Commissioner, before you do that, I'm happy for the witness to stand down. Two things: one relating to this witness, one not. You referred - I think someone referred to the stats for patient months per peritoneal incident.

COMMISSIONER: Yes.

MR MORRISON: May I say, or submit, you probably should reserve an exhibit number for them, but from where I was sitting, I think it wasn't an individual page for each of those periods.

COMMISSIONER: Yes.

MR MORRISON: So, probably, some identification of that should be made so that eventually - not now, I'm suggesting - but in due course, so that we actually have the proper record of what

she was referring to.

COMMISSIONER: To deal with that, I will attribute now Exhibit number 68 to the documents which are going to be produced to us in support of the statistics about patient months before peritoneal infection.

ADMITTED AND MARKED "EXHIBIT 68"

MR MORRISON: The second matter which doesn't involve this witness - so she can probably go now if she needs to - is the matter of the transcript from yesterday, which I raised. I am prepared to deal with it now if you still think there is a need to deal with it.

COMMISSIONER: Mr Morrison, it is entirely a matter for you. It did cause me concern and does cause me concern that, on the face of it, there's a suggestion that the nurses didn't have as good a reputation as they should have, but perhaps that's being over-sensitive.

MR MORRISON: With the greatest respect, I think it is. Can I demonstrate briefly why that is so, so at least it records the position, and I think it may be that we could utilise a few minutes doing that now, rather than later, but I'm in your hands.

COMMISSIONER: No, no, please.

MR MORRISON: All right. The transcript to refer to - one of the Commission staff was kind enough to give me some pages yesterday before the whole day became available. Unfortunately they didn't give me all of the pages. It starts at 1044, about line 13, "So, now let me just ask you one or two other things".

COMMISSIONER: Yes.

MR MORRISON: You see I was directing her attention to paragraph 42, and that's bits of it. Then at line 21, I embarked upon the proposition - and you will see in the second line I was talking about a perception - and I didn't wish to debate whether that perception was right or wrong-----

COMMISSIONER: Yes.

MR MORRISON: -----I was just asking about a perception. She didn't understand. And then I had another go at it from about line 28, saying to her that what she had written in paragraph 42, the underlying text of that seemed to be this suggested perception, and then we debated that down through to about line 38.

COMMISSIONER: Well, except, Mr Morrison, I think on each

occasion, when you asked about a perception, and it is put in terms of a perception that the nursing services didn't have the best reputation, that-----

MR MORRISON: Let me finish the line, if I may. Then you will see I was still dealing with perceptions about line 49 and 50.

COMMISSIONER: Yes.

MR MORRISON: And then over to 1045, Mr Andrews intervened saying we needed to know who held these perceptions, and so forth, so he was keeping up with the debate and so forth, so I had another go at it about line 5 or 7. Can I direct you again to 42 - back to the paragraph?

COMMISSIONER: Yes.

MR MORRISON: Again, on the basis of a perception - you will see that at line 13, thereabouts.

COMMISSIONER: Yes.

MR MORRISON: Again saying, rightly or wrongly, not debating that, and you will see that at line 22, and then the line that you referred me to is at 32, but in the context of that passage between what I've showed you already and 20 to 30, quite clearly when the word "reputation" was being - was used by me, it was used in the context, clearly, of a perception about that, not that I was asserting that it was the fact. Now, can I also say-----

COMMISSIONER: Yes.

MR MORRISON: -----if you look at the bottom of 1045, you were quite of the same mind, that that's what I was doing, because you say - you pulled me up and said, "You are asking the witness about a perception", and told me I couldn't go and transmogrify that into something else. So, with respect, that's what I was doing, and then when we had the debate later - that's at page 1057 when I objected to a question that was being put - you put it to me that I was putting to the witness - or had put to the witness that there was, in fact, this lack of reputation or this reputation, and I was pointing out to you that that's not what I had done. I had certainly raised with the witness that some might have a perception, even some on the Executive, and I didn't want to debate whether that perception was right or wrong or truly based or not truly based, but I wanted to explore with her the ramifications of the perception. So, I am content in my own mind that I did not put to the witness what you suggested I put.

COMMISSIONER: All right.

MR MORRISON: So, I don't feel I need to take it further. You just mentioned that it is in my hands. I don't think I need to take it further.

COMMISSIONER: All right. Mr Morrison, I have to say I'm

still a little bit mystified by all of this, because obviously reputation is a matter of perception. I'm not quite sure how you draw a distinction between someone having a bad reputation and someone being perceived to have a bad reputation. Aren't they the same thing?

MR MORRISON: Is it justified, I suppose, is the point.

COMMISSIONER: Yes, I accept it was never suggested that the reputation was justified or unjustified.

MR MORRISON: Mmm.

COMMISSIONER: You quite explicitly reserved that point from your questions.

MR MORRISON: And I think that's where we parted company in the debate, really.

COMMISSIONER: Well, I'm not sure that we did, because at 1057, what I took up was the suggestion that nurses had this bad reputation, and I think that was - and I still do think it was an unfortunate suggestion that there was a bad reputation or even a perception of having a bad reputation.

MR MORRISON: In any event, I suppose where we end up is that we - you have a view and I have a contrary view, but it probably doesn't advance the debate to continue.

COMMISSIONER: Let's see if we can reach agreement to this point: it was never your intention to put, and in so far as you are concerned you never did put, and I agree you never did put, any suggestion that if there was a bad reputation, it was deserved or justified.

MR MORRISON: Correct.

COMMISSIONER: What you were seeking to put on behalf of your client was that whether justified or not, there was a state of mind amongst a group of people that nurses had a bad reputation.

MR MORRISON: Some may have that perception.

COMMISSIONER: Thank you. I think that does help.

MR FARR: Commissioner, can I just indicate for the purposes of organising witnesses for today-----

COMMISSIONER: Yes?

MR FARR: Unless something unusual develops in the remainder of the current witness's evidence, I don't expect to be asking any questions.

COMMISSIONER: Thank you so much, Mr Farr. We will stand down until we are told that exercise it finished.

THE COMMISSION ADJOURNED AT 12.31 P.M.

THE COMMISSION RESUMED AT 12.44 P.M.

LINDSAY SIGRID DRUCE, CONTINUING CROSS-EXAMINATION:

MR ALLEN: Commissioner, Ms Druce has had a read of the copy of the records supplied by my learned friend and she is ready to answer the suggestion that the records do not indicate that there was any x-ray revealing migration and it would assist her evidence if the flagged pages could be put on the visualiser. The one that's open first. Thank you, Commissioner

COMMISSIONER: Thank you.

MR DIEHM: Can you read that sufficiently?-- Yes

Which entry is it? Where?-- The entry on the 23rd of January I've written, "Advised by nursing staff Mr Hilliard's catheter has migrated to the right upper quadrant as evidenced on abdo x-ray. Trying to drain while lying on his right side. He is starting to retain fluids. Condition is deteriorating" - or "condition deteriorating".

Is there any other entry in the notes that deals with this issue?-- No. No, but there's also a copy of the x-ray report in the chart.

Does it say anything about the position of the catheter?-- The abdo x-ray talks about the catheter being in the right upper quadrant.

All right.

MR ALLEN: That's the other flagged page.

COMMISSIONER: Yes. Perhaps we could have that turned up to

the next pink flag or orange flag. Is that the right page?

COMMISSIONER: "Catheter is coiled in the right upper quadrant as shown", and is there a diagram that comes with that where it says "as shown"?-- No, that would just be the x-ray.

All right. What does that indicate to you having a catheter in the right upper quadrant?-- That it isn't in the correct position to allow for the catheter to drain and effectively the catheter has migrated.

MR DIEHM: Thank you.

COMMISSIONER: Thank you, Mr Diehm.

MR DIEHM: I'm not sure what we can do about those?

COMMISSIONER: I don't think we need that any further. As I say, the outcome of all of that, you reject the suggestion there was no x-ray evidence to support the conclusion that the catheter had migrated?-- Yeah, based on that catheter migrating.

MR DIEHM: Thank you. With respect to migration, is it right - do I understand your evidence rightly to say that there can be a whole variety of reasons as to why a catheter may migrate?-- Yes.

Some of those reasons may be due to a problem with the way in which the catheter was inserted, some may not?-- Yes.

For instance, you mentioned if the patient becomes constipated that can in some instances lead to a migration problem?-- Severe constipation can cause problems with outflow draining and if severe enough to affect the bowel the catheter may move, yes.

Is one of the other causes of catheter migration - I will withdraw that and I will rephrase it. You mentioned in your evidence that it is usual to wait about one month before starting dialysis after the placement of the catheter?-- That's the most ideal.

Yes. And that's to allow, as you described it, for healing of the tissue to take place; is that correct?-- Yes.

And one of the reasons that you want the healing to have taken place first is to make the catheter stable in its position?-- Yes.

Yeah?-- Or also to prevent dialysate leak around the catheter, around the tunnel of the catheter.

All right. Is it right to say that starting dialysis earlier than that ideal one month period gives rise to increased risk of migration?-- No, in some centres they start at two weeks. We prefer to start at one month, but in centres that Dr Miach has been in he prefers to start them after a two week period.

Yes. But my question was whether or not starting earlier than one month gives rise to an increased risk of migration?-- It hasn't - I haven't experienced that, no.

How do you know - what do you say, you haven't experienced that? Have you not had a migration in a patient who was started on dialysis before one month had expired?-- The patients that have had migration before these incidents were patients that had been on for a longer period of time, greater than one month.

All right. Now, with respect to patient P30, who was the second last patient on the list, the patient who died in the intervention procedure that you described, you said in your evidence that - I'm just trying to make sure I understand the context of my note properly. You agreed with the proposition, as I have recorded it, that the reason for the problem with the catheter was that it was tunneled incorrectly. Have I understood your evidence correctly in that summary?-- Yes, that's my belief, it was looking at the external position of the catheter that it may - it wasn't tunneled correctly.

I want to ask you whether you hold that view with any certainty or whether that's just your best guess as to the reason?-- It's my opinion.

All right. You also have answered a question from the Commissioner, as I recall it, about Dr Thiele's willingness to participate in surgery for the placement of these catheters at the Bundaberg Hospital from 2004 onwards as a VMO. Dr Thiele has never said anything to you one way or the other on that topic, has he?-- No.

So you have got really no idea as to what his position on that issue would have been at that time?-- No, not at that time.

At the time of the meeting on the 15th of June 2004 at the Friendly's Hospital concerning the Baxter Program, was there discussion at that meeting at some length about these rather elaborate processes that would be put in place to facilitate the placement of the catheters as a result of Baxter's sponsorship?-- What do you mean by "elaborate processes"?

Well, the things that the Commissioner referred you to, such as Baxter paying for gaps in the fees and hospital rooms and so on, was all of that discussed at that time at that meeting?-- I can't recall. It had been discussed on a variety of occasions and it was also discussed by the Baxter representative to me and he even - we did basically a flowchart. So I just can't remember exactly at what meeting. I had several meetings with Baxter in relation to the Access Program. So I know issues of concern were raised at the meeting at the Friendly's but I just can't be specific at which date that was.

Please understand I'm not trying to test you or catch you out on saying that 10 things were discussed when only nine were,

for instance, but in general terms at that meeting was there discussion about the way in which the scheme operated, what would have to be done for the scheme to operate successfully?-- Yes, I'm sure there was, yes.

Right. Now, Dr Thiele didn't - and he was present at that meeting, wasn't he?-- He was present.

He didn't at any time put up his hand and say, "Hang on a minute, this is much more complicated than it need be, I will come as a VMO to the Bundaberg Hospital."?-- No.

COMMISSIONER: Was he asked?-- No, he wasn't asked.

Dr Keating was there?-- Dr Keating was there. I don't recall him asking him to come back to the hospital and do that, no. No, I don't recall that.

I think you told us earlier that you certainly didn't mind going yourself, having to go to the other hospital for the sake of your patients?-- Yes.

Presumably that would have been more convenient if you could deal with it all at the Bundaberg Hospital?-- At the Base Hospital, certainly.

MR DIEHM: Commissioner, the witness's statement deals with the complaints relayed to her by P23, I think the number is, matters concerning Dr Qureshi.

COMMISSIONER: Yes.

MR DIEHM: As counsel assisting has pointed out to the Commissioner, there will be some evidence from Dr Keating and others in some detail about what in fact was going on.

COMMISSIONER: I haven't identified anything in my own mind that you would need to put to the witness, as after all her evidence is only hearsay, what she has heard from the patient.

MR DIEHM: Yes. If the Commission is content, I'm happy not to pursue the matter with her.

COMMISSIONER: Thank you, Mr Diehm.

MR DIEHM: I'm reminded, I should tender the earlier version of the schedule, if I assume that's still with the Commissioner's Assistant?

COMMISSIONER: Yes. The earlier version of the schedule will be Exhibit 69 and that is the version headed "Peritoneal Dialysis Stats", and with the handwritten note on it which I think indicates that it went to Dr Keating on the 16th of June, is it?

MR DIEHM: 15th, as I understand it.

COMMISSIONER: 15th of June.

ADMITTED AND MARKED "EXHIBIT 69"

COMMISSIONER: Have we made any progress with getting the other documents that we were going to put into evidence, the details of the-----?-- Patient months.

Monthly period returns?-- I gave that-----

MR ALLEN: They have been supplied.

MR ANDREWS: I have something that perhaps the witness should identify.

COMMISSIONER: Yes.

MR ANDREWS: Can you just tell us what that is?-- Well, the first page here is a - just a graph. I'm looking at "Total Patient Month's per episode of peritonitis". That's what all Renal Units use when you are looking at infection rates. Then there's just a print-out of each year. For instance, we've got 1999, 2000, 2001 and 2002, 2003, 2004 and five and it just demonstrates the infection rate that we have experienced over the years and how we benchmark against other units and how we look at our own infection rates to see what's happening.

COMMISSIONER: And whilst I'm sure those of us up here already understand what you have said, just so that everyone is on the same wavelength, the lower the figure the worse it is?-- The worse it is, yes.

And the higher the figure obviously means that patients are experiencing many more months trouble free?-- That's right.

Mr Andrews, you will tender that?

MR ANDREWS: Yes, Commissioner.

COMMISSIONER: That will be 68.

ADMITTED AND MARKED "EXHIBIT 68"

COMMISSIONER: Mr Allen, do you have any re-examination?

MR ALLEN: No, your Honour.

COMMISSIONER: Thank you, Mr Allan. Mr Andrews?

RE-EXAMINATION:

MR ANDREWS: Those statistics, do you still have them before you?-----

COMMISSIONER: No, we've just got them.

MR ANDREWS: I have got a copy you can look at. I see that the first page headed "Total Patient Month's per episode of peritonitis" is different from the other documents which each bear the word "Baxter" in their left-hand top corner?-- Mmm.

This first page, was it prepared at the Bundaberg Hospital?-- Yes. I prepared this page in that format because I presented - I gave - I registered with the Quality Committee the activity of infection rates. So back in, I think, 2001 Leonie Raven from the quality department of at the hospital and Peter Leck came and did an audit within the Renal Unit and in preparation I think at the time for accreditation, so I discussed with - Robyn Pollock was absent on that day, so I discussed with them the quality activities that we were undertaking within the Renal Unit, one of them being the monitoring of infection for peritoneal dialysis of patients looking at peritonitis at exit sites. I do have in my possession the data in relation to the POET forms for the other years, just purely the reports printed off from the Baxter POET Program.

Ms Druce, so the figures you got for '99, 2000 and 2001, you prepared in 2000 and - in what year for Mr Leck and Ms Raven?-- I just can't recall. It may have been towards the end of - it was for the review, the accreditation review for the hospital. I can't be sure of the dates.

Now, the balance of the documents in the exhibit, which are each headed - each have the word "Baxter" in the left-hand corner, are they prepared by someone outside the hospital?-- No. No, the Bax - the software that we use is a Baxter licensed software and it's on my computer at work and I input the data in relation to episodes of peritonitis. So this is just a reporting tool.

I see. And these episodes of peritonitis, are they - the data is input by you?-- Or the other renal nurses. Mandy McDonald would relieve in my absence though.

Is it available at any time throughout the year?-- Yes.

By going to anyone in the Renal Unit?-- Only going to my computer and accessing it because it's only set up on my hard drive. But anyone in the Renal Unit can have access to it.

COMMISSIONER: And in your absence they would speak to your replacement and get access to it?-- Yes.

MR ANDREWS: I have no further questions, thank you.

COMMISSIONER: Thank you, Mr Andrews. Ms Druce, you will realise, of course, at this stage of the proceedings it's inappropriate for us to make any findings or express any conclusions, but having spoken with the two Deputy Commissioners outside, can I simply say how much we appreciate you coming in and giving us your evidence. But also I would like to say on behalf of the three of us that we are well aware of the fact that Bundaberg Hospital generally has had a lot of adverse publicity arising out of these matters and we can certainly say that the way in which you've given your evidence and the care and concern for your patients which you have demonstrated in giving your evidence has, I think, done a lot to - or should do a lot to restore people's confidence in the calibre of people who are working at Bundaberg and the quality of service they're provided. That I should add is not a comment we make only in respect of you, but also in respect of yesterday's evidence, Ms Aylmer. It is in the context of these proceedings very gratifying to find that there are people like yourselves who have been working at the hospital putting the patients' interest first throughout all of these difficult times. Margaret?

D COMMISSIONER VIDER: I would simply concur with that and thank you very much for the evidence and the way in which you have been able to present it?-- Thank you.

Thank you.

D COMMISSIONER EDWARDS: I concur too.

WITNESS EXCUSED

COMMISSIONER: We will now take the lunch adjournment and resume at, say, 2.15.

THE COMMISSIONER ADJOURNED AT 1.02 P.M. TILL 2.15 P.M.

THE COMMISSION RESUMED 2.20 P.M.

COMMISSIONER: I am sure what I am about to say will be of assistance to everyone, but the Deputy Commissioner and Senior Counsel Mr Andrews had the opportunity over lunch to explore the progress of these proceedings with witnesses. One thing we would like to get across is that we don't really see it as being within the terms of our reference, nor do we think it's particularly useful to the resolution of the issues raised in our Terms of Reference to focus too much on issues like whether people spoke in a particular tone of voice or whether they were angry or whether it was justified that they were angry and so on.

In saying that, I don't mean that in any sense as a criticism of any of the questioning asked by counsel. Particularly when you have a statement that attributes to someone a negative tone of voice, counsel's natural reaction is to challenge that if your instructions are contrary. But I think things will move a lot more quickly and will get to the heart of the problems we are facing a lot more efficiently if we can try and focus on issues of substance as to what happened, who did what if individuals are alleged to have ignored complaints, for example. That then would be an important matter but if they reacted in a way that other people took offence to that's really just a subjective view as to how the matter was handled, and really what I would like to do is to alert everyone to try and focus on the important issues that we are here trying to deal with rather than personal issues or matters of subjective impression that don't really assist us in getting to the heart of the problem.

I emphasise that those points are not intended as criticism of anyone. Indeed, the competence with which proceedings have been handled in the last day and a half has been outstanding, and I congratulate all concerned. Those remarks may perhaps assist people in restricting their interest to issues that do matter rather than those that don't.

Does anyone want to raise anything arising out of that?

MR ANDREWS: No thank you, Commissioner.

COMMISSIONER: Thank you. Mr Andrews?

MR ANDREWS: Before calling Ms Pollock to the stand, the parties are anticipating that today you will hear, if time permits, from Ms Pollock, Jennifer White and possibly from Patrick Martin and tomorrow's witnesses would be Leonie Raven and Ms Kirby. Some of the parties and, indeed I include myself, would find it more convenient if Ms Raven and Ms Kirby were postponed so that their extensive material can be better analysed, and for that purpose I propose after hearing from Mr Martin as the third of the next set of witnesses to call Ms Hoffman so that she may be cross-examined.

COMMISSIONER: That sounds sensible if everyone's agreeable to that. Mr Morrison?

MR MORRISON: Only one aspect, Mr Commissioner. I certainly haven't seen any statement by Mr Martin.

COMMISSIONER: I don't think I have yet either.

MR MORRISON: No. So any cross-examination will be necessarily truncated by the need to get instructions on matters he says.

COMMISSIONER: Of course. I think it is probably ambitious to imagine we will get to Mr Martin this afternoon anyway.

MR ANDREWS: His statement has been handed to me within the last minute or so.

COMMISSIONER: All right. Can we make sure that that is circulated? Now, I realise Mr Morrison and others will be focusing on the evidence as it unfolds so they won't have a chance to review that. It may be if we reach Mr Martin we will hear his evidence-in-chief and the witness can not literally but figuratively remain in the witness box overnight so any cross-examination can take place the following morning.

MR ANDREWS: Thank you. I call Robyn Pollock.

MR ALLEN: If the Commission pleases, I appear.

COMMISSIONER: Thank you, Mr Allen.

ROBYN POLLOCK, SWORN AND EXAMINED:

COMMISSIONER: Ms Pollock, make yourself comfortable. There's a jug of water there if-----?-- Thank you.

-----you need it. Can you tell us your full name?-- My name is Robyn Pollock.

And we are able to contact you through the Nurse's Union if necessary?-- That's correct.

Yes, thank you, Mr Andrew.

MR ANDREWS: Ms Pollock, you have provided-----

COMMISSIONER: Sorry, I do beg your pardon. Do you have any objection to having your evidence filmed or photographed?-- No. That will be fine. Thank you.

Thank you.

MR ANDREWS: Ms Pollock, you have provided a statement dated

the 25th of May 2005. Do you have a copy with you?-- Yes, I do.

Are the facts in that statement true to the best of your knowledge?-- To the best of my knowledge they are.

And any opinions you express in it, they're honestly held by you?-- Yes, they are my opinions only.

I tender that statement.

COMMISSIONER: Ms Pollock's statement dated the 25th of May 2005 comprising 14 pages plus attachments will become Exhibit 70.

ADMITTED AND MARKED "EXHIBIT 70

MR ANDREWS: Thank you, Commissioner. You are the Nurse Unit Manager of the Renal Unit at the Bundaberg Base Hospital?-- That's correct.

And you have been in that unit for nine years?-- That's correct.

And you were called Nurse In Charge of Renal Services until - well, from 1998 until March 2002 when your position was upgraded to Nurse Unit Manager?-- That's correct.

Now, Dr Patel was the general surgeon that your unit used to place Tenckhoff and central venous dialysis catheters during the period from August to December 2003?-- That's correct.

Did your unit use any other surgeons during that period?-- Not that I can recall.

Dr Patel initially was a frequent visitor to your office and spoke to you in a friendly way?-- That's true.

Now, as I understand it, there was an event in November 2003 that was reported to you about two patients that led to a cooling of Dr Patel's friendly disposition towards you?-- That's true.

Would you look at this confidentiality key? In particular, please turn to look at the patients P52 and P53. You refer to them in your statement at paragraph 10?-- Actually they are not the correct patients, I'm sorry.

Oh. I'm glad we have gone through that process. Are they on the patient kit?-- Not that I can see actually.

Well, I should correct, then, or do you mean to correct paragraph 10 where you refer to patients P52 and P53? You might be able to supply their names so that we can have them

added to the patient key.

MR ALLEN: If the Commission pleases, the patient list at P56 and P57 notes in relation to those names was P52 was P53?-- Sorry, yes, that's true.

The difficulty in the early 50s arose because the patient key which had been supplied by instructing solicitors was supplemented by the Commission-----

COMMISSIONER: Yes, I understand.

MR ALLEN: -----without some synchronisation at that point.

COMMISSIONER: Let's just make sure that all of us understand what's going on. Ms Pollock, where the statement refers to P52, is that one of the ones Mr Allen just mentioned?-- That's true. It should be - should read P56, yes. Sorry.

So wherever you refer to P52 we will understand that as referring to P56?-- Yes.

And P53?-- Should be P57.

All right. Now, are there any other patients you recall in your statement we need to clarify in that regard? On page 5 paragraph 20 there's a reference to P30. In fact, it comes in-----

MR ANDREW: On page 4 in the heading.

COMMISSIONER: The subject, "Death of the Patient P30."?-- That is correct. He was P30.

That is P30. Good.

MR ANDREWS: And one sees patient P51 on page 6 at paragraph 24; is that correct?-- I don't feel it is. I'm not aware of that patient by the name of P51.

COMMISSIONER: Mr Allen, do you have anything that you can assist us in knowing who that is supposed to be?

MR ALLEN: I would have to take instructions. My instructing solicitor's not far away.

COMMISSIONER: All right. We will leave that for the moment. I also note that there are a number of references to a Dr A. Is there some reason why that doctor's name is excluded?-- Sorry what?

Sorry, in the copy I have got, if you go to page - paragraph 22, for example, in the last line my copy says "Dr A, a nephrologist".

MR ALLEN: That was inserted by the Commission, not by the witness.

MR ANDREWS: I don't have the advantage of that copy. Commissioner, it will be because that person at the time the statement was prepared with Dr A had not been contacted to be notified that there were some adverse comments that appear about him within this statement. He has since been located in England and he's had some limited opportunity for e-mail correspondence with the inquiry staff, but his name can be inserted.

COMMISSIONER: What is his name?

MR ANDREWS: Dr Cochran, C-O-C-H-R-A-N.

COMMISSIONER: Finally, when we get to page 13 there's the reference to patient P23. We have heard evidence about her earlier today, and that is the correct number?-- Okay.

Yes?-- Yes.

MR ANDREWS: In November - I beg your pardon. On the 25th of November three nurses came to see you to discuss Dr Patel's handling of two renal patients earlier the same day?-- That's correct.

You were the appropriate person, were you, to come to because you were the manager of the Renal Unit?-- That is correct.

They told you that Dr Patel was going to test the blood flow through catheters?-- That's correct.

And they described the events which are set out on page 3 at paragraphs 10 and following?-- That's correct.

Now, as I understand it, in reading your statement you have no personal knowledge, that is you weren't there to see what's described in paragraphs 10, nor 11, nor 12?-- That's true.

Commissioner, it is intended that one of the eye-witnesses will provide a statement and that is anticipated shortly.

COMMISSIONER: The relevance for the moment is simply that Ms Pollock received a report from those eye-witnesses and as a result of that report advised the nurses to fill in a complaint and things went from there?-- That's true, yes.

Yes. Sorry, I shouldn't say complaint, an incident form?-- An incident form, yes.

MR ANDREWS: Yes. Now, you went with Gail Aylmer to see Dr Keating on the 27th of November?-- That's true.

And you recounted the incident to Dr Keating as it had been described to you?-- That's correct.

And as it appears in paragraphs 10, 11 and 12 of your statement?-- That's true.

What is it that you recall Dr Keating to have done or said?--

We raised our issues with him about the incident that happened and Dr Keating listened to what we had to say, but he basically said he needed data to support, you know, what we were saying, that we had other issues along with any infection control that - you know, if we were to pursue that further he really needed data to prove that there was - you know, things happening in the Renal Unit, basically, you know, how many infectious episodes there were in Dr Patel's patients. He said it was difficult for him to intervene in Dr Patel's practices without having that data. He did say, though, that he would speak to Dr Patel about the incident in the unit and I do believe that he did do that purely and simply because I felt it must have been the next day because from that day on basically Dr Patel would not speak to me. He basically ignored me wherever - if he was in the same room with me he would speak to somebody to speak to me. So-----

COMMISSIONER: Just on that point then, you have this meeting with Dr Keating?-- Yes.

Where Dr Keating tells you that you have to have data to support how often infections were occurring and so on?-- Yes.

We have heard evidence this morning from Ms Druce about the POET system-----?-- Yes.

-----that was in place and ultimately she has produced to us some statistics showing a very dramatic-----?-- Yes.

-----increase in the incidents of infections during 2003 and 2004. Is there some reason why when Dr Keating indicated that he needed statistics at that time no-one went to the POET system and took out those statistics?-- It was basically as a result of that meeting with Dr Keating that I thought, well, if you need data, we have got the data, so that's when I went back to Lindsay and sort of said, right, let's get on to this, you know, because I knew the data was there.

Yes?-- So that's how it all sort of - I guess started.

Right. Would it be wrong then for me to think that the POET system was set up in such a way that you could immediately go to it and get a print-out of what the current data was?-- That's correct, because it's kept up-to-date. It's like a real-time event data. So it happens - you know, in real time, so that if an adverse event happens, that's inputted at the time of that event. So, the girls that have access to it try and keep that as up-to-date as possible, so that on any given day you can go in and you can print out exactly what has happened in real time.

Okay. What usually happens with this data? I am asking in the sense it - is it usual to provide a report to the Executive at regular intervals as to what is the infection situation in the Renal Unit?-- I guess we have never really had a call to do that because they are probably - you know, when you benchmark against other units there was really - we were within guidelines, you know, within what other units were

doing. We also belong to a renal collaborative, which looks at benchmarking, you know, adequacy and infection rates and everything else. So, you know, there's forums and that happens twice a year and we participate in that. So data is sort of - you know, brought up then. That's sort of between the nurses and the neurologists of the units right throughout Queensland. But as for going back to the Executive, well, they would have the report Lindsay prepared for the audit in 2001 and we had given other in-services at the Heads of Department meetings. We sort of give presentations and I know that Mandy McDonald did give a presentation to the Heads Departments. It probably would have - just off the top of my head, I don't know, it was 2003 looking at infection rates in cuffed and noncuffed central venous catheters.

If I can, Mr Andrews passed over this probably for good reason, but if I can take you back to paragraph 7 of your statement?-- Yes.

You indicate there that you felt uncomfortable about Dr Patel's frequent visits and the length of time he spent in your office discussing not only patient matters but other personal matters. Is the implication that you felt threatened in a personal sense by Dr Patel's presence?-- I guess you could say that, yes. And the staff - you know, were aware of that because they even sort of commented on the time that he spent in my office. So we had a system worked out whereas if he was in there for any length of time they would phone me and say I was needed on the floor for a clinical problem.

Thank you, Mr Andrew.

MR ANDREWS: Would you look, please, at Exhibit 68, a copy of which is with the secretary. As I understand it, you have there a bundle of documents showing data about infection?-- That's correct.

Well, indeed, peritoneal-----?-- That's right. In our analysis population, I just like to say I didn't really need to see the data. We already knew what was going on. It was just so that we had proof to go to Executive on.

Well, as I understand it, it was on about the 27th of November that Dr Keating told you it was difficult for him to intervene but that he wanted to know how often the infections were occurring and how many episodes there were in Dr Patel's patients?-- Mmm.

Weren't you able to use data such as appears on the pages before you to immediately answer part of Dr Keating's request?-- We knew about - you know, that the peritoneal data program, I guess, was at risk because of the amount of infections that we had experienced, but we look after - you know, the haemodialyses population as well, and to get data on that is very different. We don't have a reporting system at the moment that - you know, we can capture that data. But certainly, you know, I indicated to Dr Keating that I would go back and get that data to him and that as a result was the

report that Lindsay provided this morning.

COMMISSIONER: I guess, anticipating questions you might be asked, people can say to you, well, when Dr Keating said on the 20th - 27th of November I need data to take this any further-----?-- Mmm.

-----why was it that you couldn't get the data to him almost immediately?-- I don't really have an answer to that. Yes. I mean, we have gone back - I guess we just wanted to make sure that the data we got was true and correct before you sort of go ahead making allegations against people. So, to really investigate that fully - yeah, we sort of wanted to make sure that what we actually had was exactly what had transpired.

By the same token, people might also ask why Dr Keating didn't come down to the Renal Unit and say, well, show me what data you have got and-----?-- Mmm.

No response like that?-- No.

MR ANDREWS: You asked Lindsay Druce to attend to data collection?-- Yes, yes.

Something happened on the 17th of December 2003?-- Yes.

Now, that was with respect to patient P30?-- That's correct.

He needed a Tenckhoff catheter resited, did he?-- Yes, that is correct.

Why was that?-- There was problems with the position of the catheter and he was having - I think it had migrated, so he needed that sort of - for him to have adequate dialysis, you know, with peritoneal dialysis he needed that corrected for him to sort of continue using that mode of therapy.

I've heard some of the problems that occur when catheters migrate. Was it the case that it wasn't draining effectively and that there was an infection?-- That's correct.

And because that catheter wasn't draining properly, what temporary remedy was required until that catheter could be resited?-- Well, at that time he was taken off peritoneal dialysis and placed on haemodialysis while they were having problems, and he was - the access use for that was a temporary central venous catheter. I don't recall where it was situated at the time - it was too long ago - whether it was the femoral or the internal jugular vein, but that is what he was having. That was the treatment he was having, haemodialysis, until it could be rectified.

And was it - did a complication arise when the temporary central line for haemodialysis was being placed?-- It would appear so, because the patient died as a result.

Who was placing that central line?-- It was Dr Patel at the time.

You set out the coroner's finding that the patient died as a result of haemopericardium due to the thoracic veins being perforated during the procedure-----?-- That's correct.

-----on 17 December?-- That's correct.

Do you attribute any blame to Dr Patel for that patient's death?-- I do. I believe that he was responsible for that gentleman's death.

Well, I see you set out what Dr Patel did on the 17th of December. Was it Dr Patel's actions on 17 December that you regard as the cause of that patient's death or something at an earlier time?-- No, it was the events of the 17th of December.

COMMISSIONER: Sorry, the treatment he needed on the 17th of December - this is patient P30 - was as a result of a failure of the earlier catheter placement?-- That's correct.

So I can understand, you might say if Dr Patel had got that right in the first place he wouldn't have needed further treatment on 17 December. Is that your complaint? Or is there something else?-- No, I believe that's the case, that if he - if we hadn't had problems with the Tenckhoff catheter in the first instance, he wouldn't have had to return to theatre and subsequently have a CVC line placed and then have a rupture of his thoracic veins.

Mr Andrews, unless anyone has any objection, this is the second witness we've had who makes a connection between the death of this patient and Dr Patel's treatment as a surgeon. I'm not for a moment suggesting we've made any finding about that, or that we will necessarily make any finding, but it seems to me that in those circumstances we should lift the suppression order previously made in relation to that

patient's name. Does anyone have any different view? Henceforth the name of patient P30, Eric Nagle, may be mentioned as such, and any suppression order in relation to that name is now revoked.

MR MULLINS: Commissioner, I'm sorry to interrupt, probably at an inopportune time as you finish that order. Linda Nagle is a client of the Patient Support Group-----

COMMISSIONER: I will revoke that revocation until you've had an opportunity to get those instructions from her and let us know how she feels about that.

MR MULLINS: We'll get them as soon as we can.

COMMISSIONER: Thank you.

MR ANDREWS: After the death of that patient, did you overhear a conversation between Lindsay Druce and Dr Miach?-- That's correct.

They were discussing the death of that patient?-- That's correct.

As well as you recall it, can you tell us the effect of Dr Miach's conversation with Lindsay Druce?-- Basically the bottom line was that he didn't want Dr Patel operating on his patients.

It was at a Medical Clinical Services meeting in June 2004-----?-- Yes.

-----after Dr Miach had returned from leave that you heard Dr Miach again speaking of this?-- That's correct.

What is it that you recall him to have said at that meeting?-- He was actually having - we were having a discussion about medical coverage in the areas that Dr Miach looked after - which was the Renal Unit, Medical Ward, Intensive Care and Rehab - and just how he'd been keeping statistics on the medical cover of those areas, and it came up then that - he reiterated, I guess, that he didn't want Dr Patel touching his patients because he had issues with what had happened in the past. He basically told the group there - there was three other Level 3 nurses there from those areas that I mentioned and - but he asked that that not be minuted.

Who were those nurses? Do you recall?-- Yes, there was Toni Hoffman, Dilys Carter who is a Level 3 of the Medical Unit, and Rens Schoneveld who is a Level 3 of the Rehab Ward.

Back to an earlier time in 2004, Dr Miach, on 29 January 2004, was to leave for 10 weeks' leave to return in mid- April. With whom did he leave orders about his patients? With you or somebody else?-- He spoke to us. We were aware of his request of not letting Dr Patel - but he also informed his registrar at the time, Dr Toby Gardner, about his request, and it was well known. I mean, most of the doctors on his team

were aware of his desire that Dr Patel not treat his patients.

The registrar's name doesn't appear in my statement. Could you say that name again?-- It was Toby Gardner.

Thank you.

COMMISSIONER: It is actually in paragraph 24, I think.

MR ANDREWS: Thank you, Commissioner. Dr Malcolm Cochran, a nephrologist, was recruited during the absence of Dr Miach. Is that the position?-- He was one of the two consulting nephrologists that replaced him for that time, yes.

And you don't know whether Dr Cochran was aware of Dr Miach's instructions?-- I can't say for sure whether he was.

There was another patient who, at paragraph 24 of your statement, is called P51. Can you-----

COMMISSIONER: Mr Allen might be able to help us with that.

MR ALLEN: Commissioner, if you go to the patient list to P55, you will see in brackets "formerly P51".

WITNESS: That's correct.

COMMISSIONER: It's in a sort of fade-out print in our copy, but that's the person. Okay.

MR ALLEN: As with the other two, it arises from a situation when both my instructing solicitors and the Commission's solicitors were updating the list.

COMMISSIONER: Yes. We know what we're talking about in paragraph 24 and following. We're talking about patient P55. Thank you, Mr Allen.

MR ANDREWS: P55 needed a catheter placed. Was Brisbane an appropriate place to send a patient for catheter placement?-- It was, and that was normally what would happen. If we didn't have somebody available to place a catheter, they would normally go to Brisbane. Unfortunately at the time Brisbane were having problems of their own with anaesthetists and nephrologists and getting theatre time, so they basically said that we had a service in Bundaberg and we had the resources to provide that service, so they were very reluctant to sort of treat any of our patients at that time.

You had Dr Patel, but instructions not to use him?-- That's correct.

Were there any other surgeons available?-- Not that I'm aware of at the time.

Was there any request to surgeons outside the hospital to volunteer their services or to attend as Visiting Medical Officer for the purpose of this surgery?-- I wasn't aware of

anything in place at that time.

What happened?-- Okay. Dr Cochran - because this patient needed basically dialysis fairly soon, and it was fairly urgent we get this catheter placed, he suggested that he could place the catheter. He had done it previously. I think just off the top of my head it might have been 10, 15 years prior to that, but he was willing to basically place the catheter under the guidance of Dr Wijeratne who is an obstetrician at the Bundaberg Base Hospital.

During the procedure you say that Dr Cochran perforated the bladder of the patient?-- That's correct. Lindsay Druce and myself actually went to theatre because we had some concerns. We were worried about patient outcomes, so we decided to go to theatre and just offer any support that we could to Dr Cochran and Dr Wijeratne. There was a bit of conflict, I guess, Dr Wijeratne felt at that time that he wasn't comfortable doing the procedure because Dr Patel was in theatre at the same time, so - but Dr Cochran convinced him that this was a fairly urgent thing, that we weren't receiving help from Brisbane, and that we really needed to go ahead. We gave - we have some educational materials that Baxter have provided us, and one of those is the insertion of a Tenckhoff catheter, so Dr Cochran looked at the tape and I got on to the Baxter Health Care company, talking to Brian Graham who is their clinical representative, and asked him exactly what we needed to - what instruments we needed to perform - for that surgery to go ahead. So he gave me a list of what was needed and we then checked with theatre if they had those instruments, and at the time they didn't, so I ordered the instruments to make sure that we had everything that we - to make sure that we could basically do everything that we possibly could to get this catheter inserted in a reasonable fashion.

D COMMISSIONER VIDER: What was the role of the obstetrician in this procedure?-- He knew the anatomy, so he basically - I think Dr Cochran was saying he knew where the pouch of Douglas was, so that's why he wanted - he said he'd be very aware of that, so that was why he-----

Who? The obstetrician would be aware of it?-- The obstetrician would be aware of it. I know. It was the first time he'd operated on a male in some time.

COMMISSIONER: Was anybody getting on to Dr Keating and saying, "Look, we really need a surgeon. Can we get in a private surgeon to do this?"?-- Not that I'm aware of, and I guess we felt as nurses that that wasn't our role, that sure, we would have liked to have seen that happen, but I guess, you know - yeah, we felt that wasn't our role to be sort of procuring surgical services.

There were, as I understand it, two different doctors who were, in effect, locums for Dr Miach while he was away. One was Dr Malcolm Cochran who we've just heard about, the other one was Dr Martin Knapp?-- That's correct.

Did Dr Knapp have any part to play in this decision?-- No, he didn't. He wasn't there at the time. They divided up the time that they were there to cover Dr Miach's leave. So basically I think how it transpired was Dr Knapp - over the 10 week period - did two weeks leave, then he left, Dr Cochran came in his place to cover - I can't recall. He might have been there four weeks and then Dr Knapp returned at the end of that four weeks and finished off the other couple of weeks.

So Dr Knapp wasn't on the scene anyway?-- No, no.

Thanks.

MR ANDREWS: The adverse outcome of a perforated bladder, can you be sure that that occurred?-- I can. I was actually asked to smell the urine when he perforated the bladder, and we tested - tested the specimen that was collected in a kidney dish.

Is smelling urine a-----?-- Well, it smelt like urine and it looked like urine and it tested for urine - that it was urine. So a catheter was placed subsequently, an indwelling catheter was placed into the gentleman's bladder and there was no further problem with that.

Dr Cochran has asserted that during the procedure an assisting surgeon asked, "'if I had perforated the bladder', which I knew was impossible, as I proved to him, and the nurses heard him ask this", is it possible that there was no perforation of the bladder?-- I'm sorry, I'd have to disagree with that.

How serious a complication is perforation of the bladder?-- I don't feel I can comment on that.

Does the patient still - did the patient continue to attend the Renal Unit?-- He did, and he still does.

And so far as you know, apart from the fact that he needs to attend the Renal Unit, is he in good health?-- He is. He's not actually having peritoneal dialysis. He's actually on haemodialysis.

Exhibit RP3 to your statement, I'd like you to compare it, please, with Exhibit 69. You can hand back Exhibit 68 when someone approaches you. Do you recall seeing Exhibit 69?-- I do.

What do you recall about the relationship between Exhibit 69 and Exhibit RP3 to your statement?-- Exhibit 69, I believe, was the draft document, and the document I have in RP3 was actually the completed document.

MR MORRISON: Mr Commissioner, I've just asked whether we could have Exhibit 69 on the screen because none of us have copies of it yet.

COMMISSIONER: Yes, yes, of course.

CLERK: With the names displayed, Commissioner?

COMMISSIONER: Yes, yes, that's fine.

MR ANDREWS: Are you able to say when you first received RP3, which is the final version of that draft?-- I believe it was on the day we went to see Patrick Martin, and I believe that it shows on the software when it was created, and that was the 10th of February 2004.

COMMISSIONER: So RP3, the final version, you say, is the 10th of February 2004?-- I'll check that. It was the day we went to see - I went to see Patrick Martin, myself and Lindsay Druce. I believe that was - hang on. I'll just check.

D COMMISSIONER VIDER: Yes.

WITNESS: Is that right?

COMMISSIONER: Paragraph 30, I'm told.

MR ANDREWS: Was there ever a time when, as one looks at Exhibit 69, the draft - was there ever a time that you were unaware that the surgeon for each of those cases was Dr Patel? I see that Dr Patel's name is only adjacent to one patient?-- I guess when you're doing up a document like this you like to have all your facts correct and you wouldn't go putting, sort of, information in that you knew was not correct, so until you checked that, I guess you wouldn't write that. That would be my interpretation of what's happened there.

I see. Are you able to say whether, by the time you saw Patrick Martin, you'd determined that Dr Patel was the surgeon for each of the patients who'd had adverse outcomes?-- I knew for a fact that it was by that time.

And do you remember whether you raised that fact with Patrick?-- I believe we did.

In any event, I understand you believe that Patrick received RP3?-- That's correct, at the time that we went to see him.

And he promised to speak to Dr Keating?-- He did.

Did Patrick report back to you as to the outcome of his meeting with Dr Keating?-- Patrick actually emailed me back that same afternoon and said that he had in fact spoken to Darren Keating, and while I was pleased that Patrick had raised our concerns with Dr Keating, the email suggested that Dr Keating still needed more information despite six cases being documented, and to be quite frank, I thought six out of six was pretty good, but I didn't feel that it was going to be investigated further.

Did Patrick know that it was six out of six?-- I felt that he did.

Is the email to which you refer RP5?-- Yes, that's correct.

Someone's written on it "cc'd to Darren Keating at the time"?-- That's correct.

Whose handwriting is that?-- That's Patrick Martin's.

Now, what extra data were you able to collect?-- I guess that's where I sort of perceived that if I didn't provide more data, that nothing would be done, because basically the email is saying that they would like all renal related cases uneventful versus the number of adverse events which have occurred as a result of intervention by Dr Patel, and to collect that data would have required quite a lot of time which, unfortunately, we don't have the luxury of having, so I just felt that our efforts were being thwarted and that we weren't being supported, and therefore we could - maybe had to look at other avenues to sort of - or lose our peritoneal dialysis service, which we had sort of taken quite a few years to get up and running and established.

Looking at RP5 - and I see there's a request for "stats regarding procedures undertaken by Dr Patel highlighting all renal related cases uneventful...", how many cases - how many renal related cases did Dr Patel participate in?-- I wouldn't be at liberty to say. I felt that it would be quite numerous.

So it's more than just the six catheter placements?-- Many more. He used to also place our central lines, our cuff central lines, so he did that, and as well - he did some surgery on our dialysis population. So I know he - because some of those patients had - ended up in Intensive Care and we were providing dialysis down to them while they were inpatients of the Intensive Care Unit. So we were in the Intensive Care quite a bit.

COMMISSIONER: This isn't directed at you, but I'm finding a lot of this quite mystifying. If you've got a 100 per cent complication rate with one procedure, how is that going to help anyone to compare that with an entirely different procedure which may have a 100 per cent success rate?-- It wouldn't have, but that's why I sort of felt that I was getting nowhere. I felt that I had to - we had to do something, so-----

MR ANDREWS: Now, the something you did had to do with Baxter Health Care?-- That's correct.

Brian Graham was the representative of Baxter, a very approachable person?-- Yes.

And he came to Bundaberg in December 2003?-- That's correct. I had spoken to him prior to that though. I'd been to a forum in Brisbane for the renal collaborative and actually spent some time - Baxter own a private unit at Greenslopes Hospital and we actually had a tour of that, and I spent some time at the unit with Brian, and they had just set up a new area in that to look after peritoneal dialysis services, and that's where he first sort of spoke about a program that they had

that they would be willing to - if we ever required a nurse for training our peritoneal dialysis patients for home therapy, that they could provide that service if we ever needed it. So that's where it first started. And I explained to him that we were having problems with our peritoneal dialysis population and that's where it was first raised.

What were the problems that you explained that you were having?-- They were things that Lindsay Druce highlighted in that report, from exit site infections - I mean, every exit site that we had was the wrong way. I mean, you just had to look at the patients and everyone that came - you didn't need - it was good to have the data, but they weren't - I guess there was a lot of catheters inserted in a small amount of time, which wasn't always the case, but every one of those came back with a complication. So we were aware that there was problems.

Brian visited your Renal Unit?-- That's correct.

On the occasion of one of those visits Dr Patel entered?-- That's correct.

Can you tell us what happened?-- I thought it was an opportune time to bring up - because Brian sort of said that he could offer support to the surgeons. He didn't know at that time that it was - I think I mentioned it was basically one surgeon we were having the problems with, and Brian suggested that maybe they could offer them some training, and we had been discussing this in the unit itself, and Dr Patel happened to walk through so I thought it was a great opportunity to introduce them and maybe get some resolution. Maybe he would listen to a company representative that was making these catheters and providing the equipment that we're using, and he might be able to - he obviously wasn't going to take direction from nursing staff. He'd - Dr Miach had also spoken to him prior to this about - that he felt there were issues with his technique, and that wasn't taken on board. So this was-----

Do you recall whether this was before or after the death of patient P30?-- I felt it was before. I can't be sure.

Patient P30 died on 17 December-----?-- Right.

-----if that helps?-- I can't be sure. It's a little too long ago.

COMMISSIONER: You're on leave from the end of December 2003?-- That's correct.

So it's something that occurred before you went on leave?-- Yes, yes.

It may have been-----?-- I feel that it was before the death of that patient, but I'm not 100 per cent sure.

MR ANDREWS: When Brian told Dr Patel that Baxter would be

happy to provide support or education for catheter placement technique, what did Dr Patel say?-- He basically - I can't recall his exact words, but it was along the line, "Well, you can fly me to Brisbane, you can wine me and dine me, put me up somewhere nice, and then I might listen to what you have to say", and Brian's response to that was he felt that that was an inappropriate approach, but he was willing to offer support in other ways.

You went on annual leave?-- That's true.

Returning in February, and at that stage proposals to accept the help of the Baxter Group-----?-- Yes.

-----were further advanced?-- That's correct.

Exhibit RP7 is your email to Brian Graham?-- Yes.

The general surgeon that you call "the pig of a man you met here who can't place a Tenckhoff", would that be Dr Patel?-- It would, and you can tell I was a little frustrated by that time.

Yes, I could. He clotted a graft on Saturday morning. I don't understand that?-- A graft is a synthetic tube that's put into a patient's - between a patient's artery and vein to be able to be used for haemodialysis and the patient in question was from Hervey Bay. It actually wasn't one of the Bundaberg patients.

Is declotting a graft a good or bad thing?-- It is trying to salvage that vein to try and use it for further treatment, and it is usually the first course in treatment if any synthetic graft blocks off, and they are notorious for blocking off. That is one of the complications with having a synthetic graft. Clotting is one of the risks.

Am I to conclude that the fact that it declotted - or reclotted, rather, that evening could have happened even with the best of techniques?-- That's correct.

Now, on the 15th of June you attended a round table meeting?-- That's correct.

Why wasn't Dr Patel invited, do you know?-- I assume that he wasn't welcome. I mean, that was basically, you know, the reason that we held the round table forum at the Friendly's Hospital because we had, you know, problems with his placing of the Tenckhoff catheters and Baxter had come on board and said they were willing to offer this program - they trialled it in Western Australia, I believe, and they had great success with the program - and so it was basically to talk about that program. I believe that Dr Miach had spoken to Darren Keating prior to that to - you know, to get the meeting set up and informed him of what was going on.

Was Dr Patel's name mentioned during the meeting?-- The meeting at the Friendly's?

Yes?-- I can't recall, but I don't feel it was.

The November meeting of the Renal Consultative Forum at the Princess Alexandra Hospital-----?-- Yes.

-----you attended that?-- That's correct, I usually attend those meetings every three months.

Can you tell us what you learned at that meeting?-- Well, basically one of the representatives from industry usually are asked to present some innovation or something at those meetings and at that time it happened to be Baxter Healthcare, and basically Brian was the representative that attended. He spoke about the program. He didn't actually mention Bundaberg's name. He said Central Queensland was utilising their services and the Baxter Access Program, you know, had proven successful. I think at that time - I'm not sure how many catheters - it might have been three or four had been placed - and just basically gave the other nurses - the other Level 3 nurses at that meeting the overview of what the program involved and what services Baxter were willing to

provide. At that meeting, one of the - the Level 3 from Rockhampton spoke up and said - basically she said that they had been trying to get that program passed through their Executive as well, but it was held up because their Executive felt it was a conflict with - you know, because the company was providing the consumables. So, because it was a conflict of interest, they couldn't get the program passed.

Was it suggested that they had tried to get the program approved?-- They did. That's just what she implied. She sort of said that they tried to get it approved, but Queensland Health had held it up purely and simply because they felt it was a conflict of interest on behalf of a private dialysis company procuring business off us.

You spoke of Queensland Health as if it is an entity separate from the hospital?-- I guess I'm referring to central office - you know, Brisbane.

You meant you were unsure of what she was referring to?-- No, no - sorry, I didn't explain it very well. Corporate Office.

Are you suggesting that that's what the other speaker referred to?-- Yes.

COMMISSIONER: That was the doubt in your own mind, as I read your statement. You weren't certain whether the arrangements that were then in place in Bundaberg had the approval of Charlotte Street?-- That's correct, and I sort of basically told her that we had been using, you know, the program, and that, you know, maybe she could contact our executive and find out how they got that passed.

I must admit, I'm again mystified as to why anyone would think that there's a conflict of interest. I would have thought the only inference was to improve the wellbeing of the patient, but what was the footing - or do you understand what the footing was for the suggestion that there was some conflict of interest?-- I presume - I feel that she was saying that because - once somebody is on the peritoneal dialysis program, the company that has the tender for Queensland for providing the dialysis fluid and any consumables used for the peritoneal dialysis program, it's Baxter Healthcare. So, by basically putting in a Tenckhoff catheter and picking up that bill - I'm not too sure how much that is - they would then be profiting by supplying the fluid and consumables for that patient.

Sorry, this is bizarre. You are using these catheters anyway?-- That's exactly right.

It is the same catheter that Dr Patel was putting in wrongly?-- That's correct.

So there was already a commitment to use the dialysis fluid supplied by that company?-- That's correct.

The only change was to have them put in competently rather than incompetently?-- That's correct.

And someone thought that might be a conflict of interest?-- That's correct.

D COMMISSIONER VIDER: Is that the only company that makes dialysis fluid?-- No. There are other companies, but they are the people that hold the tender for the moment, and the tender is up for review at the moment.

D COMMISSIONER EDWARDS: And they provide these appliances to other Queensland Hospitals?-- Yes, they have got the contract for-----

The whole of Queensland?-- Yes, for the whole of the state.

COMMISSIONER: Mr Andrews, I think we might take the afternoon break now. The reason I want to do that now is just reading ahead in the statement, the subheading, "Meetings with Management - 2000", in paragraphs 44 to 47 seem to me to have very little, if anything, to do with our Terms of Reference, and in the interests of not going down rabbit holes that may prove to be fruitless, I wonder whether you might give some thought as to whether they should be excluded.

MR ANDREWS: Certainly.

COMMISSIONER: Mr Mullins, in the meantime, have you had any instructions from the lady you mentioned?

MR MULLINS: My instructing solicitor will call her back during the course of the break.

COMMISSIONER: Thank you. We will break for 10 minutes.

THE COMMISSION ADJOURNED AT 3.21 P.M.

THE COMMISSION RESUMED AT 3.38 P.M.

ROBYN POLLOCK, CONTINUING EXAMINATION-IN-CHIEF:

COMMISSIONER: Yes, Mr Andrews?

MR ANDREWS: Commissioner, I don't propose to rely on paragraphs 44 to 47.

COMMISSIONER: I will strike out of the record paragraphs 44 to 47 of the statement. Just to explain that, 44 to 47 go to a matter involving particularly Mr Leck, but other individuals, including Dr John Wakefield and Glennis Goodman, which, putting it in general terms, suggests an attempt to

suppress bad news within Queensland Health. We are not particularly concerned about individual acts of that nature, particularly such as this one going back to June or July of 2000. It may well be the case - and the evidence we have received so far would suggest that those individuals were merely giving effect to a Queensland Health policy, and I don't think anyone would criticise those individuals for doing something that was consistent with their instructions from the Office. If there is a problem within the Queensland Health system generally relating to the public relations section of Queensland Health suppressing bad news and promoting only good news, then I think we need to get to the core of that problem rather than dealing with individual cases. That's why we don't propose to go into any evidence on that specific incident mentioned in those paragraphs.

MR ANDREWS: Before I take you to modern history of the 23rd of March 2005, I have been reminded of a patient name - a patient who, from time to time, went to the Renal Unit, a patient now deceased, but appearing, I believe, on the patient key as patient P53?-- Okay.

Do you recognise that patient by the name?-- Yes, I do.

And do you recall that patient?-- I do.

Did she attend regularly the Renal Unit?-- She did.

And is she deceased?-- She is.

As a result of?-- I, off the top of my head - I think she died as a result of sepsis.

That's some time recently, is it not?-- No, I think that was a little while ago. I felt that probably would have been 2003.

Do you remember early in 2003 when Dr Patel was only recently operating at the hospital, that patient to have been a Renal Unit patient?-- That's correct.

Can you tell us what happened during surgery to insert a catheter?-- I can't be sure of the exact date, but I do recall that the patient subsequently ended up in intensive care because her carotid artery had been nicked and she required airlifting to Brisbane to have a carotid patch placed on her artery.

And I gather from the fact that it was the nicking of the carotid artery that this wasn't a Tenckhoff catheter?-- No, this was a central venous line, so a cuffed catheter that's used for haemodialysis.

And why would you not have filled out an Adverse Incident Form in respect of the nick to the carotid artery of that patient?-- At the time, that would have been performed in theatre. A lot of units do it under - you know, with an interventional radiologist, but we don't have the services of

that in Bundaberg, so it is always done in theatre.

I can't be sure whether you have told me - do you recall the name of the surgeon who nicked or cut that carotid artery while placing the catheter?-- That was Dr Patel.

When central lines are placed, can you say whether they should be - are they supposed to be placed into the vein?-- They are. That's the intention, certainly.

And is there any need to be operating near the carotid artery?-- No, no, but then I guess you can't speculate. Everybody's anatomy is different and where their vessels lie, so you would hope - most people would map the veins before they sort of placed - or that's what the suggestion is, that - the guidelines suggests that it is good to map those veins before any surgery is carried out, but that's not always - you know, in an emergent situation, you don't have the privilege of doing that, so I presume that wasn't done.

And you don't know whether this patient's situation was an emergency one?-- At the time I feel it was.

On 23 March 2005, you were notified by E-mail that it was mandatory for you to attend the meeting?-- That's correct.

Who notified you?-- I think it was Cheryl - I can't, off the top of my head, recall Cheryl's name. She is one of the admin support people for the Director of Nursing.

There were about 15-----?-- Cheryl Miller, sorry.

About 15 Level 3 nurses present?-- Roughly. I would say that was an estimate.

You set out on page 12 of the statement that Mr Leck addressed the group?-- That's correct. That was about the time that whole Dr Patel story hit the newspaper.

And do you recall that he said that he knew or believed the nurse was responsible?-- He said it was a nurse, and I know that one of the people in the room actually sort of said, "Are you sure? How do you know that?" I recall him saying, "I have it from a reliable source, but it is not just one source, I have two or three people that can verify it was from a nurse."

And you felt intimidated?-- Absolutely.

You felt that the nursing staff weren't supported or valued by the Executive?-- No, I don't feel we were.

And was it as a result of that meeting that you had that feeling, or had you had it earlier?-- I think it sort of was just part of the culture of that hospital at that time, yeah.

You say "at that time". Have things changed?-- No. Well, they have, actually, yeah. I think they have for the better,

yeah.

In November 2003, you became aware that there were problems with the behaviour of Dr Tariq Qureshi?-- That's correct.

You learned this - did you ever see him behaving oddly or did you learn it from others?-- I learnt it from others. It was second-hand information.

Now, as a Level 3 nurse and head of the Renal Unit, would you have expected to have been informed about this by the Executive?-- I guess, yes, I would, yes.

And were you?-- No, no. We are co-located beside the medical unit where the incident sort of took place, and we sort of - word filtered down, I guess you could say.

Did you ever see Dr Qureshi escorted into the Renal Unit or escorted anywhere else after you became aware of the problem?-- Not that I can recall.

I have nothing further.

COMMISSIONER: Thank you, Mr Andrews. Mr Mullins?

MR MULLINS: Thank you, Commissioner. Ms Pollock, my name is Mullins. I appear on behalf of the patients.

COMMISSIONER: Sorry, I should have asked Mr Allen if he had anything.

MR ALLEN: I will briefly.

COMMISSIONER: I do beg your pardon, Mr Mullins.

EXAMINATIOn-IN-CHIEF:

MR ALLEN: Ms Pollock, you were asked some questions regarding paragraph 14 of your statement?-- Yes

That was the meeting involving Dr Keating which followed upon the report to you from three nurses in the Renal Unit about the failure to follow aseptic techniques by Dr Patel when dealing with two dialysis patients?-- That's correct.

And you gave some evidence that Dr Keating indicated that until you had data to support how often infections were occurring and how many infectious episodes there were in Dr Patel's patients that it was difficult for him to intervene in Dr Patel's practices?-- That's correct.

And the Commissioner asked you some questions, anticipating the possible further question as to why it wouldn't have been possible to supply the data that was then available as to infectious rates generally?-- Mmm.

Is it the case that what occurred after that request from Dr Keating on the part of yourself and Lindsay Druce was a process whereby specific episodes in relation to catheter placing by Dr Patel with following complications were investigated?-- That's what happened, yes. We sort of documented every catheter that had been placed in that 2003 time.

So whereas you may have been immediately able to after the 27th of November 2003 to provide general data in relation to infections, what you sought to obtain after that request was specific data specific to Dr Patel and any outcomes?-- That's correct.

And that resulted in the data which showed the 100 per cent complication rate?-- That's correct. In that time frame too I know that - we talked about why it took so long. There was - during the December period we usually close the dialysis service, it just happens every year, a Christmas closure. Lindsay Druce wasn't available for two weeks and then I went on leave too. So in that whole time - and Dr Miach was away as well, so, you know, staff wasn't there basically to do the work to get that data.

But what had led to the meeting on the 27th of November 2003 was information from three nurse eyewitnesses of the failure to follow aseptic technique?-- That's correct.

Did you then have the impression that that was not sufficient for Dr Keating because there was some denial of that behaviour by Dr Patel?-- No, at the time Dr Keating said that he would speak to Dr Patel about it, but he said, "You know, if you really - you know, if I really need to go further with this I need data to support what you're saying," and I quite agreed with him at that time. I felt that that was, you know - you

know, reasonable. I guess I knew too though that we had the data and, you know, that we had had a lot of complications, so it wasn't - I didn't feel it was, you know, an issue, we could provide that.

You felt you could readily provide that information?-- Yes, yes.

And, lastly, you were just asked about the meeting that occurred on the 23rd of March 2005?-- Yes.

And you've given that you felt intimidated as a result?-- Mmm.

Was anything said by Mr Leck as to what would happen to the nurse who had leaked the information?-- Basically he sited the Code of Conduct and confidentiality, you know, in speaking to the media, that the person responsible would be severely reprimanded. I took that to mean that that person would lose their job.

And in that context you said that you felt that in recent times things have changed for the better?-- Yes.

How do you mean that they've changed for the better?-- I just feel that nurses, you know, have been listened to. I really feel that, yeah, we do have a voice and, you know, we're basically - you know, what we say is being taken a little bit more seriously than maybe what had happened in the past.

Thank you.

COMMISSIONER: Thank you, Mr Allen. Mr Mullins?

MR MULLINS: Commissioner, I can indicate Mrs Nagle does not object to the name of Mr Nagel being released.

COMMISSIONER: All right. I will just say so that everyone understands where we are up to with the suppression orders about patient names, this is as I have noted the current list of those that are in the public arena as it were: Mr Desmond Bramich, whose name has appeared, I think, regularly in the media; Mr Eric Nagle - Bramich, by the way, was P11, Mr Eric Nagel, P30 - Mr James Phillips, P34, is referred to in our interim report; Ms Daisy Marilyn, P52, who is again referred to in our interim report; and Mr Ian Fleming, P126, obviously has been spoken of to some extent in the media already. So I think all of those names are out in the open. If there are any others that I have overlooked, feel free to bring them to my attention. Those at least we can say are no longer the subject of any suppression order.

Thank you, Mr Mullins.

CROSS-EXAMINATION:

MR MULLINS: Ms Pollock, I just remind you that I act on behalf of the patients?-- Mmm.

Can I ask you to look at a copy of RP3? It is the same copies that has just the numbers, not names? I'm sorry, could we put it on the overhead? Just as that's being put up, Ms Pollock, you were the Nursing Unit Manager of the Renal Unit?-- Yes.

And you had worked in the Renal Unit for some seven or eight years?-- Nine years - nearly 10 years actually.

Is that to the current time or the time of events 2003/2004?-- I actually started in the Renal Unit 1996, May 1996.

What was your first position in the Renal Unit?-- I was a registered nurse.

You have basically worked your way up the ladder within that unit?-- That's correct.

You have worked with many different surgeons in that unit?-- I have.

Now, you were working during the latter half of 2003?-- That's correct.

You were consistently present in the unit when Dr Patel was performing the surgeries we have seen in Exhibit RP3?-- That's correct.

Is your role a clinical role or a purely managerial role?-- Both, actually. I sort of have a clinical component as part of my role.

With the evidence that we have seen, the nursing staff within the Renal Unit seems to be relatively close; is that true?-- Yes, that's very correct.

And you share information?-- Yes.

You have regular personal contact with patients?-- I do.

During the course of the latter half of 2003, did you have regular personal contact with the patients that we have seen described in RP3?-- I did.

Can I just take you through each of these and starting with P8, which is on the first line. The first surgery that Dr Patel performed was the placement of a catheter on 15 August 2003?-- Yes, that's correct.

You knew the patient concerned?-- I do.

And you were aware that by 19 September 2003 there had been a migration of that catheter?-- I did.

And in your many years of experience in the Renal Unit you would be familiar with how the catheters tunneled?-- That's correct.

You are familiar with how they are placed?-- That's correct.

If you look at how the catheter position as described in RP3 for P8, described as upwards, it's the case, isn't it, to an experienced person like yourself that you can see that quite easily that's been placed incorrectly?-- That's true, just by looking at it.

Now, bear with me because I'm also a layperson, not a medical person. We understand that the catheters aren't used for a month so that they are allowed to settle and the wound to heal?-- That's the ideal. That's what we like ideally - that's what we aim for. That's not always possible but that's the ideal.

And the concept is they are to be essentially permanent?-- Yes.

So if they're placed upwards, it's not simply a matter of retrieving them and replacing them?-- No, that can't be done. You would have to remove the catheter and retunnel basically, yeah.

Which is basically another major surgical procedure?-- That's correct.

Did you become aware that patient P8 had his or her catheter placed upwards before you became aware that there had been a migration?-- Yes. Yes.

And did you yourself believe that you might have a problem here, given the way the catheter was placed?-- It would stand to reason that the catheter - as Lindsay described they do have a memory, the catheters have a memory, and they bend back to that shape. So you would expect with an upward facing catheter that the exit site - that there is going to be then problems where the catheter will sit in the abdomen.

Now, that was patient P8 and you say that before 19 September 2003 you had some concerns about the fact that the catheter was placed upwards?-----

MR ALLEN: I don't know that the witness said that. She wasn't asked if she held those concerns before that date.

COMMISSIONER: I'm sure this witness can clarify if she feels that what's being put to her is inaccurate?-- Okay.

MR MULLINS: I might clarify. Don't think for one moment I'm casting - what I was going to ask you was did you think it was a little unusual or did you know before 19 September 2003 that

it was placed upwards?-- Yes. Yes.

And were you concerned that that was a little unusual?-- Well, it wasn't what - you know, that's not the ideal, like we said, and most of our catheters that had been placed prior to that always had a downward facing exit site. That is what we aim for and we never had such an issue before, so.

Dr Patel had only been at the hospital by that time a few months?-- That's correct.

And did you have any discussion with him at that time about the placement of the catheter?-- Not at that time. I never spoke to him about catheter placement, but I know that Dr Miach had on several occasions.

Now, just so I can clarify. You've said it already, but the connection between the migration and the upwards placement of the catheter is on your knowledge the memory in the catheter, in the plastic you said?-- Yes. It's basically if you don't tunnel it correctly you're not going to get a good position. The catheter won't hang down. It won't hang into the lower abdominal cavity.

Now, on that same day of the surgical intervention by Dr Patel of 19 September 2003 of patient P8 occurred, patient 31 had a catheter placed?-- Yes.

Were you aware of patient 31?-- I know of him, P31.

Were you aware that he was also to have a catheter placed?-- I would have been aware.

And if we read on, that patient's summary provided by Ms Druce was that his catheter was also placed upwards?-- That's correct.

And you would accept that that's obviously wrong?-- Well, it's not what we would like. It's not the outcome that we would like.

Now, I'm not suggesting that you would go challenging surgeons about how they would place catheters, but were you starting to have a question mark over these procedures that were being undertaken?-- Well, we probably had some question marks on other procedures, so, yeah, this just added as another thing, mmm.

Are you aware how soon after 19 September 2003 patient 31 developed infection or it became a problem?-- I can't recall. I would have to see the patient's notes to be - yeah.

Now, the third placement is patient 24, which is on 30 September 2003; you can see that?-- Yes.

And that patient or that catheter was placed by Dr Patel in what is described side-upwards?-- That's correct.

So it wasn't completely upwards?-- No, but still not the optimal position.

No. And there's a date that identifies a catheter problem, which is 4 November 2003, which appears it was discovered he had an infection?-- That's correct.

Or somewhere around about that time he had an infection?-- Yeah.

So by 4 November 2003 the only three patients that Dr Patel had operated on appear to have had their catheters positioned incorrectly?-- That's correct.

The fourth was P45 and his or her catheter was placed on 6 October 2003, obviously before the complication that we see from P24, but that was also placed or was placed sideways. Do you know patient P45?-- I do.

Can you recollect the placement of that catheter?-- Yes.

And further surgical intervention was required for that patient, although that was performed privately; that's correct?-- That's correct.

Now, by late November 2003, you were aware, were you not, that there were some problems associated with Dr Patel from your own knowledge within the Renal Unit-----?-- Yes.

That's right?-- That's correct.

Did you have any knowledge of other problems with Dr Patel outside the Renal Unit?-- I had heard, you know, second-hand information, yeah, that, yeah, that there were other areas that they were having issues with him.

Now, in your many years of experience within the Renal Unit up until late November 2003, had you ever seen these types of problems on such a degree of regularity?-- No.

When your nurses approached you about the incident involving Dr Patel, this comment that "doctors don't have germs", was that really just a trigger for you to go and speak to management about other issues that were really troubling?-- That's basically what happened, yes, it was a trigger.

And the truth was you could see a catastrophe looming. One hadn't occurred, but if the surgeon was putting the catheters in the wrong way, at least from your perspective if patients were getting infections, then there was a catastrophe looming potentially?-- There was a high risk of something about to happen.

On 27 November 2003, yourself and Ms Aylmer go to visit Dr Keating?-- Yes.

And you say in your statement that you discuss this "doctors don't have germs" issue?-- Yes.

You say that Gail Aylmer also raised other issues that had concerned her?-- That's correct.

She raised wound dehiscence as a problem?-- Yes.

She raised the problems about infection in the Renal Unit?-- That's true.

Was that raised during the course of the discussions?-- It was general, you know, his return to theatre, his infection rates, his wound dehiscence were all - we felt were an issue throughout not just the Renal Unit but the hospital.

Did you in the context of raising the infections within the Renal Unit raise the actual placement of the catheter?-- Not at that time. Probably - well, I didn't know - no, I didn't, no. I had - I can't remember when, but at some time during that whole sort of couple of months, we sort of tried to find out why they weren't being tunneled correctly and we found out that Dr Patel was inserting them laparoscopically without having the correct instruments available to him, yeah.

Now-----

COMMISSIONER: How did you discover that?-- Basically we wanted to know, you know, why the tunneling was a problem, so we - I spoke to some of the staff in the operating theatre and just said, you know, how does he, you know, insert them and basically he was doing them laparoscopically - sorry, laparoscopically, and when I spoke to the Baxter company, they sort of - to find out exactly what instruments were needed to do that, I didn't feel that theatre had access to that equipment for him to be able to do that and maybe that's why, you know, the exit sites were coming up, you know, facing upwards, sideways, et cetera.

Was this before or after you had that or you were present at that conversation when someone from the Baxter company offered to Dr Patel the opportunity to give him educational training in inserting the catheters?-- I can't be sure when it would have been before or after, yeah. It was probably around that time to the best of my knowledge. It would have been around that time but I can't recall, you know, whether it would have been before or after.

Thank you.

D COMMISSIONER VIDER: Can you do Tenckhoff catheters now laparoscopically but you need particular attachments?-- You need specific instruments to be able to do it and basically we'd probably - the past patients before, you know, Dr Patel's had never had them done completely, you know, under laparoscope, they sort of had an open incision as well and that wasn't happening.

MR MULLINS: Can you recollect before Dr Patel started to perform this surgery ever having seen a surgeon insert these

catheters upwards or sidewards?-- We weren't ever in theatre normally when a Tenckhoff went in, so-----

COMMISSIONER: I think what Mr Mullins means though is had you ever seen a patient with a catheter that had been placed with the protruding end being pointing upwards or pointing sideways?-- There possibly could have been one but it might not have been done at our hospital. We also had patients come that had catheters placed from, you know, Greenslopes Hospital and other places. So, you know, I can't be sure and say, "No, it never happened," there possibly could have been one in that time.

But it's very unusual?-- It is very unusual.

MR MULLINS: So when you have incident after incident after incident occurring up to the end of November 2003, this was a new situation for you?-- It was.

Apparently the Director of Surgery was performing these insertions of these catheters in a way that was wrong?-- Well, it wasn't optimal, no.

Now, I am taking you to a meeting of 27 November 2003. You mentioned you don't think you mentioned the surgical placement of the catheters at the time, but you talked about wound dehiscence problems, with infection in the renal units, "the doctors don't have germs" issue. At the time of that meeting, did Dr Keating tell you - or I will withdraw that and ask you this question: did you know that Toni Hoffman had made complaints about the conduct of Dr Patel's surgery prior to your meeting on 27 November 2003?-- I couldn't recall, you know, definitely. As I said, somewhere our patients had, you know, treatments in intensive care, so we would have been aware of what was happening down there because we were spending some - you know, quite a bit of time down there and I guess that's how I sort of knew that things weren't, you know, always the best down there either with the staff.

COMMISSIONER: I don't mean to embarrass you asking you this question, but is Toni Hoffman a particular friend of yours or-----?-- I wouldn't say she's a personal friend but she's a work colleague and I have great respect for her.

It just strikes me that this is the sort of thing that nurses on their tea break or in the lunch room, or something like that, would be likely to mention to one another?-- I didn't actually normally see Toni when we did treatments in the Intensive Care Unit. It was one of the registered nurses, you know, that was looking after assigned care for that patient. So I normally wouldn't be speaking to Toni in the times that we had patients in intensive care, so it wasn't from Toni that I probably heard most of the reports, it's from other staff, it's registered nurses that worked in the unit.

Great.

MR MULLINS: Just clarify for me again, did you know yourself

that Toni Hoffman had had a meeting with Dr Keating where she had also expressed concerns - I shouldn't say "also" - where she had expressed concerns about Dr Patel's surgical practices?-- I can't recall if it would have been at that time. I certainly was aware of it further down the track, but at that time I don't recall, no

Did Dr Keating say to you at that meeting on 27 November 2003, "Well, look, this is not the only problem we have got in the Renal Unit, we also have some other problems that we're looking at."?-- No.

Now, Dr Keating asked you in that meeting of 27 November 2003 to get statistics to backup your complaints?-- Yes, that's correct.

You told the Commission you had no concerns, that you would get those statistics?-- That's correct.

And the reason you had no concern was because you were aware that these problems had been evolving consistently since he started commencing surgery?-- That's correct.

And it was just a matter of putting it together?-- That's correct.

Was one of the reasons you used the "doctors don't have germs" incident as a trigger was because that was overheard by a number of nurses?-- No.

No?-- No, no. I just thought that was unacceptable practice and felt very strongly that, you know, he was sort of defeating what we were trying to achieve. So that certainly wasn't the case, I don't feel.

Gail Aylmer had about - more than 10 years experience at that time-----?-- Mmm.

-----as a registered nurse. You had about 10 years experience or more as a registered nurse. You'd had a long period with the Renal Unit but you say it was reasonable, you thought, for you to have to go and get that statistical evidence to prove the case that you were presenting at the time?-- I believe so.

Now, you go off to get your statistical evidence and you say that you spoke to Lindsay Druce at the time and said to her, well, let's get the evidence so we can fix this or avoid this looming catastrophe?-- That's correct.

Did you know that Lindsay Druce had actually approached - sorry, soon thereafter Lindsay Druce approached Dr Patel and spoke to him about the problems with the surgery and the issues surrounding infection?-- I was aware of that, but I was also aware that Dr Miach had already broached the subject numerous times with him.

There was no point in you approaching Dr Patel?-- Well, you know, he wasn't going to listen to a consultant so why would he listen to a nurse?

Now, on 30 - if I take you back to Exhibit RP3, can I ask you to look at P30, and on 17 December 2003 the catastrophe occurred?-- That's correct.

The problem that you thought was looming in fact happened?-- That's correct.

Now, that patient also had the catheter placed sideways?-- That's correct.

And we have heard today there was some evidence that that catheter had also migrated?-- That's correct.

Was there an Incident Form completed in respect of that event?-- Not that I'm aware of. But like I said, these procedures weren't done within our unit so we're not there to actually see how they are placed. So that would have been why we - it wasn't - an Incident Form wasn't filled out for that.

After that event you told us that Dr Miach informed you that he did not want Dr Patel to touch any of his patients?-- That's correct.

And that put you in a very difficult position?-- It did.

Because you had no surgeon?-- That's correct.

And the Director of Surgery - I am sorry, Dr Miach had suggested the Director of Surgery at the hospital could not carry out surgery on his patient?-- That's correct.

Ask I take you to patient 51.

COMMISSIONER: Do you mean 51 or-----

MR MULLINS: 55.

COMMISSIONER: Patient-----

D COMMISSIONER VIDER: 55. Yes, 55 is referred to in the statement as 51.

MR MULLINS: I apologise, patient 51. You deal with paragraphs 24 through to 27 in your statement. This surgical procedure on patient 55 occurred obviously after 29 January 2004 because Dr Miach had gone on leave?-- That's correct.

And as I understand it, this surgery was relatively urgent?-- It was.

The patient basically needed some sort of access to her dialysis. Using Dr Patel was not an option?-- That's correct.

COMMISSIONER: Mr Mullins, we have been through all of that. If you want to add something to it, I don't want to discourage you, but there's little merit in just repeating evidence we have already heard.

MR MULLINS: Thank you, Commissioner. I won't be terribly long.

COMMISSIONER: Thank you.

MR MULLINS: You attempted to obtain some assistance from Brisbane?-- That's correct.

Are you aware of the - did you - you didn't contact Brisbane yourself?-- No. It would have been the Registrar, Toby Gardner, who would have spoken to Brisbane.

All right. So, their options in carrying this - or obtaining this result are very limited?-- That's correct.

We have Dr Cochran, who was a nephrologist?-- That's correct.

And the name of the obstetrician was Dr?-- Wijeratne.

Wijeratne. Now, you have told us in your evidence that you were concerned about how the procedure would be performed because Dr Cochran hadn't performed the procedure for some 15 years?-- That was - to the best of my knowledge, that's what I am sure he said at the time.

And Dr Wijeratne had - was an obstetrician/gynaecologist?-- That's right.

And had never performed the procedure?-- That's true.

You were using Dr Wijeratne as a specialist in anatomy?-- That was Dr Cochran's intent.

Yes. And you watched a video to see how it was that you would place this catheter?-- No, I didn't watch a video. Dr Cochran was given the video just to see - to refresh, I guess like a refresher, this is how - that is what Baxter provide, this is how they - you know, this is the product we're using, this is how - you know, what the product guidelines state, that this is the way we would like them inserted.

Can you remember who was actually present at surgery in the theatre?-- Well, there was myself and Lindsay Druce, Dr Wijeratne, Dr Cochran. I don't recall the anaesthetist. It could have been Martin Carter, I'm not sure, and there was two other nurses, theatre nurses, but I don't recall their names.

You have described the outcome of the surgery procedure as being unsatisfactory?-- That's true.

And the reason you went to such lengths to have the procedure carried out to the best of your ability was to avoid another catastrophe by the use of Dr Patel?

COMMISSIONER: It wasn't?-- It wasn't - yes, sorry. It wasn't to avoid another catastrophe, we just - you know, were carrying out Dr Miach's wishes.

MR MULLINS: There were no other options available to you?-- I am sure the medical staff would have pursued them and they felt that there wasn't. I know that Dr Cochran also phoned Brisbane and he was very frustrated with the attempts that he had trying to get a patient down to Brisbane. Basically they refused to take them. So, he felt there was no other option. This patient was going to die. So that's the way we went.

It's the case, isn't it, you didn't have enough confidence in the Executive at the hospital to approach them about the problem?-- Well, you know, you go to your consultant who looks after your service and, you know, you are guided by what they - they want to do, and if they feel that they need to approach the Executive I am sure - I am sure he would have. I had no idea whether he did in fact do that or not.

Thank you, Ms Pollock.

COMMISSIONER: Thank you, Mr Mullins. Mr Devlin?

CROSS-EXAMINATION:

MR DEVLIN: Ralph Devlin is my name. I represent the Medical Board of Queensland?-- Yes.

Can I just go through some of the correspondence here and put it in its time context. Dr Miach, you say in paragraph 22 of your statement, went on leave on the 29th of January; correct?-- That's correct.

It was on the 2nd of February that the operation with patient 55 was done which had the suboptimal outcome; correct?-- That's correct.

On the 10th of February, then, if we look at Exhibit HP5, the Acting Director of Nursing says this to you, "I spoke to Darren shortly after you left this afternoon and explained your concerns. He will speak with Peter Leck. However, the long and short of it is that I - that I need to see some stats regarding procedures undertaken by Dr Patel highlighting all renal related cases, uneventful versus the number of adverse events which have occurred as a result of an intervention." So do we read that as being an instruction from the Acting Director of Nursing to look across the board at the renal procedures that Dr Patel had carried out in the available period that he'd been doing work, surgical work, for the Renal Unit? Is that how we read that?-- I interpret it as - yeah, all surgery that Dr Patel had performed on renal patients.

Do I understand your evidence so far to be to this effect, that you and other staff in the Renal Unit already had concerns about other aspects of his surgery?-- That's correct.

Well, can I ask why the suggestion of the Acting - well, it looks like an instruction to me?-- Mmm.

Of the Acting Director of Nursing wasn't implemented at that point to drive home the point with management who apparently at that point weren't convinced?

COMMISSIONER: I think, Mr Devlin, when you refer to it as an instruction it's only fair to refer to the last couple of lines where the author says, "I guess it is really up to us whether we want to progress this with Dr Patel ourselves in light of your findings. Something to bear in mind anyway." It's not really the language of an instruction.

MR DEVLIN: I will revert to the word "suggestion".

COMMISSIONER: Yes.

MR DEVLIN: My question was along the lines of was there a reason why you didn't take up this suggestion to actually do a full analysis?-- Probably the reason that wasn't undertaken

is we didn't have the hours to put into that to be able to do that and we felt that the evidence - you know, with the catheter access placement that we'd had that, you know, that was enough evidence to substantiate some sort of investigation.

But it was really important?-- It was important.

If we go to RP6 then. This is a week later, 18th of February. We have got to read it from the bottom up, I take it. 17th of February, "When's it convenient for us", says Paddy Martin, "to get together so you can give me the lowdown on renal services for Dan Bergin?" Now, Dan Bergin is the zone manager?-- That's correct, the Central Zone manager.

Is there - did you go to a meeting with Dan Bergin or-----?-- No.

Just with Paddy Martin?-- Just with Patrick.

Okay. So, is there any cultural reason why having reached what you saw was an impasse here, having determined that you could not put the resources into that further analysis that Paddy Martin suggested, was there any cultural or organisational reason why you couldn't have a go at going around your management to go to this zone management who must have more overarching powers? I mean, I am sure there's a good reason, but perhaps you can explain it from your point of view?-- The reason Dan Bergin wanted the lowdown on Unit Services is they have got a plan that they are sort of working on on how they'd like most units to run and that is home therapies, and for any home therapies that - you know, for that service to be successful you have to have good access surgeons. That wasn't the case. Dan Bergin - I am sure they knew of our problems because there was meetings with central zone and they had them regularly.

What were their nature? I see, just routine meetings?-- Central Zone get together - there's a meeting chaired by Peter Hollett, Dr Peter Hollett, who's a nephrologist from Nambour. He sort of has been chairing those meetings for - probably from that time basically - it's been some years now - looking at renal services for the Central Zone which encompasses from basically us down to Royal Brisbane.

Thank you. Well, then, can I revert to my original question? Is there some cultural or organisational reason from your point of view that the impasse that you sensed with your own management, as you saw it, could not have been addressed by going - addressing those concerns to the zone manager, Dan Bergin?-- Dan Bergin already knew of those problems, because we'd had meetings with him. You know, we presented some data - we'd been to a few meetings with Dan Bergin.

Wait a minute. Had you presented the - what you saw as the statistical support for your concerns, namely RP3, to Dan Bergin?-- No. No, these were just basically percentages, I guess you'd call them, of people on, you know, different

types of therapies and what was the obstacle, you know, to getting more people home, doing home therapies, and that was access surgeons.

Let's go back to the issue at hand here. You and your staff had developed what you saw as legitimate and serious concerns?-- Mmm.

Based upon the analysis developed in RP3 by the 10th of February?-- Mmm-hmm.

When it went to your Acting DON and presumably taken to Dr Keating-----?-- That's correct.

-----by the 18th of February you are being asked about some info for Dan Bergin?-- Mmm.

This specific information, is there some cultural or organisational reason why - all I want is an explanation, I'm not trying to be accusatory at all, I am just - want some information on why the path to Dan Bergin couldn't have been taken on this specific matter?-- I don't have an explanation for that, I'm sorry. I probably didn't feel it was my role to be able to do that.

Well, the situation was, however, that by reason of the evidence collected in RP3 - let's call a spade a spade. You and your staff had lost confidence in the person who would ordinarily deliver the surgical services?-- That's correct.

That's pretty serious, isn't it?-- It is.

You had attempted to advance those concerns to your management through the Acting DON?-- Mmm-hmm.

You felt there was an impasse, whether that be so or not. That's how you felt about it?-- That's correct.

And I'm just wondering if there's some cultural reason you can put your finger on or some organisational reason why the next step to Dan Bergin wasn't at least attempted on this specific information? Is your answer still, look, I just can't answer that question?-- I have never thought to take it to Dan Bergin, I guess. I guess, you know, you go by the Director of Nursing at the time, and maybe - you know, if he had suggested that maybe we would have done that.

And the other suggestion that he did make in RP5 in his communication on the 10th of February simply was not attempted because of what you saw as time constraints on your valuable time and that of your staff, would have been a big job and too big for you to attempt?-- Well, that's true. We could have got - we could have attempted to get some data out of the statistical people in hospital, but even that would have been - you know, a very onerous task and it wasn't attempted. We felt that we had enough evidence to - you know, sort of have alarm bells ringing, I guess.

COMMISSIONER: I think, Mr Devlin, to be fair, Ms Pollock has already said there was another reason and that was simply that she'd gone to Dr Keating with fairly cogent evidence of a problem and that was ignored and really didn't see any point doing a complete review of Dr Patel's treatment of renal patients when you already had evidence there was a combination of 100 per cent completion rate with this group of patients,^ there was no point in gathering this evidence.

MR DEVLIN: I guess I just wondered what the zone does if it's not yet another place to go.

COMMISSIONER: I am looking forward to hearing what the zone was.

MR DEVLIN: I was interested in what it was like for someone at the grass roots level.

COMMISSIONER: Yes.

MR DEVLIN: Being confronted with what they saw as an impasse. That's all.

COMMISSIONER: Can I ask-----

MR DEVLIN: I will move on, though. Did you have confidence in Paddy Martin?-- I did. I felt that he - you know, followed, you know, things as far as he could. You know, I felt that he sort of was supportive of us, I guess.

COMMISSIONER: I am just thinking, following up Mr Devlin's point, and that's a very good point and a very useful one, but was at least part of the reason you didn't take the matter to zone level that you expected that that would be Paddy Martin's or someone else's function to take that to zone level, if they thought it appropriate?-- I would expect that would be the case, that I - you know, would - it would be their - you know, part of - they would offer to do that or, you know, sort of, yes.

D COMMISSIONER VIDER: In your experience, have you ever known of anyone within Queensland Health who's bypassed the district management and gone directly to the zone management?-- No, I haven't. Yes, so I guess that's another thing. You speak to - you know, colleagues and they are in the same position as you, they have experienced problems and - I mean, none of them had sort of said, well, you know, that is what we have done. We have bypassed our - our hospital Executive. That's a pretty big step.

COMMISSIONER: I guess to be fair also to Mr Devlin, that's really what he was driving at when he asked you about a cultural or a cultural reason why it just wasn't done. That wasn't-----?-- No.

-----seen as being your role to leapfrog the district management and go straight to zone management?-- That's exactly right. I think, you know, I was an NO3 and basically

that wasn't an expectation that we would do that.

MR DEVLIN: I guess that's-----?-- Yeah.

-----why I started asking you those questions, you know.

COMMISSIONER: We have got the answer, Mr Devlin. So we're all happy.

MR DEVLIN: It appears you did a lot better than I did. Can I go to the last sentence then in that first paragraph and see - of RP5 - "I guess it is really up to us whether we want to progress this with Dr Patel himself in light of your findings. Something to bear in mind anyway." Well, really the way you tell it the point had been reached where you went about to contact Dr Patel with your RP3?-- That's exactly. He wasn't speaking to me at that time so - I don't sort of find that he would have agreed to listen to me.

And it seems, then, that if we move then as quickly as you can through the timeframe, that the Baxter idea which seems to emerge at - around about RP6, which is the 8th of March, Mr Graham-----?-- Brian Graham.

-----Brian Graham is communicating with you about a particular patient, and I think we know that Dr Miach comes back from holidays, doesn't he, some time around this point, but I will just put this question to you. Is it that before you had to worry about what the next move was you had this opportunity to embrace the Baxter program?-- Well, we - it sounded - yes, like it was going to solve all our problems.

When did you hear of the availability of the Baxter program then? Can you give us any assistance from RP7 and RB8? See, we see there's a fair bit of time gone by and the proposal seems to go to Dr Miach in late April?-- That's correct. We had to basically wait for him to come back from his sabbatical leave before we could progress the program. We needed to make sure that he was happy - that's the way he wanted to go, because he was - you know, the nephrologist in charge of the program.

I think he told us he had some previous contact with the Baxter program?-- He had. That was-----

Elsewhere?-- That was in December. He had spoken to Baxter briefly about it, and then went on leave.

So, from the nursing staff point of view, embracing the Baxter program was a way of attempting to deal with the impasse which had develop developed a few months earlier?-- That's correct.

Thank you. Just a couple of small matters of detail. Paragraph 18, do you know who the nursing staff were who assisted with the second procedure during which patient 30 passed away?-- No. That was done in theatre so I'm not aware.

No. All right. And again more about cultural issues and how you stood on this point, in paragraph 21 the Medical Clinical Services Meeting in June^ of '04, I presume the Medical Clinical Services Meeting is to discuss the delivery of medical services, clinical services?-- It's about clinical services in the medical division.

Now, where did it leave you that Dr Miach said to the meeting, "Dr Patel is not to operate on my patients but don't record it."?-- Well, that was his wishes. He was the chairman of the meeting. I mean - and it was known at that time anyway. I mean, most of his doctors are on his team, they were all aware, quite aware, of his - you know, wishes.

His attitude on it?-- That's exactly right. That wasn't a hidden fact. That was-----

Well, presumably in a big organisation those meetings have to be held by all sorts of levels of staff?-- Mmm.

Resolutions have to be made or initiatives recorded and events recorded. Presumably ultimately the minutes go to assist management at the hospital?-- That is correct. The minutes go on to the Executive.

Did it occur to you that you were in something of a rock and a hard place to have the chairman of the meeting deliver such an important statement and yet say, "Don't record it.", for posterity?-- Well, we were just complying with his wishes, yeah.

Did it occur to you at the time that this was a difficult situation?-- Oh, it was a difficult situation for all - for all people at that meeting.

And did it occur to you at the time that by that means management doesn't get to see the minutes, they have got to hear about it some other way? I am not being blameworthy when I put it to you like that, but did that occur to you?-- Just run that by me again.

It's not going to go in an official document?-- Mmm.

It's an important statement made by an important member of the team?-- Yeah.

About a very serious matter, but it's not the minutes?-- No, but I guess I have heard that statement quite a few times but then - so, you know, the impact probably wasn't-----

So, you wouldn't have given a single thought to the position of management when they read minutes that don't contain such an important matter?-- It's not - I wouldn't say that.

Well, I'm not being - again, I'm not apportioning blame, I'm simply thinking about your thought processes, asking you about those in a meeting when such an important thing was said?-- He's the consultant that we report to, so-----

He says-----?-- We comply with his wishes.

He says, "Don't record it."-----?-- That's exactly right.

That's set in stone?-- Yes.

All right. Thank you.

COMMISSIONER: Mr Devlin asks you whether you thought about management's reaction. By this time had you seen anything to indicate that management was the slightest bit concerned in hearing the problems that you'd been trying to bring to their attention?-- No.

MR DEVLIN: I have nothing further, thank you.

COMMISSIONER: Thank you, Mr Devlin. Just going back to the cultural issue that Mr Devlin raised, I take it that nursing's your full-time career, as it were, and it's to some extent your livelihood?-- Yes.

Did you feel under - that your position would be threatened if you bypassed the local Executive and went to Zone Management or indeed anybody else to articulate their concerns?-- Yes. I guess that probably wasn't in my best interests to do that. I felt that.

Yes. And would it be fair to say that maybe this issue wouldn't have surfaced if it wasn't for someone as courageous as Toni Hoffman-----?-- That's correct.

-----taking that risk?-- That is correct.

Anything arising from that, Mr Devlin?

MR DEVLIN: No, thank you.

COMMISSIONER: Ms Pollock, it's now about quarter to 5. We normally rise between 4.30 and 5 o'clock. If it's convenient, I'd prefer to continue going and finish your evidence this evening if that suits you?-- That would. I'm not available tomorrow morning.

Right. Does that suit everyone else?

MR FARR: Yes, thank you.

MR DIEHM: Yes, thank you.

COMMISSIONER: Mr Ashton?

MR ASHTON: Yes.

COMMISSIONER: Mr Andrews?

MR ANDREWS: Certainly agreeable for me, yes.

COMMISSIONER: We might have a short break and then continue. Can I just get estimates as to how long we are likely to be? Mr Farr?

MR FARR: Perhaps 10 minutes.

MR DIEHM: 15 minutes.

COMMISSIONER: Mr Ashton?

MR ASHTON: About the same.

MR MORRISON: I will underbid all of them, your Honour.

COMMISSIONER: Is that right?

MR MORRISON: I don't have a question yet.

COMMISSIONER: Let's see if we can keep it that way. We will rise at this point and resume in five minutes.

THE COURT ADJOURNED AT 4.44 P.M.

THE COMMISSION RESUMED AT 4.52 P.M.

COMMISSIONER: While the witness is returning to the box, can I mention a few things for the record. The first concerns the fact that the week before last I had, as is well known, a meeting with the Premier, giving him an update on the progress of the Inquiry, specifically with reference to whether I considered that there was any need for an extension of the Terms of Reference or whether we would finish within time. Under our Terms of Reference the Premier is the appropriate person to report to on those matters.

The Leader of the Opposition, Mr Springborg, has requested, as it were, equal treatment. I have no difficulty with that, and I have therefore arranged to meet for lunch with Mr Springborg tomorrow. He is in Bundaberg in any event. I just mention that in case anyone sees any difficulty with it, but the purpose is simply to provide him with an update similar to that which has been provided already to the Premier.

I would also mention in that context that Mr Springborg has indicated a preference that that meeting be regarded as a photo opportunity, so if any of the press wish to take advantage of that, Mr Springborg will have no objection.

The second matter for the record along a similar line is that the two Deputy Commissioners and I have been invited on Wednesday of next week to a meeting of the local medical association. Again we see no difficulty in attending that meeting and we're grateful for the courtesy of being invited. Needless to say, we won't be discussing matters of substance at that meeting, but we see no difficulty in accepting that offer of hospitality unless anyone wishes to raise any concern in that regard.

The third thing that I wanted to raise concerns Exhibit 70, which is the statement which is already in evidence of the present witness, Ms Pollock. I'm just wondering whether - and this doesn't have to be done urgently, but the current version of the statement has a few problems with it with the references to patient numbers and Dr A, and also the fact that a number of the paragraphs have been deleted, paragraphs 44 to 47, and if we have the resources available, I think it would be desirable to replace Exhibit 70 on the record with an exhibit - or a copy of that exhibit which is entirely up-to-date and in order.

The fourth thing, again as a matter of housekeeping, is that with the confidentiality key, as it's called, the document which gives us the names that relate to the patient numbers, we've discovered that amongst us at the Bench we seem to have different versions of it, and I know that there have been different versions used from time to time, so I will ask the staff of the Inquiry to ensure that a completely up-to-date copy is made available and that the legal representatives for the parties also have copies of an up-to-date version of that

so that there's hopefully no more confusion.

Mr Andrews, we'll have no difficulty attending to those things, will we?

MR ANDREWS: No, no difficulty.

COMMISSIONER: Does anyone want to raise anything arising out of those four points? Mr Diehm?

MR DIEHM: Yes, thank you, Commissioner.

COMMISSIONER: Thank you.

ROBYN POLLOCK, CONTINUING:

CROSS-EXAMINATION:

MR DIEHM: Ms Pollock, my name is Geoffrey Diehm and I'm the barrister appearing for Dr Keating. Could Exhibit 69 be put on the document reader, please, Commissioner? Ms Pollock, this document, I think you said in your evidence earlier, was one you recognised as being the initial draft of the figures put together by Ms Druce with respect to the catheters, the dialysis catheters?-- That's correct.

Now, in terms of the timing of things, if I can ask you to assume this context for this document: that it was a document that was provided to Dr Keating on the 15th of June 2004 which was the date, as it happens, that there was a meeting attended by a number of people from the Bundaberg Hospital at the Friendly's Hospital with respect to planning of the implementation of the Baxter program?-- That's correct.

Now, when I asked questions of Ms Druce about that this morning, she thought that it may be that the reason why that document was being provided to Dr Keating on the 15th of June was because it in fact was this document that was distributed in February of 2004 to the likes of Dr Miach and to Mr Martin, rather than the document which is RP3 in your statement, and that perhaps the origin of RP3 was that it was an updated version of the document that was finalised after the 15th of June?-- I don't believe that's the case.

Well, do you know when this document was discarded by virtue of being updated with what appears as the document in RP3?-- I believe that this document was updated - you know, this was a document being used in January, and I believe it was updated to the RP3 version in February, 10th of February 2004.

What makes you so certain of that?-- Just on the other version, the RP3 version, it actually - not - on the computer

it will tell you when that document was created, the RP3 document.

And have you looked at the computer to determine that reference?-- I have.

When did you do that?-- Oh, that was some time ago. When I was giving my statement to the CMC, actually.

What caused you to carry out that exercise?-- I just wanted to be sure of my dates.

Okay. Did you go back to look at the document that is on the screen, Exhibit 69, to find out-----?-- I did not.

Does it appear as a separate document on the computer?-- It does.

Mr Martin's email - the document RP5 - back to you after your meeting with Lindsay Druce and Mr Martin - and please accept that I don't have the benefit as yet of Mr Martin's statement to see what he has to say about any of these matters, but on one reading of that document, I suggest to you that one might query whether in fact data in the form of a written document had been provided to Mr Martin at that time. Is there any possibility that in fact what you did with Mr Martin at that stage was to simply report to him verbally upon what your conclusions were?-- I don't believe I did. I believe that we took the RP3 document and presented that to him at that meeting. That's how I recall it happening.

The document wasn't emailed to him?-- No, we actually took it as a hard copy to the meeting.

When Mr Martin replied with that email, was it part of your thought process to say, "Well, what more statistics could you want? We've already given you statistics in written form that show a 100 per cent complication rate with respect to this important procedure."?-- That was my interpretation of the email.

That would have been a fairly easy matter to respond to him by way of a reply email, wouldn't it, to simply reply and say, "Well Paddy, we've already given you statistics that show a 100 per cent complication rate with respect to this very important procedure."?-- I don't know whether I did at the time or not. I can't recall, and I tried to get into my email account, and unfortunately I've deleted - I could not find anything to say that I had done that.

Do you recall doing it?-- I don't, I'm sorry.

You did tell the Commissioner before, though, that you continued to have confidence in Mr Martin?-- I did. He was acting in that position for not much longer after that, but I did feel that he - you know, he truthfully did discuss things.

So when he responded by seeking further information, further statistics over and above what you had provided, you remained confident that if you were to provide him with that information that he would do something with it?-- Yes, I would have assumed he would.

Nevertheless, for the reasons you've explained to us, you were unable to proceed to extract any further statistics?-- That's correct.

The time constraints with your job?-- That's correct.

Did you go back to Mr Martin and say, "Look, Paddy, there is nothing more we can do. We don't have the resources all the time to pursue these things. It's really in management's hands."?-- I believe that I spoke to him about that, saying, you know, that I felt that we had provided enough data and, you know, I just felt that what was the use providing more if what we'd already given wasn't taken seriously. Now, when that happened I cannot tell you, and I have no proof of that.

Do you think that what you'd already - the information you had already provided hadn't been taken seriously?-- Well, that was the - that was the interpretation I had of that - from that email from Patrick.

I'm sorry, I thought that you said that you had confidence that if you were to go back to Mr Martin with further information, that he would do something about it?-- I'm not referring to Patrick Martin, I'm referring to Darren Keating.

Patrick Martin's response was that, in effect, he endorsed Dr Keating's approach, wasn't it? They were as one with respect to what they were suggesting happened?-- I don't know that that's the case.

And in terms of doing something about it-----

COMMISSIONER: Sorry, just to interrupt there, in your discussions with Patrick Martin that the suggestion - to use Mr Devlin's phrase, the suggestion that you'd come back with further statistics, were you able to ascertain whether that was his suggestion or whether he was simply relaying a suggestion that he'd got from another source?-- I felt it was - he was relying information that he got from another source.

And who did you understand that source to be?-- I understood that to be Darren Keating.

All right. So to answer the suggestion that has just been made to you by Mr Diehm that Martin and Keating were at one on this point, what was your understanding of Patrick Martin's state of mind?-- I felt that Patrick thought that we'd - that he was basically in agreeance with me, saying that we had provided, you know, enough information to warrant, sort of, investigation.

Right.

MR DIEHM: I'm sorry, does that come from something else he said to you, not from what's in his email?-- No, that was just how I've interpreted it, and speaking to him later, you know, that's what I sort of-----

Well, I'm sorry, does that mean that something he told you later was that this was all Darren Keating's idea and that Patrick Martin himself thought that you'd provided enough information?-- I did feel that way, yes.

Did he tell you that?-- Not in those exact words, but that's what he implied.

Because his email says, "I need to see some stats regarding procedures undertaken by Dr Patel"-----

MR ALLEN: Is that a question?

MR DIEHM: All right. I'll rephrase it. His email says, "I need to see some stats regarding the procedures undertaken by Dr Patel", and by that he's saying that it is his need for those statistics, having spoken to Dr Keating?-- I read it as, "If you could provide some information", and then he goes on to say, "I guess it's really up to us whether we want to progress this." So I'm reading that differently, I'm sorry.

What he says is, "I guess it is really up to us whether we want to progress this with Dr Patel himself." That's another proposition, isn't it?-- Yes.

A separate one aside from providing statistics as to whether or not we actually take the matter up with Dr Patel, apart from taking it up with Dr Keating. Isn't that what he's saying?-- That is what he's saying, but that was never the intention.

The meeting that you had with Dr Keating on the 27th of November 2003 gave rise, I suggest to you, to two types of complaint that was being advanced by yourself at that meeting. The first was the specific complaint about the incident as described by the three nurses in the Renal Unit with respect to handling of the patients and the risk of infection, and the second category were some broader areas of complaint with respect to the practices of Dr Patel?-- That's correct.

Now, Dr Keating's response to that, both verbally and practically, I suggest to you, was firstly with respect to the specific incident about the handling of the patients, was that he raised the matter with Dr Patel?-- That's correct.

His response to the broader issues was to ask for data, statistics. Is that right?-- That's correct.

And you thought that that response to that broader issue at the time you thought that was reasonable?-- I did.

You've given evidence about the statistics available from the POET database?-- Yes.

And you've explained that they're realtime statistics, and we've seen what they demonstrate in terms of infection rates. When Dr Keating asked for statistics about the broader issues - which included episodes of infection in the Renal Unit, did it not?-- That's correct.

When he asked for those statistics, what was immediately available to you would have been the statistics from that database?-- That's right, but that only captures the Tenckhoff catheter program.

COMMISSIONER: It's a specific program put out by the manufacturer of the catheters?-- That's right. That's exactly right. That only looks at that cohort of patients. It doesn't look at anything else.

Understood.

MR DIEHM: Just the same as this document - or RP3 also only captures-----?-- That's exactly right.

-----the catheters?-- Yes.

COMMISSIONER: So if the question was that Dr Keating wanted broader statistics, you couldn't just press a button and get that out of the POET system?-- No, you couldn't. That was a very - that was a huge - because the email says "on all renal related cases". Now, we have over 50 patients. I mean, that's very extensive, to capture information on all renal related cases.

MR DIEHM: The document - I'm sorry, as at the meeting of 27 November 2003, that's almost three months before the request in the email. You could have almost immediately provided him with the statistics from the POET system?-- That's true.

And at the time of providing the information as set out in the report RP3, you could have provided with that the information from the POET system?-- That information would have just been the POET information, that's correct, but like you say, you don't want to go ahead with data that you haven't, you know, checked to make sure it's correct. You don't like to make allegations unless you know that information to be correct.

That's understood, but the thing is what the POET data could have shown that this couldn't show, and what it does show now that it's been produced to the Commission, is a comparison between those incidences of infection to other years and it shows a significant difference. Is that right?-- That's true. That data would have been up to - that would have been just the data up until the end of 2003 at that time.

Yes. But up until the end of 2003, given what we see in RP3, you would be expecting that the POET system would be showing

up that data quite dramatically, wouldn't it?-- Yes.

And in comparison to other years, it would show a significant change?-- Yes.

And that sort of information was not provided by what is contained in RP3?-- No, that was then given to him a couple of months later.

What was given to him a couple of months later?-- That data.

In RP3?-- Yes.

All right. Now, you say it was given to Dr Keating-----?-- Sorry-----

You didn't give it to him, did you?-- No, it was - I felt that it was given to him by Patrick Martin.

You assumed-----?-- I assumed it, yes.

All right. Just one other question on the POET data. You mentioned something in your earliest evidence - oral evidence here today about benchmarks, and can you tell us whether the data from the POET database was within a benchmark - or within benchmarks for the year 2003 with respect to the dialysis catheters?-- Are you talking just about this report?

Yes?-- From that data?

Yes?-- I don't have-----

You can't say. You don't have the benchmarks available to you?-- No, no.

COMMISSIONER: Sorry, I thought you told us yesterday that standard is - this morning-----?-- That was Lindsay.

Sorry, that was Lindsay. I beg your pardon. Her evidence was that standard was between 20 and 22, I think?-- Yes.

Is that your understanding, or don't you know?-- Yes, yes.

MR DIEHM: That will suffice for my purposes, Commissioner. It was just something that arose out of her earlier evidence that I was concerned there might have been a difference.

COMMISSIONER: Thank you.

MR DIEHM: Can I ask you some questions about the patient P30. Now, that's the patient who died - I think I've got it right - the patient who died as a result of the surgical intervention-----?-- Yes.

-----on 17 December 2003. Now, there is some information, of course, referred to in RP3 with respect to that patient, but your evidence here describes, in a rather detailed way, your specific concerns that you have now, and that you had then,

about the way in which that patient was managed and the reason why you think that contributed to his death. Now, you've given evidence to say that there was no incident report completed, and you've explained yourself from the point of view that he died in surgery and not in the Renal Unit so it wasn't your responsibility in that respect, but I'm wondering whether you can tell us whether you described your concerns about the circumstances of that patient in such a way to Mr Martin when you met with him in February?-- I don't know that we spoke about specific patients, you know. I might have mentioned to him that, you know, it was a coroner's case, but that was basically, you know, as - it wasn't mentioned in detail.

And you never related your detailed concerns with respect to that patient's management to Dr Keating?-- No.

With respect to patient P55 - now, this is the patient who had the operation performed by Dr Cochrane during Dr Miach's absence?-- Mmm.

It is fair to say, is it not, that before that operation was undertaken, you held considerable concern about the risk to the patient's safety and welfare for him to undergo that operation at the hands of those two doctors?-- I don't know that I would call that concern for his welfare, but I was concerned about the way in which the catheter would be placed.

That means concern for the patient's welfare, does it not?-- I don't sort of - I wouldn't put it in those terms, sorry.

You had a procedure about to be performed in circumstances where you say that you know that the last six times it had been done at the Bundaberg Hospital by a general surgeon, as you understood him to be, it had been performed improperly or wrongly?-- Mmm.

And, indeed, in one of those cases, that had resulted in the death of one of the patients?-- Mmm.

COMMISSIONER: Indirectly.

MR DIEHM: Indirectly. And you were watching a situation where the preferred option, as far as you were concerned, as far as the medical staff was concerned - this patient being transferred to Brisbane and having the operation done there wasn't available - and instead the operation was about to be performed by a nephrologist who had not performed the operation for 15 years, and assisted by an obstetrician?-- Mmm.

Those circumstances must have been very concerning to you, weren't they?-- They were a concern, but I still had, I guess you would call, faith, in that Dr Cochrane, you know, sort of was very convincing in putting his point across to myself and the nursing staff that he would be able to perform that.

You say that you attended in the operating theatre for the operation?-- That's correct, yes.

How often have you done that in the last 10 years?-- Probably three times.

A rather rare occurrence?-- Yes. It depends, actually - sorry, if I can further that a little bit?

Yes, please?-- The other two times was when I was - I was the clinical nurse looking after the peritoneal dialysis program, so, unless, you know - I haven't been involved clinically with that program for some time, so that was the other two instances of when I attended was when I was in that role.

All right. The reason for your attendance was because of your heightened concern for the patient undergoing this operation with these two doctors who were really quite inexperienced in performing it?-- That's true.

Now, you did not raise those concerns with the Director of Nursing?-- At the time, no.

You did not raise those concerns with Dr Keating?-- No.

You knew that the issue had not been brought to the attention of Dr Keating at all?-- I can't say that for sure. I have no idea on that, sorry.

Did you have any indication that the matter had been raised with Dr Keating?-- I have no knowledge.

COMMISSIONER: Did you have any indication one way or the other?-- No, I didn't, so I can't comment on that.

Thank you. Would you expect, in the ordinary course, to be informed of what went on between-----?-- No, no.

-----medical staff and Dr Keating?-- No.

MR DIEHM: You say in your statement that Dr Cochrane explained to the obstetrician assisting him the politics concerning Dr Miach's patients?-- That's correct.

What were the politics that you were referring to?-- I was referring to the fact that Dr Miach's team in his absence let Dr Cochrane know of his wishes that Dr Patel was not to operate on his patients.

Did the politics extend to these arrangements or this ban, as it were, on Dr Patel operating on Dr Miach's patients not being disclosed or revealed to the Executive?-- I can't comment on that, I'm sorry.

You see, you were asked some questions earlier about the minutes in June - in the June '04 meeting?-- Mmm.

And how Dr Miach-----?-- This - sorry.

Dr Miach directed him not to minute what was in there?-- Mmm.

What I'm asking you is was there ever any statement made by Dr Miach or, indeed, any intimation made by him that this direction of his was to be kept within the unit and was not to be shared with management?-- No, I felt that he had discussed it with management. I thought that they - you know, that they were aware of that.

Why, then, do you think - why then, in your understanding, did Dr Miach say not to minute his comment in June '04 meeting?-----

COMMISSIONER: I will disallow that question. It is not for this witness to speculate. Dr Miach may have been concerned about defamation and all sorts of other things. I don't think you can fairly ask this witness to speculate - unless Dr Miach gave some indication to you?-- No, he didn't. That was his wishes, yeah.

You will have your chance to ask Dr Miach.

MR DIEHM: Certainly, Commissioner. I did not mean by my question - I accept I inferred it - I did not mean by it to ask the witness to speculate it. I was just wanting her to share any information that she had. Excuse me a moment, please. That's the cross-examination, thank you.

COMMISSIONER: Thank you. Mr Ashton?

CROSS-EXAMINATION:

MR ASHTON: Commissioner, may I say, respectfully, I greatly value your guidance in your remarks after lunch, but I didn't take those to extend to the March 2005 meetings.

COMMISSIONER: Yes, that's a bit more problematic. You know, if I could give you some sort of formal ruling now, I would, but that's a little bit too delicate to do on the run, so I will leave it to your discretion, as long as you don't waste a lot of time over it.

MR ASHTON: Thank you, Commissioner. It does give occasion to some awkwardness so I will do my best. Ms Pollock, my name is Ashton, counsel for Mr Leck. You are the Nurse Unit Manager of the Renal Unit?-- That's correct.

You have staff reporting to you - 7.3, I think your statement says?-- 7.3 FTE. I'm one of those, so it would be 6.3.

Do those staff report to you?-- Yes.

You are their superior?-- I'm their line manager.

Yes. Are you responsible for supervising the performance of their duties?-- I am.

In matters such as patient care and so on?-- That's correct.

What do you do when one of them fails to - fails in their performance; say, is lax in hygiene or maybe late for duties, or something of that sort?-- I would approach them and ask them if there was a problem.

And if it were heated, what would you do? How do you deal with it?-- Well, yeah, it is a performance management issue, so you could sort of tell them - you know, we have a

performance appraisal done every six months, and that it would be brought up - you know, it would be sort of - you know - you know, it would be placed on that - on their performance appraisal at that time.

It would be a gentle reprimand, but you would give them a chance to pick up their act, as it were?-- That's exactly right.

Would you agree with me that that being so, that it is not really fair to suggest that when Mr Leck uses the word "reprimand", that that means "dismissal"?-- I think you had to probably be there at the time. Yeah, that was my interpretation of it, and that's all I'm - that is my interpretation. Other people in the room may have felt differently. I'm just saying that was my interpretation.

I understand that. I ask, with respect, how you can interpret the word "reprimand" to mean "dismissal"?-- I had been involved in other times where, you know, there was a code of conduct issue with Mr Leck, and - so, I sort of took them pretty seriously because of past problems that we had had in regards to-----

"Reprimand" just doesn't mean in the English language - it doesn't mean "dismissal"?-- No.

COMMISSIONER: It's not limited to dismissal. It may include that in some circumstances. But you are perfectly right.

MR ASHTON: Thank you.

COMMISSIONER: When someone uses the word "reprimand", that doesn't ordinarily mean "dismissal".

MR ASHTON: Thank you, Commissioner. Are you quite sure he used that word at all, incidentally?-- To the best of my knowledge, that's what I recall. He might not have used that word. I can't be 100 per cent sure. That was just my-----

I know you are trying to be fair - and I particularly ask this because in your statement you use the word "reprimand"?-- Mmm.

In your evidence, you use the word "severe reprimand" in response to a question, but it is possible none of those words were used by Mr Leck?-- That's possible. That was my recollection of events at that time.

Yes. Do you remember - do you know who convened that meeting?-- I'm not sure. The E-mail came through Cheryl Miller, who was the admin support person for Di Walls at that time.

If I put to you that she convened the meeting, you wouldn't disagree with that?-- No.

I see from your statement that it had already commenced when

you arrived?-- Yes.

And do you agree that Mr Leck was there for about a five minute slot and left and the meeting continued after he left?-- That would be fair to say. I'm not sure. It could have been longer. I don't, you know-----

All right. Do you remember a nurse at the meeting asking Mr Leck something like, "Are you going to track down the person responsible for the leak?", words to that effect?-- I think somebody did ask who - you know, how did they know it was a nurse. I do remember somebody bringing that up.

You mention it in your statement, but I'm just putting to you do you remember somebody asking, "Are you going to track this person down?", or words to that effect?-- I don't recall, to be quite honest.

I see. Because I was going to put to you that Mr Leck had responded that that was not a priority at that time. Do you remember his saying words like that?-- I don't, I'm sorry.

You don't deny he may have said that?-- No.

Did he use the word "disappointed"?-- Yes, I do recall that.

To describe his feelings?-- Yes.

Did he refer to team work?-- I don't recall. I do remember disappointed, but I don't recall team work, I'm sorry.

If I put it to you, you don't disagree he may have said that?-- No.

Did he refer to the organisation's values?-- I don't recall, I'm sorry.

Again you don't disagree with me if I put it to you that he did use those words?-- No.

And the fact that Patel was going through an accountability process?-- I do recall that he spoke about the review that had been - and I had been giving evidence to that review.

Yes, you have given your evidence to Dr Fitzgerald on that-----?-- It was one of his team.

One of his team?-- Yes.

And is that what you mean in the expression "being handled" in page 48 - sorry, paragraph 48 of your statement - it was "being handled"?-- Yes.

Was that a reference to that he was complaining that there was an accountability process going on?-- Yes.

And did he also refer to what he regarded as an issue of fairness in that process being affected by the leak?-- Yes.

Now, I know you felt that - and you have said in your statement that matters had been - if they had been better managed, this position wouldn't have arisen?-- Mmm.

But given that they hadn't been better managed and the position had been reached, was it reasonable or was it wrong of Mr Leck to raise these matters that I have just listed to you?-- I don't - I feel he had a right to be disappointed, sure, but it was just that he was very upset. He was visibly upset and that was very evident.

All right. Have you complained to the CMC that his raising those matters and being upset amounted to official misconduct?-- No, not that I can recall.

COMMISSIONER: Have you been involved in making any complaint to the CMC?-- I have been interviewed by the CMC.

That's a different matter. The CMC approached you and spoke to you about various matters?-- Yes.

But have you initiated any complaint?-- No.

MR ASHTON: I'm speaking specifically of Mr Leck in this meeting?-- No.

Have you asked or authorised anyone else to do that on your behalf?-- No.

Thank you. Nothing further, thanks, Commissioner.

COMMISSIONER: Thank you, Mr Ashton. Look, given the request you made - which is, I think, a very fair one - I am prepared to make a ruling in these terms so as to assist you and also hopefully Mr Morrison and Mr Diehm in limiting your cross-examination as appropriate, and also to assist counsel assisting in excluding evidence that we would regard as not very valuable - the ruling is as follows, and it will be on the transcript: it is of no assistance to the Commission of Inquiry in considering the issues raised in our Terms of Reference to receive evidence regarding the tone of voice or other emotional indicators in connection with meetings or discussions canvassed in evidence. We are more interested in evidence of what was said or done, rather than witnesses' interpretation or subjective feelings as to the intent or impact of, or motivation behind what was said or done. This applies also to the meetings of 23 March 2005 and 7 April 2005.

MR ASHTON: Thank you.

COMMISSIONER: Does that address your quandary?

MR ASHTON: It helps. Thanks, Commissioner.

COMMISSIONER: Thank you. Mr Morrison?

MR MORRISON: No questions.

COMMISSIONER: The terms of the ruling, does that assist you?

MR MORRISON: It does. Can I reflect on it and raise it later?

COMMISSIONER: Of course.

MR MORRISON: I'm trying to keep within one's mind the scope of all the meetings that have been referred to in a variety of statements. It is just hard now to bring them all to mind and say does your ruling deal with most of what I suspect it does, but if there is something extra, may I raise it?

COMMISSIONER: Certainly. Likewise, Mr Diehm, if you wish to raise anything at any time, you are more than welcome to do so. I hope that will have some impact on reducing the scope of fairly pointless evidence as to whether people thought that something was said in anger rather than in jest, or sternly, but not angrily, and so on. You know, it is just a matter of impression when it all comes down to the final analysis.

MR DIEHM: Commissioner, I wonder how far it goes. For instance, questions have been asked even from the Commissioners of witnesses at times, such as this afternoon with this witness, as to - you asked her whether she had ever thought that - or had any cause or reason to think that the management were interested in these things.

COMMISSIONER: Yes.

MR DIEHM: That's another example of the same problem.

COMMISSIONER: I think that's a very different matter, though, because that's not - that is direct evidence of the witness' state of mind rather than evidence of the witness' interpretation of someone else's state of mind.

MR DIEHM: Yes.

COMMISSIONER: I think that is a pretty fundamental difference, but I'm happy to listen to anything - any further submissions you want to make about it.

MR DIEHM: Thank you.

COMMISSIONER: Mr Mullins?

MR MULLINS: If I could probably reserve my position on that? We have a witness, Linda Parsons - I don't know if you have her statement yet - but she says she was spoken to in a condescending way, so the extent of the meetings-----

COMMISSIONER: That actually highlights the sort of problems we had. What you and I find condescending might be very different from what Ms Parsons finds condescending, and I think putting emotional labels on conversations is not going

to assist in any way.

MR MULLINS: Thank you.

COMMISSIONER: Now, Mr Farr?

MR FARR: Thank you, Commissioner.

CROSS-EXAMINATION:

MR FARR: Ms Pollock, my name is Brad Farr. I appear for Queensland Health and some of its employees. Can I ask you this: Paddy Martin, he was only the acting DON for a short time after the E-mail of 10 February 2004, wasn't he?-- That's correct.

If I suggest he finished in that position around the 10th of March 2004 - so, about four weeks later - would that accord with your recollection?-- I can't recall the exact date, but that would be about the time, yes.

All right. You found him to be someone that was helpful?-- Yes.

And conscientious, I understand?-- Yes.

You were of the opinion that he acted appropriately when you took issues to him, some of which you have spoken about here today?-- Yes.

The response that you received from Paddy Martin on the 10th of February in the document RP5 that you have been referred to many times speaks of requiring more or other statistics?-- Mmm.

Did you actually know what the statistics were he was after?-- In the E-mail it sort of says about other renal-related cases.

Yes, other renal-----?-- Yes.

But did you inquire of him to what extent further information was required?-- I didn't say exactly. I didn't sort of go to him and say exactly what did you mean by that, no.

I see. Did he speak to you at any stage subsequent to that E-mail asking any follow-up information?-- Not that I can recall. I don't recall, I'm sorry.

I appreciate you would not have devoted all of this to memory, but is there some possibility that there were some discussions about that topic?-- I don't really want to speculate, I'm sorry.

You can't say?-- No.

All right.

COMMISSIONER: Would it assist if I put it to you this way: it wouldn't surprise you if there may have been some other discussions that may have escaped your memory?-- That's true.

MR FARR: Thank you, Commissioner. Can I move on to another topic? You said in the course of your evidence a little while ago that you have not seen anyone go outside of their line management for the purposes of making a complaint. Did I understand your evidence in that regard?-- I probably didn't say "outside of their line management", I just said I hadn't heard of somebody going to their zonal manager.

The zonal manager?-- Yes.

And did you also say a little later that you didn't consider doing such a thing, at least in part, because you were concerned it would jeopardise your position?-- It is fair to say, yes.

Given that you have never seen anyone do that, on what basis were you able to form the opinion that it might jeopardise your position?-- That was just the feeling I got, I guess; that if - you know, you work through the system and, you know, if you have a problem, that's who you report to, but I - I don't know what gave me - that's just the way I felt.

All right. Given that you have never seen such a thing occur, would you accept that the feeling that you had might not have been an accurate assessment of the situation?-- Mmm.

Would you agree that that could be the case?-- It could be.

You spoke also of - in relation to patient - in paragraph 24 - P55. This is the man that you had hoped to transfer to Brisbane for catheter placement?-- Mmm.

I take it you were referring to the RBH?-- That's correct.

And did I understand you to say that they had, at that particular time, some problems of their own?-- That's correct.

That's your understanding?-- That was my understanding.

Ordinarily, is it the case that if Bundaberg had a difficulty with a placement of a catheter, that a transfer to Brisbane would be the way that you would overcome the difficulty?-- That's what would normally happen.

On this particular occasion, it would seem that there was just an accumulation of matters which caused Brisbane to be unable to assist?-- That's correct.

And Brisbane indicated that you should be able to do it there?-- That's correct.

You didn't speak to people from Brisbane yourself?-- No. That was the medicos talking between themselves.

Okay. Did you learn of what Brisbane was told?-- No.

Just one other matter on Patrick Martin: the document regarding the peritoneal dialysis catheter placements for 2003, the graph that we have all seen, you have been asked questions already about the fact that it, in itself, doesn't indicate whether this is all of the procedures that were conducted by Dr Patel or whether these are the ones that went wrong; you appreciate the difference between the two?-- Yes.

You appreciate also, no doubt, that when one is looking at outcomes in medical procedures, it is important to know if there is a poor outcome - whether it is a poor outcome from just one procedure or a poor outcome from 100 procedures?-- Mmm.

That would be most important?-- Yes.

Do I understand your evidence to be that the highest you can put Paddy Martin's knowledge of that topic on this document was that you felt that he knew it was all of the matters that Dr Patel performed, but that you can't say that for certain?-- That's true. I felt at the time he did say that, but I can't be 100 per cent sure on that.

I see. All right. That's all I have.

COMMISSIONER: Thank you, Mr Farr. Mr Allen, any re-examination?

MR ALLEN: Just one matter.

RE-EXAMINATION:

MR ALLEN: You were asked a number of questions about the speed at which you could have supplied some statistics to Dr Keating as requested in a meeting which occurred on the 27th of November 2003?-- Yes

Is it the case that very soon after that it became clear to you that Dr Patel had indicated that he would no longer perform renal procedures?-- That's correct, yes.

And was that at least by the 3rd of December 2003 as indicated in an e-mail which was RP2 to your statement?-- Yes. Yes.

Would it be fair to say that that would have, to some extent, reduced any need for urgency in building a case against Dr Patel as requested by Dr Keating?-- I think that's fair to say, yeah.

Thank you.

COMMISSIONER: Thank you, Mr Allen.

D COMMISSIONER VIDER: I've got a question. You've mentioned a few times today that you've spoken about who your line manager is and you understanding the reporting mechanisms, which also indicates that you understand the structure of the organisation and the framework within which it operates and how its authority lines are drawn, et cetera. I asked you earlier had you ever considered going to the zonal manager and bypassing the local district and you said no you hadn't. Am I right then in presuming that you would not ever have imagined - given the clinical situation you were dealing with with the patients that come to the Renal Unit - that you ever would wake up one morning and say, "I've had enough of this. I'm off to the zonal manager." That's not a thought you could imagine having?-- No, I didn't sort of ever feel that - I always felt somehow, some way we would get, yeah, some resolution within the hospital, yeah.

COMMISSIONER: You will appreciate that one of our more onerous functions in this process is to make recommendations to the State Government to improve the structure of public health services in Queensland and I wonder whether following on from Deputy Commissioner Vider's question you can give us any guidance from your experience as to what sort of changes you feel would make - would have made it easier for you to bring to light the problems that you had observed with Dr Patel. For example, one of the suggestions that's been

raised a number of times is that it would be desirable to have practising clinicians running hospitals rather than people who, whatever their other qualifications and skills, aren't involved in day-to-day clinical work; do you have any views about that suggestion?-- At the end of the day I guess people just have to find out what's happening on the ground level, what's happening at the coalface and maybe that wasn't happening, you know, to the extent that it should have.

Another suggestion that's been mooted a number of times, to put it in my words, is the idea of having a one-stop shop complaint body which isn't part of Queensland Health, that's independent of Queensland Health, where everyone, whether they're patients, nursing staff, administrative staff, medical staff, anyone else, can go to and know that either their complaint will be dealt with by that body or at least that body will oversee dealing with the complaint if it's referred back to hospital administration or referred to the Medical Board, or referred to Charlotte Street, at least there's one person that you have to deal with as the person making a complaint?-- I think that would be a great idea, yeah. Yeah, I just feel that I know that the system isn't working properly at the moment and it really needs to be looked at.

You have obviously thought about this problem a great deal over the last two years?-- Yes.

Are there any other suggestions or comments that you would like to offer us as to resolving these problems?-- I think we've all just got to work together. I think it's all about team work.

Mr Andrews?

MR ANDREWS: I have nothing further, thank you, Commissioner.

COMMISSIONER: You are excused from further attendance. I won't repeat the comments that I made at the end of the previous witness's evidence, but you can be assured that the sentiments I expressed then are equally extended to you from the members of the Bench. We do appreciate your time and we recognise the amount of effort that you have put into looking after your patients.

MR MORRISON: Mr Commissioner, just with the comments you just made about the excusal?

COMMISSIONER: Yes.

MR MORRISON: Can I ask you just to reflect on the fact that Mr Martin's statement hasn't yet come and for this witness in particular it maybe that things will arise - questions might want to be asked out of what he said of this witness.

COMMISSIONER: I take the force of that, Mr Morrison. I'm still inclined to excuse the witness from further attendance on the understanding that if we do need to recall you at some time, you won't be too far away?-- No, no, I'll be here.

Thank you.

WITNESS EXCUSED

COMMISSIONER: One last thing before we rise, I realise it's quite late, but I've been handed by the secretary a document which was handed to him by a member of the press gallery relating to statements apparently made in Brisbane today in Parliament House emanating from Dr Brian Senewiratne relating to incidents involving other overseas trained doctors in other parts of the State, an incident in Townsville involving a patient who was diagnosed as a stroke victim, so it is said, and left to die when it turned out that he merely had bleeding within his skull. Another overseas trained doctor who it is said couldn't make himself understood on ward rounds. Yet another overseas trained doctor in respect of whom different complaints are made, and the report that was handed to me ends with this statement, "Health Minister Gordon Nuttall wouldn't respond directly to Dr Senewiratne's explosive claims. His staff have said the complaints should be referred to the Morris Royal Commission."

The press gallery has asked whether we have any response to those matters. I simply want to make our position very clear about issues of this nature and really to say two things. One is that, as I said at the beginning of the very first day of the sitting, by singling out and identifying overseas trained doctors in relation to matters of this nature, we do run the very grave risk which has been commented on in the media of creating some sort of racist backlash. From everything we have heard again and again, there are some extraordinarily good and competent foreign trained medical practitioners in this State, and the last thing we want to do is to add any fuel to the fire of racism that may exist within our community. I think it goes without saying that racism is generally based on ignorance and our entire object in these proceedings is to bring the facts to light so that the ignorance disappears.

We have here evidence of one overseas trained doctor who is said to have been guilty of at the very least negligence in relation to his patients. It would be an absurdity for everyone - for anyone to assume that because one non-Australian trained doctor was negligent, that therefore it applies to all of them.

Indeed, if I could be permitted to encourage the media, I notice that again and again we see Dr Patel referred to as "Indian", "Indian trained". It is my understanding that he was born in India and did his Undergraduate Degree in India, but most of his training was, in fact, in the United States. I suppose it sounds less - well, it doesn't sell as many newspapers if you describe him as "US trained doctor Jayant Patel", but I think people should be very sensitive of the

fact that if he's continually identified as "Indian trained" that will have an unfortunate effect on people's views in relation to other people, other medical practitioners trained outside traditional western countries.

So that's one thing I want to make clear and I again urge calm over this issue. As I said, we're here to find out the facts and our very sincere hope is that when the facts are brought to light and appropriate recommendations are put in place that will benefit everyone, not least of all the other overseas trained medical practitioners in our system who will then be able to hold their heads up high and say, "Well, I'm practising here because I got through a Medical Board system and I've been approved by Queensland Health because I am competent doing my job," and will sweep away the problem we have at the moment where people seem to be able to practice in Queensland without necessarily jumping through most rigorous hoops to get to that position. So that's one thing I wanted to say.

The other thing I wanted to say is about the scope of the Inquiry. I have mentioned the meeting with the Premier the week before last and the gist - I don't propose to go into details of what was discussed - but the gist of what was said by me to the Premier was that if our Inquiry is confined within its current Terms of Reference, hence specifically with reference to the issues in Bundaberg, we are reasonably confident of finishing on time. But if we are asked to deal with similar matters arising in other hospitals throughout the State, obviously it will be a longer and more expensive exercise. I am keen, I know that the two Deputy Commissioners are keen, and I am sure I'm not breaking any confidences when I say that the Premier conveyed to me that he was very keen to fix the problem as quickly as possible and that means running this Commission of Inquiry to an outcome hopefully by the end of September, rather than by the end of the year or some time next year. For those reasons, we are very reluctant to allow the scope of the Inquiry to go any further than it is at the moment.

Having said that, we have tentative arrangements in place, probably at some time during August, to travel to other parts of Queensland in what we hope would be a pared-down version of this trip to Bundaberg to hear evidence of selected incidents in selected parts of the State. That is not because we feel that we can do a complete Statewide audit. If we were doing that, then this would turn into another Fitzgerald Inquiry and we would be going for years and probably never be close to the truth. But we do feel that there is a need to base our final report and recommendations on at least a sample that goes beyond Bundaberg and that's why we will be looking at some incidents in other places.

But we would urge those in Government and, indeed, those in Opposition as well to bear in mind that the ultimate outcome of this Inquiry has to be some sorts of improvements to the present system of delivery of health services in this State, and if there are to be some such improvements, the sooner they

happen, the better. So we remain resistant to the idea of extending this Inquiry to look in detail at similar complaints throughout the State.

But, of course, we are here as the servants of the Governor-in-Council and if the Governor-in-Council asks us to extend our Terms of Reference, we will do what we are told. Do you wish to add anything?

D COMMISSIONER EDWARDS: No.

D COMMISSIONER VIDER: No.

MR DIEHM: Mr Commissioner-----

COMMISSIONER: Yes, Mr Diehm?

MR DIEHM: Without meaning to interrupt, Commissioner, there was one matter I wanted to raise before we conclude today and that is the status with respect to the Commission providing to the affected parties the statements or other information that has been provided by the CMC to the Commission.

COMMISSIONER: Yes. Look, I'm glad you've raised that because Mr Andrews did mention that to me yesterday. My understanding of the situation - and I will ask from Andrews to clarify this if I have got it wrong - my understanding is that the statements used for the purpose of evidence in this proceeding have come essentially from three sources. In respect of some witnesses, we have the benefit of statements from the CMC and they're being used as the source of evidence from those witnesses. Some of the statements have been prepared by Mr Allen's instructing solicitor on behalf of members of the Nursing Union and we're using those statements as the source of evidence. Some have been prepared by our own investigative staff and that's the source of the evidence that will be called as evidence-in-chief.

In those cases where the source of a statement is the CMC, then I understand that the statements have been made available or will be made available and is that-----

MR ANDREWS: The only correction to that is that the CMC has, indeed, provided some transcripts spanning quite a number of topics rather than statements. Those transcripts are made available to this Commission of Inquiry to do with as it pleases. Currently, I hope to urge you not to disseminate those transcripts in their current form but to allow-----

COMMISSIONER: To better review it and pare it back to what's relevant to the Terms of Reference?

MR ANDREWS: Yes.

COMMISSIONER: That will certainly be my intention. Does that answer your questions, Mr Diehm?

MR DIEHM: Well, it does, Commissioner. If I may just say

that due to what Mr Andrews has just referred to-----

COMMISSIONER: Yes.

MR DIEHM: -----it is my submission that what the affected parties should be given is any information that has been provided to the Commission that affects them and is within the Terms of Reference.

COMMISSIONER: That affects them and within the Terms of Reference, I agree with that, and that is the intention, as I understand, from Mr Andrews as well.

MR ANDREWS: That's quite so.

MR DIEHM: My residual concern is - and this is sort of coming out, with respect, for instance, with this witness this afternoon and others over the last couple of days - is that it seems that some of these witnesses are the sources of that information and we would not have got that information today and that, of course, means cross-examining her if we wish to.

COMMISSIONER: I think yesterday's and today's witnesses are an example of those where we have relied on statements obtained by the Nurses' Union in the first instance. Obviously, the witnesses have been interviewed by Inquiry staff and statements have been added to and so on, and I expect in that process - again, Mr Andrews will be able to clarify this - if there is anything in a CMC record of interview relevant to the witness, that is cobbled into the statement as we go. So when we produce a final statement, whilst the bare bones of it may be the Nurse's Union draft, then it will include anything our people and the CMC think relevant of the witness. Is that-----

MR ANDREWS: Yes.

MR DIEHM: My concerns may be without ultimate substance then.

COMMISSIONER: I think so.

MR DIEHM: Yes, thank you, your Honour.

MR MULLINS: I should also put on the record, the patients - my instructing solicitors have supplied a number of statements in draft to assist in the investigation.

COMMISSIONER: Yes.

MR MULLINS: It wasn't contemplated that those would be distributed to all and sundry and I know they haven't been mentioned yet. In terms of the broad principle that the Commission will distribute all documents that have been supplied to them, can there be a caveat on that and I will take some instructions on that overnight?

COMMISSIONER: Our attitude would be - I didn't mention patients' statements because that's a category we haven't got

to yet, but what we would expect to happen with those patients - certainly what I would expect to happen is that they will be interviewed by Inquiry staff and more comprehensive statements or possibly less comprehensive statements, if there are things in it irrelevant, will be prepared no doubt based on the initial draft provided to us and that is what will be circulated and the members of the Bench don't even get to see the version that is not used.

So, for example, we haven't seen the CMC records of interview with people to the extent that those might have been used to prepare the statements. Similarly we haven't seen statements from your clients. What we will see is the version that everyone else sees.

MR MULLINS: Thank you.

COMMISSIONER: Mr Morrison, did you-----

MR MORRISON: Just one matter, and Mr Andrews may be able to respond to it. I assume Mr Diehm's concerns, the most immediate one is, for instance - I give it to you only as an example - I can't tell you in relation to, say, Nurse Hoffman, is the statement with which we have been supplied has anything to do with anything she said to the CMC.

COMMISSIONER: I think in Ms Hoffman's case it all came from the Nurse's Union, Mr Allen?

MR ALLEN: That is so.

MR MORRISON: In which case the problem is highlighted.

COMMISSIONER: And that should be looked into before she returns to the witness-box.

MR ALLEN: I've missed the meaning, is that as to whether or not any transcript of interview of the CMC should be made available?

COMMISSIONER: Well, I think the point that Mr Morrison is making is a perfectly fair one, that if he's going to be put in the position of cross-examining Ms Hoffman, he shouldn't be restricted to a statement that's been prepared by the solicitors for the Nurse's Union. He should be entitled to be aware of what she said to other investigative authorities on other occasions. That is a fair point, so long as it's relevant to the issues here, and so on, and we will have that checked to make sure that the representatives of those parties affected and, indeed, everyone else are provided with material that may be relevant to their cross-examination.

MR ANDREWS: Commissioner, with respect to that, I might say it's my submission that procedural fairness does not require that there be a disclosure of all of the material that has been gathered preliminary to the calling of a witness. If there is, for instance, a requirement for Inquiry staff to consider all material that's been gathered, for instance, with

respect to the current witness, just for example, to make a determination about whether it could be used by a party for the purpose of cross-examination, the task of assessing that material would significantly magnify the duties of the Inquiry staff. It is my submission that procedural fairness requires that any party who might be adversely affected by the witness by the evidence which is put before you has an opportunity, it given reasonable notice that a witness will be called, whose evidence might impact upon them positively or negatively, that they be given an opportunity to cross-examine that witness. That if any submissions are to be made eventually, which are contrary to the interests of that party, that they be given notice of what those submissions are and an opportunity to make submissions in response. But procedural fairness does not require discovery in the way that one might expect in a trial.

COMMISSIONER: Mr Andrews, what you say is no doubt technically correct. I guess that my present intention anyway is not to adhere to the minimum standard of procedural fairness but to be as fair as possible without running into insuperable difficulties in terms of exhausting the Inquiry and what can be done. I'm inclined to adopt as our model the best practice prosecution in the criminal law, which is to provide to the accused person any evidence that may assist them, whether or not we propose to adduce that evidence.

I just ask everyone to be patient and cooperative about these things. We're certainly not setting out, Mr Diehm, Mr Morrison, Mr Ashton and others to trick your clients or deprive them of an opportunity to access relevant evidence. But you will also appreciate that counsel assisting and the legal staff within the Inquiry do have a great deal to do and they can't spend all of their time sifting through material to see if there's something that might possibly be of assistance to you that hasn't otherwise come up.

I would like to see if we can find some practical way to overcome this; for example, as it were, lending to you copies of statements so that you can review them. If there is something that you feel that you should be given a copy of, then you can ask for it, and if the request is a reasonable one it will be granted - something like that anyway - so that your clients have the maximum of procedural fairness with the minimal inconvenience and expense. Does that sound reasonable?

MR MORRISON: It does, Mr Commissioner. I wouldn't argue with it. It is perhaps easiest dealt with in the way you suggest, but in relation to, for instance, the transcript, it's a terribly easy thing that we be provided the transcript in the way you suggest - and the Commission staff don't have to pass their eyes over it, we unfortunately do - but we have an interest in doing exactly that.

COMMISSIONER: Well, Mr Andrews, we might work out what we can do to streamline the process of making as much as possible available to the parties interested.

MR ANDREWS: Yes. I'm concerned, for instance, that there be transcripts in which the CMC, approaching this matter completely afresh and with no defined issues, have asked questions spanning a wide range of topics, some of which have elicited answers from persons that are terribly defamatory about other people but they are answers that are in no way relevant to this Inquiry or its Terms of Reference, and I'm reluctant to disseminate that material. The practical alternative for the Inquiry staff would be to try and isolate from within a long document the passages that might be relevant to any particular party, but that becomes an onerous task

COMMISSIONER: It does, and since Mr Morrison so generously offered to take that burden away from Inquiry staff and take it on himself - and I'm not talking about general dissemination, I'm not talking about copies going to the public at large or even necessarily beyond the lawyers-----

MR MORRISON: Not at all.

COMMISSIONER: But if Mr Morrison wishes to have a transcript that deals with lots of irrelevant things, and on the understanding that it won't go beyond him and his instructing solicitor, then I don't see that that's going to be a problem.

MR ANDREWS: It's a Fielder and Gillespie sort of disclosure. That's a very practical alternative.

MR MORRISON: I'm content for that approach, in my own case, I can't speak for others, and if I feel the need that we need to review that I will raise it.

COMMISSIONER: I might do some work overnight on precisely that, but I would expect to trust any of the members of counsel representing particular individuals or organisations here to be in a position to use their discretion to seek instructions on particular matters as they see fit, without necessarily having to show copies of the document to anyone.

MR MORRISON: Quite.

COMMISSIONER: Mr Diehm, does that sound all right?

MR DIEHM: It does, Commissioner, yes.

COMMISSIONER: Anyone else? Mr Ashton?

MR ASHTON: That sounds fine.

COMMISSIONER: Mr Farr?

MR FARR: Yes, I agree. The only difficulty I perceive is with the number of us involved, one document might spend some time going from person to person.

COMMISSIONER: I think there are electronic copies of most of

them, so we can make them available.

MR FARR: If that's the case it certainly would make things easier.

COMMISSIONER: Our photocopier broke down, but subject to that they should be available. Does that affect anyone else? Mr Devlin, that really doesn't worry you?

MR DEVLIN: Not at this point, thank you.

MR DIEHM: The only other matter that arises from it, Commissioner, is the question about the order of witnesses, because as was intimated earlier today, for instance, there was a proposal that Ms Hoffman would be returning into the witness-box potentially tomorrow.

COMMISSIONER: We have got two witnesses before Ms Hoffman.

MR ANDREWS: Yes, it is feasible to call Jennifer White and Mr Martin. There are requests for Mr Martin's statement, which can only be supplied if it's photocopied.

COMMISSIONER: Yes.

MR ANDREWS: It may be that the Inquiry staff can scan it and distribute it electronically or perhaps turn it into a CD.

MR FARR: I think there must be a photocopier here because my solicitors did photocopy a document in this complex today.

COMMISSIONER: Apparently we have got a slow speed photocopier we are making do with at the moment, but there's a high speed one available in the morning. I didn't know there was such things as high speed photocopiers, but there we go.

MR ANDREWS: If I am to infer that the parties would prefer to see - prefer to have Nurse Hoffman's evidence postponed - I see heads nodding and shaking which makes it difficult for me to deduce what the consensus is - there are other witnesses who can be put into precede her, but I would otherwise be content to call Ms Hoffman. I know that there are some counsel who can't return next week who are keen to conclude their cross-examination of Ms Hoffman and she may be lengthy.

COMMISSIONER: That makes sense and it may be that some people will need to have two bites of the cherry. It may be Mr Diehm - I might just single you out as an example - you may have some questions and then returning next week you may have some more questions, but I think that's going to be the best way to do it, so we can make some use of the time available.

MR ANDREWS: So, in the circumstances, the calling of Ms Hoffman tomorrow seems to meet with a lot of approval, as it's certainly convenient for me.

COMMISSIONER: That is what we will do then. I also-----

MR ALLEN: Commissioner-----

COMMISSIONER: Yes.

MR ALLEN: Can I just raise something there? Obviously as matters were conducted in Brisbane, Ms Hoffman's evidence has been separated into at least two distinct parts-----

COMMISSIONER: Yes.

MR ALLEN: -----in Brisbane and Bundaberg, and she will be cross-examined by several counsel and, in my submission, it would be unduly onerous for the further process of her cross-examination to be again separated and part-heard with a possibility of her needing to be recalled to be further cross-examined by any number of counsel. It would be unfortunate even to the extent of her being required to be part-heard in cross-examination over the long weekend, in my submission. So, in my submission some arrangements should be reached so that once her cross-examination begins it can be concluded.

COMMISSIONER: Look, I doubt that it would conclude this week, anyway. Mr Allen, I don't think I am giving any secrets away in saying that all three of us on the Bench have been

enormously impressed with Ms Hoffman and the way she gave her evidence. That's not saying that we accept everything she said, that's a matter that we have got to make decisions about ultimately when we have heard all of the evidence, but she is obviously a person with great strength of character and ability, and whilst your submissions have a lot of force I think given that she's the person who has brought us all here in the first place through her courage I don't think she would object about her asking her to bear with us just a little further to make sure that everyone has the opportunity that natural justice entitles them to have.

MR ALLEN: Should we expect that her evidence will begin first thing tomorrow?

COMMISSIONER: No, I think you will have one or two more witnesses?

MR ANDREWS: Look, I'm content nevertheless to put in Ms Hoffman. The other witnesses are local and subject to anything that counsel for the nurses can - subject to anything you, Mr Allen, can tell me. I assume that it's convenient for them to be postponed until after Ms Hoffman?

MR ALLEN: It has been raised with Ms White, who was to be called, and although she would have preferred to have matters dealt with she is content if Ms Hoffman was to give evidence tomorrow morning.

COMMISSIONER: What's the harm in doing it this way tomorrow morning?

MR ANDREWS: Nothing. The only harm was to protect Mr Morrison from the risk of having to interrupt his cross-examination. It's Mr Morrison, I understand, who must be in Brisbane next week.

MR DEVLIN: I am in a similar position.

MR MORRISON: I will explain my difficulty if I may, Mr Commissioner. I am not able to be here next week but, having said that, I have privately elbowed everybody else out of the way in order to go first with Ms Hoffman.

COMMISSIONER: Yes. Mr Devlin, you are in a similar position?

MR DEVLIN: I am in a similar position. My junior would be here next week and I would like the opportunity to cross-examination Ms Hoffman.

COMMISSIONER: We will make sure you two are first cabs off the rank.

MR DEVLIN: Thank you.

COMMISSIONER: That allows us to call Ms White and there was also a suggestion of calling-----

MR ANDREWS: Mr Martin.

COMMISSIONER: -----Mr Martin.

MR ANDREWS: And I am told that his statements were produced by the photocopier.

COMMISSIONER: Right.

MR ANDREWS: They have been disseminated this afternoon.

MR FARR: We act for Mr Martin.

COMMISSIONER: Yes.

MR FARR: He has been notified halfway through today of the possibility of giving evidence quickly, so he's in the Commission's hands. He's available to give evidence if required. He is do it at-----

COMMISSIONER: Why don't we start with Ms White, have Mr Martin probably tomorrow afternoon, and that will give Mr Morrison and Mr Devlin the opportunity to start with Ms Hoffman, either tomorrow afternoon or the whole day on Friday. Would you expect - Thursday. Would you expect to finish on - within that time, Mr Morrison?

MR MORRISON: I can't guarantee that, no. It very much depends on, as you would know from your experience-----

COMMISSIONER: Of course, of course.

MR MORRISON: -----on how things go, and I don't want to say more about that. But then there's Mr Devlin as well. There's not much chance of the two of us being done within a day.

MR DEVLIN: I shan't be that long.

MR MORRISON: There you go. I am the long one.

COMMISSIONER: All right.

MR MORRISON: I am reconsidering in light of what you have said today.

COMMISSIONER: Yes, of course.

MR MORRISON: So-----

COMMISSIONER: All right. Well, let's have Ms White first. We will see about Mr Martin. If Ms White is finished, say, by 11, 11.30, 12 o'clock, then Mr Martin. But if she's still going at lunchtime then Mr Martin will have to be asked to come back next week.

MR ANDREWS: That's convenient. Thank you.

COMMISSIONER: Okay. What time tomorrow?

MR ANDREWS: Let's start late, say 9.30.

COMMISSIONER: 9.30. All right.

THE COMMISSION ADJOURNED AT 6.23 P.M. TILL 9.30 A.M. THE FOLLOWING DAY