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Transcript of Proceedings

MR A J MORRIS QC, Commissioner

SIR LLEW EDWARDS, Deputy Commissioner

MS MARGARET VIDER, Deputy Commissioner

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IN THE MATTER OF THE COMMISSIONS OF INQUIRY ACT 1950

BUNDABERG HOSPITAL COMMISSION OF INQUIRY

COMMISSIONS OF INQUIRY (No. 1) 2005

BUNDABERG

..DATE 28/06/2005

..DAY 14

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THE COMMISSION RESUMED AT 9.40 A.M.

MR A MACSPORRAN (instructed by Brian Bartley & Associates) for the Director of Nursing, Ms Linda Mulligan

COMMISSIONER: Good morning, ladies and gentlemen. Mr Andrews, is there anything we need to deal with before Ms Hoffman proceeds with her evidence?

MR ANDREWS: No, Commissioner, we can proceed straight to the evidence.

COMMISSIONER: Thank you. Ms Hoffman, you're, of course, still under oath.

MR MACSPORRAN: Mr Commissioner, may I announce my appearance for Ms Mulligan?

COMMISSIONER: Yes indeed, Mr Macsporran.

MS McMILLAN: And I appear instead of Mr Devlin this week.

COMMISSIONER: Thank you, Ms McMillan. Now, who is next?

CROSS-EXAMINATION:

MR HARPER: Ms Hoffman, my name is Harper. I appear on behalf of the patients in this matter. I won't be particularly long today. I might just outline at the start the areas I'd like to talk to you about. Firstly I'd like to talk to you about some of the issues relating to documentation, and hence their concerns. Secondly, my clients would like to know what processes are in place for communication with the patients at Bundaberg Hospital and, thirdly, about the complaints handling processes. If I might take you to the start, you spoke in your statement about Dr Patel and his, effectively, falsification of records during theatre et cetera. Can I take you through again the process upon which those notes are taken? I understand it is generally the surgeon - in the case of Dr Patel, it would have been Dr Patel who took those notes?-- Yes, that's my understanding, yes.

Is it only his responsibility to take those notes?-- I don't work in theatre, so that's something that I'm not exactly sure of, so-----

Generally in your practice as a nurse, is it common for other - staff other than the treating doctor to record things in the patient notes?-- Sometimes doctors dictate things to other doctors, to junior doctors, and they write them in the notes,

but other than that, no.

Okay. So, for example, the anaesthetists wouldn't be expected, if they had noticed something adverse, to take a note of that in the patient notes?-- They would be expected to do that themselves.

Sorry, they would be expected to do that?-- They would be expected to do that themselves, yes.

Similarly, any nurse on duty at the time would be expected to note any adverse concerns arising from the surgery in the notes?-- Once again, I don't really know what the nursing staff do in theatre. It's very rarely that they write in the chart. They may write on the anaesthetic record, but it's very rarely that they actually write in the chart, from my knowledge of that.

You mentioned in your evidence that at the handover of patients in the ICU there are occasions on which the theatre notes did not reflect what you understood to be the case from information you had received?-- Yes, that's right.

Would you expect in those circumstances that someone else would have highlighted that discrepancy in the notes?-- Yes, I would.

And who should have been highlighting those discrepancies in the notes?-- Whoever made the mistake or noticed the mistake first should make - should have put in an Adverse Event Form or an incident report.

I might take you then - and forgive me if you explained this before, but you spoke in your evidence-in-chief about two sorts of documents, Adverse Incident Reports and Sentinel Event Forms?-- Yes.

Can you just explain for me again what is the distinction between - what is a sentinel event, firstly?-- A sentinel event is something that's extremely serious. There's a list of them. Queensland Health has been in the process of changing this over the last couple of years. There's a list of what constitutes a sentinel event and they could be something like suicide of patient in a hospital or amputation of the wrong limb, wrong blood product given, a baby being taken, I think - there's a list of these things. Death of a patient during transfer is one, if I recall.

What other sorts of instances where there's been the death of a patient would attract a Sentinel Event Form?-- If - probably if the patient died from something that went wrong during their stay in the hospital.

So effectively some manifest-----?-- Rare-----

-----obvious negligence?-- Yeah, or I think the other category is a rare event, a rare or - yeah, event.

And an Adverse Incident Report then, how does that differ?-- It's not as serious as a sentinel event. It could be anything from a medication error to a malfunction of some equipment, something like that. To my knowledge also - and I mean, I could be wrong about this - a Sentinel Event Form would go directly - or was supposed to go directly to Central Zone at one point and actually bypass the hospital system and be dealt with at that level then come back to be investigated.

So a sentinel event takes it automatically up a level?-- Yeah, it did do. I'm not quite sure where it stands now, whether the District Managers and the Director of Nursing and that sort of thing have to look at it now, because it was in a period of change.

Okay. An Adverse Incident Report though, where does that go to?-- That goes also to - supposed to go directly, I think, to the Quality Department at the hospital.

And again, any person involved with the surgery or the treatment of a patient can file an Adverse Event Form?-- Yes.

So that includes the anaesthetist?-- Yes.

Any nurse on duty?-- If they were there and they were - you know, saw what happened or-----

Can I ask, when there is a Sentinel Event Form filled out, is the family of the patient or the patient him or herself informed?-- Not necessarily to my knowledge, no.

Is it encouraged that they should be informed?-- I haven't heard - ever heard that, or been told that.

I take it it's not discouraged that they be informed?-- They should have already been - if something has happened to the patient in theatre or wherever, or intensive care or something, they should have been informed that something bad has happened to their relative anyhow. So they may or may not be aware that a form has gone in. But the doctor should have explained to them that something has gone wrong during surgery.

So, for example, you spoke in your statement, and when you gave evidence in Brisbane, about where someone's spleen would be nicked and it would just be recorded as a splenectomy?-- Yes.

Would the other staff on duty at the time have been able to file an Adverse Incident Form in that circumstance?-- It should probably have been up to the theatre staff to do that, the people that were involved or were directly involved in that situation. So it should have been generated by the surgeon in theatre or other theatre staff that saw it, or perhaps the anaesthetist, if he was aware of it as well.

Would someone have informed the patient the reason for the splenectomy?-- They should have.

D COMMISSIONER VIDER: Could I just clarify something there? You said on Thursday that sometimes nothing was documented-----?-- Yes

-----in writing?-- Yes.

It was a verbal handover from the theatre staff to the intensive care staff?-- Yes.

Where the information was passed that a splenectomy had been performed?-- Yes.

Or some other surgical intervention as a result of a complication during the elective surgery procedure?-- Yes, that's right.

So there would be, in a patient's record, the possibility that that splenectomy is not formally documented-----?-- That's right.

-----on the surgical - or surgeon's report?-- Yes, yes.

MR HARPER: Can I take you to the sections of your statement regarding patient P11 which is, I think, Mr Bramich, and you talk there about a Sentinel Event Form having been prepared. As I understand it that was prepared by you?-- It was actually prepared with the aid of Dr Jane Truscott who was acting in the quality improvement role at the time. She came down to the ICU and helped me fill in the form. We filled in the form and I wrote an accompanying statement and it was sent - she took it away.

What, in your view, categorised that as a sentinel event rather than an adverse incident?-- Because we had a death of a patient during - well, in the process of being transferred.

Okay. That, though, was not specifically - one of the specific guidelines you mentioned earlier about what is a sentinel event?-- It does say death of a patient during transfer.

Okay?-- Whether they actually mean RFDS transfer or transfer to another hospital or what, I'm not quite sure, but it does say that.

So any death during a transfer-----?-- Yeah.

-----should be reported as a sentinel event?-- That's my understanding, yes.

Do you recall any communication with Mrs Bramich after that process was worked through?-- I haven't spoken to Mrs Bramich since I left the hospital that night, until just now.

Can I ask you generally about - I'd like to talk to you a little bit about complaints processes and how they're handled within the hospital. I say at the outset, obviously

complaints come in at various points and they get escalated at various stages depending upon what the patient's concern is and how seriously they regard it. Within Queensland Health, is there any process when you commence employment about how to handle complaints from patients?-- I think - it depends on the hospital that you work at.

Right?-- And I think during orientation now at - say, for instance, at Bundaberg, I think the new orientees are given a lecture in risk management and adverse event reporting. I believe that's the case.

Just about your experience, when you started, was there training given at that time to staff about receiving complaints?-- I actually can't remember, and it - if it was, it was very different to what's being done now anyhow.

If there is a complaint to any member of staff, what reporting process is there for that staff member about that complaint?-- About a staff member or-----

No, sorry, speaking on behalf of the patients. If a patient complains to anyone within the system, what's the process by which that staff member then must report that complaint?-- Oh, we have guidelines that we should follow to advise them on how to make complaints, and there's actually like - in the waiting rooms and places like that there's things up on the wall which actually advise them on how to either contact the District Manager or - I mean, firstly, if they're able to, we do ask them to try and resolve the issue with perhaps the nurse in charge or the nurse who is caring for the patient, and if that can't be done then they have the right to write to District Manager and also to go to the Health Rights Commission.

If a complaint comes to a nurse, where does that nurse take that complaint from there?-- If the complaint came to me?

Just for example to you?-- I would see if it was something that I could deal with and, if it wasn't, then I would pass it on up the line to my line manager, plus also to - it needs to go to Quality Department.

Do the complaints from patients routinely get discussed at any of the managerial meetings?-- There is a standing agenda at the clinical forums where we do look at complaints, and we put in a budgetary report every month where - there's a place where you can put in compliments or complaints and if there's anything there that's happened during that month, you write it in there and send it on to the Director of Nursing.

So in those circumstances complaints from the patients should be recorded - if processes are being followed, they should be recorded then?-- They should be, yes.

D COMMISSIONER EDWARDS: They should go on to the Director of Nursing, did I hear you say?-- Yes, in the budget report that we do every month, that's one of the forms where she would

receive complaints.

MR HARPER: Say from your experience, do you routinely, when you receive a complaint, advise the patient about where they can take it further if they're not satisfied with how it's been dealt with?-- Yes. We actually don't receive that many complaints in intensive care, and a lot of complaints come the other way. From my understanding they come - some patients may go directly to the District Manager and they deal with them, or the Director of Medical Services, so we - they may actually go the other way. We mightn't hear about them.

So if a complaint went to, say, the District Manager-----?-- Yes.

-----then the District Manager would hopefully go down and speak to the staff involved?-- Yes, you would hope so, yes.

MR HARPER: I have nothing further, Commissioner.

COMMISSIONER: Thank you very much. Mr Diehm? Sorry, I wonder whether - Ms McMillan, do you wish to cross-examine now or is it intended to wait until Mr Devlin comes back?

MS McMILLAN: That was the plan, as I understand, if you're still content.

COMMISSIONER: That's fine. Yes, thank you.

MS McMILLAN: Thank you.

COMMISSIONER: Mr Diehm?

MR DIEHM: Commissioner, knowing the way that you have indicated that you intend to conduct these proceedings, obviously if something were to come out of Mr Devlin's cross-examination that affected my client, I'd be permitted to ask some questions after that.

COMMISSIONER: Of course. That goes without saying.

MR DIEHM: Thank you.

COMMISSIONER: Mr Diehm, like all counsel, I'll trust your responsibility. I made some observations last week about what I see as being the important issues and the undesirability of descending into issues such as who said what at what meeting and whether they were angry or that sort of thing. But I'll leave that to your judgment as to what you think is appropriate to best represent the interests of your client.

MR DIEHM: Thank you, Commissioner.

CROSS-EXAMINATION:

MR DIEHM: Ms Hoffman, you probably know, but I'm Geoff Diehm, counsel for Dr Keating. Ms Hoffman, can I clarify with you your perception of when you first made a complaint to Dr Keating concerning the clinical competence of Dr Patel?-- I believe it was in the first few months after Dr Patel started.

And are you referring there to either or both of your meetings with Dr Keating, the first in the company of Glennis Goodman, and the second in the company of Dr Joyner?-- Yes.

So you regard what you were complaining about on those occasions as being complaints about Dr Patel's clinical competence?-- Yes.

Amongst other things, perhaps?-- Yes.

With respect to your meeting, the first of those meetings with Ms Goodman and Dr Keating, is it right to say that the three particular matters that were of concern to you and that you voiced at that meeting, were firstly some issues you had with respect to his behaviour in the ICU?-- Yes.

And by that I'm referring to things that he said and attitudes that he demonstrated towards ICU staff?-- Yes.

The second thing was that you thought that the performance of oesophagectomies - I've, in rehearsal, got that right every time, Ms Hoffman - the performace of oesophagectomies, you thought, involved excessive demands upon the ICU in terms of caring for the patients post-operatively?-- That's not the only concern. It was excessive demands upon the ICU that we had, but it was also looking at what we knew about research-based evidence that we had that with oesophagectomies, aftercare is one of the most important parts of doing the operation, and to have good outcomes the literature actually stated that you needed to do - a specialist needed to be doing at least 30 per year in a hospital. So we were looking at that side of things as well. It wasn't just the undue - it wasn't just about the effect that it had on the ICU. I was more concerned about the patients weren't getting the best care that they would have if the surgery was being done by a specialist in Brisbane.

D COMMISSIONER VIDER: And can I clarify that the Bundaberg Hospital Intensive Care Unit was categorised as Level 1?-- Yes.

And that has its ramifications?-- Yes.

In terms of it puts a framework around the sorts of clinical patients that you should accept?-- Yes, that's correct, and the other overriding issue also was we didn't have an intensivist, and we still don't.

Yes.

COMMISSIONER: So really, you're making two quite separate points. One is that there just weren't enough oesophagectomies at the hospital that a surgeon could build up the expertise to do them effectively?-- That's right, and really the person who is doing them should be a specialist gastroenterologist. It shouldn't just be a general surgeon. It's a very specialised form of surgery.

Were there cancer specialists amongst the medical staff at the hospital?-- Surgical cancer specialists?

Or medical specialists?-- There's a visiting oncologist, I believe, that visits to order chemotherapy, that sort of thing. But other than that, no.

Before Dr Patel arrived, was it your experience that to have an oesophagectomy performed in Bundaberg was a rare event?-- Yes, there was - since I was there there was, I think, one other that was done there by a different surgeon, I believe.

MR DIEHM: Ms Hoffman, I might be able to help you with that. The oesophagectomy done by another surgeon - tell me if this fits with your recollection - was one that was performed in late March 2003 and saw the patient remain as an inpatient at the hospital until about the 9th of April 2003. Does that sound about right to you?-- I recall a patient, and I don't recall any of those other details in terms of time frames. I don't have those details with me.

If that time frame is right, that coincides, does it not, with the arrival of Dr Patel at the Bundaberg Base Hospital?-- Yes, it would do.

If that time frame is right then the position for Dr Patel arriving at the Bundaberg Base Hospital is that he may well have seen that there was another oesophagectomy which had been performed at the hospital, perhaps creating the impression to him that this was an operation that was within the scope of practice at the hospital?-- That could have well have been the case.

If I can just ask you to look at a document that I'll open up at a particular page which, down the bottom, you will see an entry for a patient with the number P162. Commissioner, this, no doubt, will involve another patient identity that isn't the subject of the key presently.

COMMISSIONER: Certainly.

WITNESS: So, what patient-----

MR DIEHM: Sorry, we are trying to wait until we get to the appropriate part. It is coming up at the bottom of the screen now. You will see a reference to a patient there who is described as having a malignant neoplasm and the admission date is 25 March 2003 and the discharge date 9 April 2003, so it is cancer of the oesophagus, and then is seems there 25 March 2005, "oesophagectomy by abdominal", et cetera.

COMMISSIONER: Mr Diehm, I'm certainly not going to prevent you from exploring this if you consider it relevant, but just for the moment I can't see how-----

MR DIEHM: I was merely trying to confirm the dates of when this prior procedure was performed at the hospital.

COMMISSIONER: I don't think we need to trouble Ms Hoffman about that. You can establish that in due course.

MR DIEHM: Commissioner, would it be suitable to receive that document into evidence now? It speaks for itself.

COMMISSIONER: Yes, certainly. At the same time, I'll remind journalists of the order previously made regarding disclosure of patient's names. There was a patient name appeared in this document and that name isn't to be mentioned without his permission or, if he is no longer with us, the permission of his family or next of kin. The document headed "Oesophagectomy and Whipple's Procedure, 1 January 2002 to 31 March 2005" will be Exhibit 89.

ADMITTED AND MARKED "EXHIBIT 89"

MR DIEHM: Thank you, Commissioner. Ms Hoffman, the questions I asked you before were about the reasons or the matters of complaint that you raised with Dr Keating in your meeting with Dr Joyner and Dr Keating. Please take it that I wasn't trying to trivialise your concern with respect to the ICU capacity, and the phrase I think I used was "excessive demands". Excessive demands can, obviously, mean that it is putting a strain beyond what the unit is capable of supporting and that can obviously have implications for patients. So, don't take my question as meaning that you were only concerned about your or your staff's welfare. The third matter of concern that you

have raised with Dr Keating was concerning the patient - sorry, I will rephrase that - was concerning a practice that you complained of with respect to Dr Patel of describing patients as stable when they were not?-- Mmm.

Now, that was something that he did with respect to P34; is that right - he was the first of the oesophagectomies that Dr Patel performed?-- Yes.

And had he done it with respect to any other patients?-- That was the first patient that I recall Dr Patel caring for in the ICU. I think when he first came, I think I may have been on holiday. I think that was the first patient that I recall Dr Patel having anything to do with or myself having concerns about that I can recall.

All right. Now, with respect to P34, you gave evidence in Brisbane that this patient had been refused surgery at a tertiary hospital in Brisbane?-- Yes, that's my understanding, yes.

Which hospital was that?-- I don't know.

Do you know who the doctor was that refused the surgery?-- No, I would have to look at the notes - his notes.

You would have to look at his notes?-- The patient's notes, yes.

You think there's something in the patient file from Bundaberg Hospital that reveals information of that kind?-- There could be. There may not be. But I'm not sure. I don't know the surgeon's name who refused the surgery or the hospital that refused it, but I know that he had been refused surgery in Brisbane.

COMMISSIONER: Where did you get that information from?-- From the doctors when he came into the hospital - when he came into the Intensive Care Unit - from, I think, the anaesthetist and I think from even Dr Patel himself. That's my understanding.

Do you have a clear recollection of discussing that with Dr Patel or Dr Patel mentioning that to you?-- No, I remember him speaking of it, and I remember conversations with his family as well where his family said that, you know, he wasn't - he couldn't - they wouldn't operate on him in Brisbane. I'm just trying to think if I remember discussing it with Dr Patel or not. I remember it was being - you know, it was widely discussed that he - they had refused his surgery in Brisbane and so Dr Patel said he would do it there.

We will try and track that down through other sources, but is it your recollection or do you have a recollection one way or the other as to whether the refusal was because, for example, waiting lists were too long, or something like that, or simply for clinical reasons?-- No, it was because he had so many comorbidities and he was so unwell normally and I think they

thought his cancer was too advanced that to operate on him would have put him through unnecessary - an unnecessarily large operation that he probably wouldn't survive from. We had quite a few conversations prior to him coming in because I know I had to get extra staff in to prepare because he was going to require dialysis as well, so that's - it was like a combined effort with Dr Miach involved - that we would be bringing this patient in to hospital and that he would be requiring dialysis. So, he was going to be of a higher acuity post-operatively than normally.

When you talk about cooperation with Dr Miach, that might suggest Dr Miach was, in fact, in favour of having the operation performed. Do you have any recollection about that?-- No, he was not in favour of having the operation performed to my knowledge, no.

MR DIEHM: In your evidence in Brisbane, you said with respect to that particular matter that - page 40, line 10 - you were asked: "What was Dr Miach's attitude to this surgery?" You said, "From what I can recall, Dr Miach was in agreement with the surgery and he was handling the dialysis part of it." The questioner said, "Right.", and you said, "Because I think that they had come to the conclusion that maybe this patient had little chance if he was operated on, whereas if he wasn't operated on at all, he wouldn't have any chance of survival, so I think at that point, Dr Miach was in agreement to that surgery."?-- Well, he was in agreement to helping them with the dialysis and being consulted from that side of it, but you would have to ask Dr Miach that question himself.

Thank you. It was a multi-team effort, that's what you were saying with respect to the-----?-- Yes.

-----preparation for this surgery?-- Yes.

There was considerable planning over quite a number of days?-- A couple of days, yes.

And there were people from the Renal Unit involved?-- Yes.

People from the Surgical Unit involved?-- The surgeons were involved.

The surgeons, yes?-- Yes.

And people from Intensive Care as well?-- Yes.

The anaesthetists are presumably included in that involvement?-- They are the only people that-----

Well, you were involved as well?-- And the nursing staff, yes.

Ms Hoffman, do you know where P34 was when he was diagnosed with his oesophageal cancer?-- No.

If I were to suggest to you that the diagnosis was made by

endoscopy or, at least, the provisional diagnosis was made after an endoscopy on 23 April 2003 at Bundaberg Hospital, does that ring any bells to you?-- No.

Nor, presumably, would it ring any bells for me to suggest to you that during that endoscopy, a biopsy was taken which was reported on by pathology on the 28th of April 2003, confirming the diagnosis of cancer?-- No.

That the patient was a patient at the Bundaberg Hospital over that time until such time as he was seen by Dr Patel on the 10th of May 2003 as a result of the referral to Dr Patel within the hospital?-- I'm not aware of any of these things, so, I'm not sure if - to answer yes or no, like, I'm not aware of this procedure - I mean, of these things happening.

All right. The reason why I ask these things of you is to find out whether you were able to shed any light - if these matters that I'm suggesting to you are the true course of care with respect to this patient - whether you are able to shed any light on how or where or when it may have been that this patient was seen and assessed by a tertiary hospital in Brisbane?-- No, I'm not.

Do you say, though, that if you were to look at the file for the patient, you may be able to find something-----?-- I may be able to if it is written in there, yes.

Commissioner, may I say that my solicitors made a request of Queensland Health to bring in a number of files to the hearing. I'm not sure whether that's been able to be done, and this patient's was one of them.

COMMISSIONER: As matters stand at the moment - I mean, let's approach it this way: I think you have made the point and it is an important point that Ms Hoffman is really only able to give hearsay to these matters. In an ordinary Court of law, that evidence wouldn't be admissible. Obviously we are not bound by the rules of he have, but the fact that Ms Hoffman has no direct knowledge obviously takes a lot of weight out of that part of her evidence. If the situation can be demonstrated to be different from hospital records or the absence of hospital records, then so be it.

MR DIEHM: Commissioner, I appreciate that, and I do appreciate the bounds of how far one needs to go with respect to these matters, particularly for a witness who can't really deal with it.

COMMISSIONER: And please, I'm sure no-one will think I'm being critical of Ms Hoffman, the fact is, Ms Hoffman, you have no direct personal knowledge of the matter you have been discussing. All you can tell us is what you have heard from other people?-- And when I became involved with the patient.

But you didn't know - you weren't involved when the cancer was diagnosed?-- No.

Or when surgery was refused at a tertiary hospital in Brisbane?-- No.

MR DIEHM: Thank you, Commissioner. I'll move on. Ms Hoffman, the second meeting that you had with Dr Keating in his first few months concerning Dr Patel was the meeting you attended with Dr Joyner; is that right?-- Yes.

Now, the purpose of that meeting was to ventilate concern - to ventilate concerns about the carrying on of oesophagectomies at the Bundaberg Hospital because of the implications for post-operative care in the ICU?-- Yes.

Do you think that the position is that this was a concern that was not so much raised in your meeting with Ms Goodman, but rather one that was raised in the meeting with Dr Joyner?-- I don't understand that question, sorry.

Sorry. Do you think that the issue of the implications for - sorry, I will rephrase that. Do you think that the concern about the Bundaberg Hospital performing oesophagectomies was something that was more the focus of the meeting with Dr Joyner than it was with the meeting with Miss Goodman?-- Well, I spoke with Mrs Goodman about the issues first and that's why we went to see Dr Keating.

All right. Is it right to say that the other issue that there was with respect to the meeting with Dr Joyner and Dr Keating was about many concerns regarding care for patient P18, the second of Dr Patel's oesophagectomy patients?-- Yes, yes.

And perhaps if it helps you, that there was a concern on Dr Joyner's part that the patient should be transferred?-- That came afterwards, and I'm not sure whether that was being discussed at that meeting or not - whether the patient should be transferred. I know that the doctors went to see Dr Keating about the transfer at some point, but I don't believe it was in the same meeting that I was at with Dr Keating.

Were you involved in the issues about the concern regarding transferring patient P18?-- Yes.

And, as you say, you are aware that that matter was raised with Dr Keating?-- Yes.

The problem was that Dr Joyner thought that P18 should be transferred and Dr Patel did not?-- Yes.

Are you aware that what Dr Keating did was arrange for Dr Younis to assess P18?-- He could have done.

Are you aware that there was subsequently a meeting between Dr Keating, Dr Younis, Dr Joyner and Dr Patel to discuss the transfer issue regarding P18?-- I understand that there was a meeting where it was decided that the patient would stay in ICU another 24 hours and they would reassess the patient.

Was it something that was brought to your knowledge that Dr Younis shared with you and Dr Patel that the patient did not, at the time of his assessment, need to be transferred?-- No.

In any event, what happened was that there was agreement, of course, that the patient would be reassessed after a day or two and what happened was that he was reassessed and a transfer was requested. It took some time to organise. Is that the sequence of events from there?-- A transfer was requested. A transfer was requested on - according to my E-mail dated 19th of the 6th, this patient had already returned to theatre twice for wound dehiscence and returned to theatre again for repair of a leaking jejunostomy. I wrote to Darren and Glennis outlining my continuing concern with the lack of sufficient ICU back-up care to care for a patient who has undergone such extensive surgery. This was when both the Royal Brisbane and the PA both expressed their concern about why such large-scale surgery was being done at Bundaberg Base Hospital when there was no - when we were having trouble caring for the patient post-operatively.

Were those concerns that were expressed to you?-- From Royal Brisbane?

From these other hospitals?-- Yes, I heard the conversations, yes, I did.

You heard the conversations?-- Yes, I was present when the conversations were taking place.

Taking place between who?-- The doctor who was arranging the transfer and the doctors in Brisbane, and they were also relayed to myself at other times as well.

Well, who were the doctors at Bundaberg having these conversations?-- They would have probably been - usually the transfers were left up to the intern or the JHO who was in the ICU.

You can't recall specifically who it was?-- No, I can't - because they change every three months. I can't recall.

These conversations are happening by telephone?-- Yes.

The doctor in the ICU at Bundaberg presumably having the telephone up to their ear?-- Yes, yes, that's right.

So, you can't actually hear what's being said by the person in Brisbane at all, can you?-- No, but you can hear the reply.

All right. Now, I just want to go back, forgive me, to following the meeting with Miss Goodman and Dr Keating and yourself. Now, I'm going to suggest to you what followed as a result of that meeting and invite you to comment on it. I suggest to you that when you raised your concerns with respect to Dr Patel's behaviour towards the ICU staff, Dr Keating suggested to you that you should meet with Dr Patel and

discuss your issues with him?-- Yes.

That you should explain your view about the ICU capability?-- Yes.

And that you should talk to him in terms about the need to work as a team?-- Yes.

Did you, following that meeting with Dr Keating, in fact meet with Dr Patel and discuss those matters with him?-- Yes.

And did you report back to Glennis Goodman that it went well - your discussion with Dr Patel?-- No, I can't imagine that I did because it didn't go well.

How did it go?-- Dr Patel stated that he wasn't going to practice medicine like that. He didn't agree with transferring his patients out and that - yeah, that was the - that was the overriding end to that meeting.

Are you aware as to whether Dr Keating also met with Dr Patel and discussed these issues with him?-- No, I'm not.

Now, I'll ask you not for the last time - I'll come back to this topic on a few occasions later on - but with respect to Dr Qureshi, can I ask you a question at this point in time: is it the case that you don't know one way or the other about whether Dr Keating took any action concerning the various complaints that were made about Dr Qureshi?-- I know that he asked me to call Dr Qureshi and get Dr Qureshi to call him back and that I was to notify the staff in the hospital that Dr Qureshi was to require a chaperone.

Aside from that, are you unaware one way or the other as to whether Dr Keating took any particular steps with respect to pursuing investigations or complaints or otherwise managing the concerns that have been expressed?-- No.

COMMISSIONER: For all you know, Dr Keating might have taken all the appropriate steps; he might have referred the matter to the police or referred it for an internal departmental investigation or brought disciplinary charges or whatever; you just don't know what happened?-- No, I don't know what happened.

MR DIEHM: Thank you. Commissioner, I won't pursue those matters with the witness. A new topic, Ms Hoffman: wound dehiscence. You said in your evidence in Brisbane - at page 63.15 for those who may refer to a transcript - that following the meeting held at the behest of Ms Aylmer in July of 2003 - do you recall what I'm speaking about there?-- I recall the meeting. I don't - that's the meeting - same meeting - I don't recall going to that meeting.

Okay, I think you said you may have been on holidays?-- Yes.

But you recall the fact of the meeting?-- Yes, I recall the meeting being called and the reasons why Ms Aylmer wanted the

meeting called.

Yes. In Brisbane, you said that following that meeting, you couldn't get - and when you say "you", we are talking about the group of you who were interested in this issue - couldn't get data because Dr Patel was changing the charts?-- Yes, that's what we believed, yes. Yes.

Are you aware that Ms Aylmer did, in fact, get data on some 13 suspected cases?-- Yes.

All right. So presumably there hadn't been changes to the charts that stopped her getting that data?-- No.

What makes you say that you couldn't get the data because Dr Patel was changing the charts?-- The data - there was - we were having patients in ICU that had wound dehiscence, very frequent wound dehiscence, and yet the statistics on things that Dr Patel was showing us didn't say that, didn't reflect that, and this is when we were - we couldn't understand why we were seeing so many wound dehiscences, and it was well known around, you know, in the Surgical Ward and with Infection Control and the other Nurse Manager in the Surgical Ward that all of these wound dehiscences were going on, but we couldn't get accurate - we couldn't get any accurate data which was saying this. So we had a lot of different discussions about what constituted wound dehiscence and there was some difficulty at the forums about coming to agreement about what exactly was a wound dehiscence and yet we had - we were having these patients go back to theatre to have their wound dehiscences repaired.

These forums you are speaking of are the ASPIC Clinical Forums?-- Yes.

And you've been present in the hearing of this Commission when we've been discussing with other witnesses meetings that took place between April and October of 2004?-- Yes.

D COMMISSIONER VIDER: Could I clarify a point, please? If a patient returned to the operating theatre specifically for wound dehiscence, what would be written on the surgeon's report?-- Yes. I don't know if they used the word "wound dehiscence" or what they did. You know, I can't recall looking to see what they wrote.

So it's quite possible that a clinical audit of the medical records, if that's not recorded it won't reveal that fact?-- No.

COMMISSIONER: And it wouldn't have taken a lot of ingenuity to come up with another form of words that would conceal the fact that there was wound dehiscence, that would go in as wound infection, or something of that nature?-- I think one of the things that I saw was, like, described as "wound coming apart at the edges" or, you know, different things like that.

Yes?-- But there was - there was a concern that we had these wound dehiscences and there were these returns to theatre, but we weren't seeing it in the coding, and at one point Dr Patel actually went away and came back with a result, some coding that he had got from one of the different areas from - and it showed that his incidence of dehiscence was less than normal. But we knew that that wasn't the case because we had the patients in ICU who were having these wound dehiscences. This particular patient that Mr Diehm's is talking about had

already been back twice for wound dehiscence. This is the subject P18.

What Deputy Commissioner Vider is raising with you is a matter of some concern to all of us, that there's been a lot of speculation in the press about clinical reviews from the files, and that sort of thing. But from what you are telling us, a review merely from the written file is not going to tell anyone a lot, unless you speak to the people who are there and know exactly what happened to the patients?-- You need to speak to the people that were there and that knew what was going on with the patient, but also to - and I told this to the internal review, that you had to marry up what Dr Patel had written in comparison to all of the other things that were written in the chart, including, like, for instance, if they had been in intensive care, including all of the nursing notes in intensive care, because you would be getting a totally different picture. Where Dr Patel was saying the patient was stable, for instance, where if you looked at the nurses' notes in ICU the patients weren't stable at all. So you had to very carefully look through these charts and marry each little piece up to the other, and that went for everything, including the pathology reporting, coding Death Certificates. It went through everything, you know, that the documentation was not accurate.

MR DIEHM: Thank you, Commissioner. So the problem arises, you say, because the records being kept in the surgery when the patient would be returned to surgery for dealing with wound dehiscence weren't properly recording what the problem was?-- Yes. I'm not saying that happened all of the time, but that happened - I believe that happened some of the time, yes.

Some of the time?-- Yes.

You mentioned P18-----

D COMMISSIONER EDWARDS: Only with Dr Patel's patients, or was this a culture?-- No, I don't think I've ever come across people who've falsified records before, no. I don't believe that I have, no.

MR DIEHM: You mentioned in answer to one of the questions from the Commissioner patient P18, he was the oesophagectomy patient, was he?-- Yes, he was the one that we were referring to before.

Yes. And did he have dehiscences?-- Yes.

But were they not recorded as dehiscences?-- I can't remember. I just know that when I referred to them in my e-mail-----

Yeah?-- -----to Dr Keating and to Glennis that he had already returned to theatre twice for wound dehiscence.

Yes?-- So I'm not sure whether - I mean, I've gone through

the chart and we've got wound dehiscence out of there from somewhere, so it could have been written in there or it may not. I'm not sure.

I will ask you to have a look at this document, please?

COMMISSIONER: This is part of the file, is it, for patient P18?

MR DIEHM: It is, Commissioner. We can see from the document, Ms Hoffman, that this particular document is dated 15th of June 2003, refers to the surgeons being Dr Patel and Dr Ingras. Do you think I've got that name right, Ingras?-- Yes.

So that's the assistant surgeon?-- Yes.

And this is an instance, is it not, of a patient, indeed P18, being returned to theatre because of what is recorded in the operation report as being a wound dehiscence?-- Yes.

All right. Tell me if you are able to assist us. That's not actually Dr Patel's writing, is it?-- It doesn't look like it.

At the bottom of the page it'll probably show it, but it's likely to be Dr Ingras' writing; do you think so?-- Yes.

Yes, thank you. Could I ask you to turn over to the next page, not the back of it but the next page. Again, an operation report for the 12th of June 2003, surgeon Dr Patel, assistant Dr Coleman, and the purpose of return to the surgery is for repair of an abdominal dehiscence; is that right?-- Yes.

So we can see that certainly in the case of patient P18 there was no falsification of the records, the word "dehiscence" was plainly being used by the doctors involved in the repair?-- Yes.

Thank you. Commissioner, I'm in your hands. I suspect it's probably not technically necessary for the notes to proceed to evidence, but if you'd prefer to do so-----

COMMISSIONER: I think the record speaks for itself. You have put the matter fairly to the witness and she has agreed with you, so there is no need to clog the records with further exhibits.

MR DIEHM: Thank you. Yes. Thank you. Now, you've expressed this concern with respect to the ability to get data because of the changing of the charts. Can you tell me when it was - and I'm not looking for a precise date, I'm just looking for a context. We've got Ms Aylmer calling for a meeting in early July 2003, we've got the ASPIC Forum raising in April 2004 the issue of wound dehiscence. Can you tell me in that context when it was that you formed the view that it was not possible to get data because records were being changed?-- It

probably was quite - I mean, we - I can't remember but I can't - I'd say that, you know, we - we had been watching things happen for a period of time before we actually realised what was going on.

All right. So this wasn't a concern that you had immediately after the July meeting was called by Ms Aylmer, it was something that developed over time as to your concern that you couldn't get data for the reason that the records weren't properly recording what was happening?-- I can't - I can't remember what I was thinking in July 2003, except that we all had concerns and we all had concerns about where these things were being captured. You know, we had concerns about - I mean, as you know, one of our indicators, clinical indicators for theatre and for ICU is return to theatre within a certain period of time. So these figures must have been showing an increase and so we were concerned about where the incident reports were. We were concerned about a lot of documentation within the hospital.

Okay. When you say you were concerned about where the incident reports were, what you were concerned about was they weren't being done?-- Yes, yes.

So as at July 2003 you already had concerns then that whatever data there was wasn't accurately recording the situation?-- Yeah, I think I had some - I already had formed my view that there was some - there was some documentation, definitely documentation issues.

Now, the people that had these concerns, included yourself obviously as the Nurse Unit Manager of ICU?-- Mmm.

Were they shared, to your knowledge, by the Nurse Unit Manager of the Surgical Ward?-- They were, and she did say that she did have concerns about issues that were going on.

About what, sorry?-- Issues that were going on with Dr Patel's patients.

All right.

COMMISSIONER: Who is this you are referring to, which Nurse Unit Manager?-- Nurse Dianne Jenkins.

Right, yes.

MR DIEHM: Thank you, Commissioner. The next - sorry, another person who shared your concerns about the fact that the data wasn't properly reflecting the situation was the Nurse Unit Manager for Theatre; is that right?-- Yes.

And that was Ms White?-- Yes.

Now, the three of you would be people very well placed to observe the actual occurrences of wound dehiscence?-- Yes.

In fact, amongst the Nurse Unit Managers in the hospital, you

three would be the most likely to see them?-- Yes.

Then if you had concerns about the reliability of the data there was, it would have been a fairly simple matter to keep some data for yourself, would it not?-- I did do - I did keep data for myself. Well, I started to at some point keep just little notations in our admission book about what sort of complications Dr Patel's patients had.

I'm specifically asking at the moment about wound dehiscence?-- Yes.

Did you keep information about that?-- I did do, but I'm not sure at what point that I did start to write it in our book. I don't think way back at this point I would have, but I did do at some point. I did start.

COMMISSIONER: It obviously takes a while for a pattern to emerge?-- Yes.

You don't realise there's a pattern until there have been a few?-- Yes, and also we were still - Dr Patel - we were still trying to bring these issues up at different - at the forums, and things like that, and that was when Ms White was trying - or one of the other nurses was trying to explain that Dr Patel would just laugh at us and they wouldn't pay - they were not paying any attention to us at the meetings and things. It was very difficult to bring these issues up because we just weren't being taken seriously or listened to, and also he - he just said, you know, "You need to get a dictionary," and, like, something to the point of, you know, "Read what the definition of wound dehiscence is," because he had a different idea of what wound dehiscence was than what we did.

D COMMISSIONER VIDER: What was your agreed outcome of those discussions? Did you end up agreeing on a common definition of wound dehiscence?-- I don't - I don't think that we ever did. I mean, I have my own from when I was taught, but I don't think we ever had a general consensus with Dr Patel about what constituted a wound dehiscence

And what was your definition in the Australian setting that you were using to define wound dehiscence for the clinical surgical sense of the meaning?-- Well, it was any wound that came apart past the superficial layers that required someone to go back to surgery for it to be repaired. It didn't necessarily have to go right down to the, you know, muscle or fascia, or anything like that. That was my understanding of it. Someone who needed to go back to theatre to have a wound repaired, you know, that was a wound dehiscence.

COMMISSIONER: Ms Hoffman, I'm going back to a point that Mr Diehm was making and I think making very well. Obviously there are some issues on which you may well be critical of Dr Keating, but on this issue it took quite some time for you to realise that there was a problem happening, problem developing as a pattern emerged and I imagine you would agree with Mr Diehm that one couldn't criticise Dr Keating for

failing to spot that pattern any quicker than you did?-- No, that's right. I mean, I didn't have any criticism of Dr Keating at this point in time really at all. My only concern was that Dr Patel was still - was still - nobody was reining him in. Nobody was - and it wasn't my place, as Mr Diehm suggests, that, you know, I sit down and talk to Dr Patel and tell him about the level of the ICU; that's, you know, up to Dr Keating to do, and it - as it wasn't my place to tell Dr Patel what sort of surgery can and can't be done, you know, at Bundaberg Base Hospital. What I was doing was voicing my concerns and, you know, I would like this e-mail I sent looked at where I talk about the ongoing issues regarding transfer of patients and the designated level of ICU needs to be discussed in detail at a later date and plus I talk about his behaviour, and what happened with this particular patient is we had a bed for him and then because Dr Patel didn't want him to go and they had this meeting, unbeknownst to me, the transfer was delayed, the patient - the patient got sicker because the transfer was delayed, and then I think we ended up having to wait another five days before a bed became available in Brisbane. The whole time the patient's condition was deteriorating. These were my concerns, that we were - that we were acceding to what Dr Patel wanted but at the detriment to the patient, the patient's care, and I just - I just thought that right from the beginning these things could have been - if Dr Patel said this is what we do at this point, this is our role delineation, these are the types of surgery that we do, this is - we only have this many staff to do this and that and probably the issues that have occurred may not have happened. That's what my concern was. At that point I didn't have any other issues with Dr Keating.

Yes?-- And the issues with Dr Keating, once again, I mean, this didn't - this - it didn't happen until this all came out and we got to this point, you know, and became an issue between Executive and myself. Like, this is not what it was meant to be about, it was never meant to be about personalities or Dr Keating and myself.

I understand that, but I'm sure you understand, as everyone else here understands, that there are parts in your statement which I'm sure weren't put there to criticise Dr Keating but reflect on him in a way that some people may think is adversely and that makes it necessary for Mr Diehm to protect his client's interests?-- Yeah.

That's why I want to make sure that there is - that any dispute or difference or disagreement is as confined as it possibly is, and I wanted to check with you that you've really got no criticism with Dr Keating's involvement at the stage we're talking about at the moment?-- No, other than those things that I thought he could have, you know, detailed what the hospital does do to Dr Patel.

Yes?-- And stand up to him rather than just let him do what he wanted, sort of thing.

Mr Diehm, since we interrupted, we might take the morning

break for 10 minutes or so.

MR DIEHM: Thank you, Commissioner.

THE COMMISSION ADJOURNED AT 10.50 A.M.

THE COMMISSION RESUMED AT 11.14 A.M.

TONI HOFFMAN, CONTINUING CROSS-EXAMINATION:

COMMISSIONER: Thank you, Mr Diehm.

MR DIEHM: Thank you. If I can pick up where we were before we rose, you were mentioning your concern that Dr Keating didn't respond to, amongst other things, the content of your e-mail that related to what you identified, the scope of surgery of procedures such as oesophagectomy and the capability of the ICU unit and what it could handle with respect to caring of these sorts of patients. Of course, that was the subject matter of your meeting with Dr Keating and Dr Joyner, wasn't it, those matters?-- Not all of those matters, no. The meeting that we had were - was primarily about the oesophagectomies being done.

Yes?-- Those other issues, I'm not sure what - were discussed at that meeting or not.

We may be at cross-purposes. The context of the concerns with respect to oesophagectomies was about whether the operation should be done and in particular its implications for the ICU unit to try and care for the patients afterwards?-- Yeah. Once again, I'd just like to make it clear that it wasn't the implications so much for the ICU or the nursing staff, but it was our concern for the patients' well-being.

All right. I wasn't trying to suggest to you otherwise, Ms Hoffman. Now, in the context of P18, whose care gave rise to that meeting, I want to put some dates to you, and I'm not by these meaning to test your precise recollection with respect to dates but to draw your comment about whether or not the timeframes or scales involved sound about right with respect to the way this patient was managed. That oesophagectomy took place on the 6th of June 2003. If you wish to refer to documents you have, by all means, please do?-- Yes.

Yes. The patient remained in ICU but without ventilation until the 13th of June 2003 when he was discharged to the Surgical Ward?-- Yeah. I can't remember that but I will take your word on that one, yep.

All right. The patient required further surgery on the 15th of June 2003 and was readmitted to ICU following the surgery, this time on ventilation?-- Mmm-hmm.

That on the 17th of June 2003 was the date on which there was a joint discussion between at least Dr Joyner, if not Dr Younis as well, Dr Patel and Dr Keating in which the decision that we talked about before, to keep the patient for a further 24 hours and then to reassess, was made. That was the 17th of

June 2004?-- Yeah. Yep.

All right. Now, following the management of P18, I'm asking you whether you are aware of Dr Keating consulting Dr Patel and Dr Carter with respect to the broader management issues for the ICU of patients of this kind?-- No.

Are you aware of there being some such meeting?-- No.

I suggest to you that there was and that what was agreed as a result of that meeting was that for the ICU dealing with patients of this kind it was acceptable - and I'm talking about ventilated patients - it was acceptable to have them in for 72 hours, up to 72 hours, and to then consider transfer of the patient if it was to go beyond that time. Do you have any knowledge of that-----?-- No.

-----outcome?-- No, I do not.

It wasn't communicated to you?-- No, it was not, no, and seeing that I was the person organising the staffing and managing the unit, plus the budget, you would have thought that I would have been notified about that, or even included in the discussion.

Yes?-- Perhaps even at the meeting.

D COMMISSIONER VIDER: You routinely accepted ventilated patients for 24 to 48 hours?-- Yeah. We often kept them for much longer than that, but that was what our role delineation said, you know, short term ventilation, 24/48 hours, and - you know, uncomplicated patients. That's what it said. But we - we often kept them for much longer than that. It depended on lots of things, if Brisbane didn't have a bed or sometimes Brisbane wasn't able to take - you know, didn't want to take the patients that we had and things like that. There were various reasons why we kept them for longer.

And if you kept them for longer that was an agreed clinical outcome reached by the staff in the intensive care unit, medical and nursing staff, so you all knew what you were doing in particular respect to a particular patient?-- Yes. Usually, yes. Yeah. Yep.

MR DIEHM: Thank you. You said just before the break that it wasn't your place to talk to Dr Patel about the issues such as the ICU capability, working together as a team, and some of those matters Dr Keating asked you to talk to him about?-- I did talk to Dr Patel about working together as a team. I asked him what we could do to - so that we could reach - you know, a professional work - because we could have a good working professional - professional working relationship. I did speak to him about that, but I think that Dr Patel just had unrealistic expectations of what our hospital - what a hospital could do and what it couldn't do.

Yes. But, I'm sorry, what I'm addressing my question to you is your observation that it wasn't your place to talk to

Dr Patel about those-----?-- It wasn't my place to tell him what sort of surgery he could do or he couldn't do. It wasn't my place.

Dr Keating didn't ask you to tell him what surgery he could do or couldn't do, did he?-- I don't remember what Dr Keating asked me to do.

I put a number of things to you earlier?-- Apart from just speaking to him and trying to - you know, work out some sort of working relationship with him.

D COMMISSIONER VIDER: In your opinion did Dr Patel understand the calculation of intensive care units in the Queensland Health care system?-- He may not have. He may not have. I think that was one of the hardest things with the - with overseas trained doctors and doctors that came in from overseas. Their orientation is so bad. They don't - they don't get an orientation. When Dr Patel received his - you know, package or whatever that they get in the States, he should have known what sort of a hospital he was coming to. They should - that should have been spelt out to him, what he would and would not be able to do in this hospital, and I think that's one of the - one of the big things that we don't do with doctors, we just - you know, we just sort of dump them in and they don't - they find out thought trial and error what does and does not happen in these hospitals and even how Queensland Health works with retrieval systems and ICU beds and things like that.

So you don't know if Dr Patel was ever formally told-----?-- No, I don't know.

-----of how those processes-----?-- No. He may not have ever been.

-----worked.

MR DIEHM: Ms Hoffman, you don't say, do you, that in a circumstance where you as the Nurse Unit Manager of ICU had some issues with respect to Dr Patel's behaviour towards you and in particular your staff that it was inappropriate for Dr Keating to suggest that you talk to him about those issues?-- No.

Now, returning to the wound dehiscence, and I will take the Commissioner's observations on board, again dealing with this topic, you mentioned that you did collect some data yourself based on your own observations about wound dehiscence?-- I wrote down if a patient return had a wound dehiscence. That's what I mean by the data I collected.

Yes?-- We have got - we have an admission book that has a whole lot of things in it, you know, if they go to theatre, how long they are on a ventilator for, things like that, and what I mean is I wrote down - you know, "wound dehiscence", and put a "P" next to it if it was Dr Patel's patients, and I started doing that quite late. I don't think I started till

probably 2004.

D COMMISSIONER VIDER: That's wound dehiscence that required return to the operating theatre-----?-- Yes.

-----for reclosure of the wound?-- Yes.

MR DIEHM: And when you say "late", and then you said "in 2004", is this after the matters have been raised at the ASPIC meetings?-- I can't recall all the dates.

Okay. Has the information that you collected been detailed in the evidence that you have given to this Commission?-- It's - yes, I think so, yes, I think so.

So any information you have collected is, for instance, referred to in your statement-----?-- I believe so.

-----about episodes that patients were having?-- Yes. It what - we also had - we also had decided at the - that earlier meeting that the central collecting point for any wound dehiscence if it happened in someone else's ward would be Di Jenkins and we would call her and tell her that a wound dehiscence had occurred.

Yes?-- So we had already decided that. So apart from me just identifying that in my area for my own recollection, we were - we had already devised what we were going to do at an ASPIC meeting, and that was to have Dianne Jenkins be the central collecting point for any issues of wound dehiscence.

Thank you. One of the other things that was decided at the ASPIC forums and indeed was reinforced right from the first meeting raising this topic in April of 2004 was that whenever there was an episode of wound dehiscence there would be a report, an Adverse Event Report lodged?-- Mmm-hmm.

Is that right?-- That's right.

Were you the person who was agitating for that to happen?-- I was - I don't know. I can't remember. I would have - I would have liked that. I mean, I would have wanted that.

It was something that the group was adamant about, must happen, wasn't it?-- We were concerned that we didn't know where the adverse events were going to or where they were being generated from.

Yes?-- If - yes. So we were concerned about whether they were being done and whether - yes, where they were being generated from and where they should have been done.

Are you aware of whether any Adverse Event Reports were completed after April of 2004 concerning wound dehiscences involving Dr Patel's patients?-- No.

You are not aware?-- I'm not aware, no.

You certainly didn't complete any?-- No, I didn't complete any.

None of these people, these other nurses, Nurse Unit Managers, who shared your concerns about this topic told you that they had completed one?-- Not that I - not that I can recall, no.

Did they tell you that they were experiencing and observing episodes of wound dehiscence?-- Well, we were discussing - we were discussing it, yes.

So and when you say discussing it, these are casual discussions, not at formal meetings?-- We did try and bring them up at formal meetings, yes, we did.

Which formal meetings did you try bringing them up?-- At ASPIC.

At ASPIC?-- Yep.

So any that you raised in formal meetings at ASPIC would be referred to in the minutes?-- They should be, yes.

D COMMISSIONER EDWARDS: Ms Hoffman, referring to that, in your statement a number - I can't recall you said - at one stage there were a number of junior doctors who raised the matter of deshiscenes of wounds and I think you might have said that Dr Patel did not agree that that definition was appropriate?-- Yes.

Could you expand that view in the light of the questions you have just be asked?-- Even - I think it was even the nursing staff too, he said to us that we had to look up the definition of wound dehiscence because a superficial wound break-down wasn't a wound dehiscence. He had a different - he had a different definition of wound dehiscence than what we did.

But his definition was not accepted by the administration or the surgical teams, or was it?-- I don't - I believe his was - was accepted. His definition was accepted, I believe, yeah.

COMMISSIONER: And just so that I understand the difference, your view was that anything that required to be repaired by way of return to surgery is classed as a dehiscence, doesn't have to go right through to the muscle or whatever?-- That's - that's my view of it, yes.

Hi view, however, was that there had to be a complete parting of the-----?-- Yes.

-----the join, as it were?-- Yes.

Had to go right through to the - whatever the subsurface was, the muscle or the bone?-- Yes.

Or the cavity?-- Mmm, that's right.

And I think you told us when we were in Brisbane that you

became aware sort of anecdotally or in a hearsay way that junior doctors had been told by Dr Patel not to use the word "dehiscence"?-- Yes, yes.

D COMMISSIONER VIDER: Just for clarification, though, your definition of wound dehiscence is where it does require return to the operating theatre. You are not talking about something where there's a superficial parting of the edges that can be held together with Steri Strips or something?-- No.

It's the return?-- No. It's the return - something that would require return to theatre.

For closure?-- Yeah.

MR DIEHM: Ms Hoffman, the ASPIC committee did reach an agreed definition of wound dehiscence, did it not? In 2004?-- What date is that?

I shall try and take you to the precise month. You agree that in April of 2004 when the matter was first raised at the ASPIC committe that there was discussion about the need to establish a definition for wound dehiscence?-- Yes.

Now, that was a meeting at which Dr Patel was not present. Do you recall that?-- Yes.

And somebody was sent away to work on finding a definition that the committee would agree to?-- Yes, yes.

And do you recall that agreement was ultimately reached about it?-- I don't actually recall that.

Can I ask you to have a look at this document, please?

COMMISSIONER: While that's being handed up, you no doubt recall that Exhibit TH11 is the minutes of that April meeting, and all it says relevantly is that a definition of wound dehiscence was also requested. It doesn't seem to identify whose job it was to provide that definition.

MR DIEHM: Thank you, Commissioner. If you can look at that document?-- Mmm.

What I suggest to you is that that is the definition of wound dehiscence that was agreed to by the ASPIC committee?-- Yeah. I actually don't remember this. I don't remember it.

All right?-- But I agree with it.

You agree with that?-- Mmm.

You agree with that definition?-- I agree with that definition, yes.

By you don't recall it being-----?-- I don't - I just don't recall it, no, I don't.

All right.

COMMISSIONER: We might mark that as an exhibit, if that's convenient.

MR DIEHM: Yes, please, Commissioner.

COMMISSIONER: That will be Exhibit 90, the definition of dehiscence from - I think it was the Sander's Encyclopaedia, want it?

MR DIEHM: Miller and Keane. While that's being marked, could Exhibit 65 be brought up on the screen, please. And if you could turn up, please, the minutes for the meeting of the 9th of June 2004, the first page.

COMMISSIONER: You don't have any idea, you, Mr Diehm, about the derivation of the word dehiscence?

MR DIEHM: No, Commissioner.

COMMISSIONER: I should have asked Mr Andrews. He knows everything.

MR ANDREWS: I will inform you later, Commissioner.

COMMISSIONER: Thank you.

MR DIEHM: Now, we can go to the second item on the agenda, so you will have seen perhaps, Ms Hoffman, there's the minutes of the meeting of the 9th of June 2004. At the top, "Wound Dehiscence". You can see that the definition that I have just shown you from Miller and Keane 1987 was brought to the meeting by Di Jenkins?-- Yes.

Does that help you recall that that was the definition that was adopted by the ASPIC committee?-- It doesn't help me recall the situation, the incident, because I think you might see I had an apology for that meeting.

You think that - you were an apology. Indeed. Indeed. Well, let me ask you, do you accept that that was the definition?-- Yes, I already have accepted it.

If that exhibit may be returned. You said that in the April 2004 meeting - you accepted that Dr Patel wasn't present when the topic of wound dehiscence was raised. It would be right to say, would it not, that nobody at that meeting identified Dr Patel as being suspected of being the cause for an increased rate of wound dehiscence?-- No.

COMMISSIONER: Is that because you all knew who you were talking about and there was no need to put the name down in the minutes?-- Yes, and, you know, it was - you'll have to remember what - it was a long time ago. We were still trying to work out what was actually going on. Even much later than that I can remember we had a meeting and we were still discussing wound dehiscences, and it got quite heated at times and Peter Leck said to us, "Be kind to each other, especially when you're talking about wound dehiscence." We didn't also know - we were still looking at other reasons, I think, probably, you know, about things that we looked at - suturing material, and were the juniors closing up and things like that. We were still trying to work out whether or not it was Dr Patel or it wasn't, and we were all coming from different areas. I was in ICU, the other people were in surgical wards, someone else was in theatre. We didn't have a global picture of what was going on, a global picture.

MR DIEHM: In February 2004 you will recall that you approached Peter Leck regarding some concerns that you had about Dr Patel?-- Yes.

And you will recall that at that time you didn't ask him to take any action?-- Yes.

Because you perceived that there might be solutions to the problems that could be worked through?-- I was hoping that we could.

It really was the case, wasn't it, that whilst you had concerns about Dr Patel that were developing in your mind, it wasn't until the incident involving Mr Bramich that you really became convinced that he was such a serious problem that something had to be done to remove him?-- No, I was convinced much earlier that he was - that we had a serious problem on our hands, but Mr Bramich was just the - for me was the pivotal moment where I decided that we just could not allow anything else to go on with Dr Patel's patients. I mean, for a long time it was daily discussion in the hospital amongst the bed manager, myself, and the other people that we saw about Dr Patel and the issues and the complications that we saw. It wasn't just with - it wasn't just then that I decided. I had already - and so had my fellow co-workers - we had already reached - we already had grave concerns about Dr Patel's patients.

COMMISSIONER: But it is fair to say that the case involving Mr Bramich was the last straw for you?-- For me it was the last straw. For me it was. I could not let any more patients suffer.

And just to follow up Mr Diehm's point, in a sense you had an advantage over people in the administrative offices because you were there from day-to-day seeing what you saw with your own eyes?-- Yes.

And even then it took quite some time for you to overcome your natural assumption that this man is a qualified surgeon, he must know what he's doing?-- Yes. I mean, I assumed that, you know - I mean, it's only now in hindsight that we know all these things, that we know he'd been falsifying records since 1982, we know that he was struck off here and struck off there. It's only now that we know those things. But at that time I had assumed that this man's references had been seen and, you know - I mean, we knew he used to brag a lot, but still we thought there would be a modicum of truth to what he was saying, so even - I did have grave concerns from the beginning because, as I sad to Dr Keating, I think on the second time I saw him, it was like we were coming from two different planets, our thought processes were so different, but when that happened to Mr Bramich, I couldn't - I could not not speak up. I had to do something then, and that - you know, and that's when, you know, I did.

I guess what we need to have clarified is this: I think I made it very clear - and I'm sure the Deputy Commissioners will join with me in saying this - that if at the end of the day someone's done something wrong, whether that be Dr Keating or Mr Leck or anything else, we will be quite fearless in making appropriate recommendations, but at the same time we don't want to chase down false issues, and it strikes me, from what you're saying, that even with your direct knowledge and observation of what was going on, you were very reluctant to jump to the conclusion that Dr Patel was a menace to society, that you really gave him every chance to prove to you that he did know what he was doing and he wasn't harming patients or killing them, and I assume for those reasons you'd agree that really you can't criticise anyone else for not arriving at those conclusions any sooner than you did. It wasn't for Dr Keating or Mr Leck or anyone else to jump to those conclusions any quicker than you did. Is that a fair comment?-- I think that's probably a fair comment.

MR DIEHM: Thank you, Commissioner. Ms Hoffman, you said in your evidence in Brisbane at page 105 line 5 that you cannot recall wound dehiscence from - episodes of wound dehiscence involving any other surgeons at Bundaberg Hospital?-- I can't recall any, no.

You do not mean by that, do you, that there weren't episodes of wound dehiscence in your time at the Bundaberg Hospital involving other surgeons?-- No, I just said I can't recall them.

You're aware that part of the process that the ASPIC Committee went through involved Di Jenkins bringing some data back to the forum concerning a comparison of episodes of wound dehiscence over a period of two years?-- I thought Dr Patel brought that back.

Well, let's not squabble about who brought it back. That's unimportant, but the data was brought back and it did show, did it not, that there had been earlier episodes prior to Dr Patel's arrival at the hospital of wound dehiscence?-- I'm sure there was, yes.

One of the patients that you mentioned in your evidence in Brisbane specifically was patient P14, and that was a patient that's at 101 to 102 of the transcript. I can't immediately give you paragraph numbers, but I'll read this to you and, if you have any doubt, remind you which patient this was. This was a patient who had a procedure, you said, for colon cancer, but when the patient was opened up it was discovered that she had ovarian cancer as well, and that because the cancer had spread she was just closed back up again, but your point was she went through a procedure that was unnecessary because - made unnecessary because there had been no CT staging - CT scanning to stage the development of the cancer done before the operation. Do you recall the patient I'm speaking about?-- I recall the patient, yes.

With respect to that patient, had you looked at the file before you gave your summary for that patient?-- I had a very cursory look at the files when I was trying to decide which patients I should put in my report to Mr Leck, and she was one of the patients that I identified. This was - these were only patients that I was asking for the audit to be done on, if you remember. I wasn't asking for anything else but for these patients to be investigated by an independent auditor.

COMMISSIONER: And you weren't pretending to have done that audit yourself?-- No.

You were simply saying, "These are files that are of concern."?-- These are the ones that I had concerns about. I looked through the files. These were the patients that I had concerns about, that I wanted somebody else to go through and have a look and determine whether or not there were issues or whether there weren't. They were the ones that I had concerns about in the ICU.

And to anticipate what I suspect is going to be Mr Diehm's line of questioning, you didn't yourself have anything to do with the surgery on this patient. You weren't there-----?-- No.

-----when it took place-----?-- No.

-----or the presence or absence of CT scans?-- No, no.

Any information you have is drawn from the notes?-- That's right, and a lot of the information also is information that we've found out now that - you know, that Dr Patel wasn't doing staging CT scans and things like that. We didn't - I didn't know back then that he wasn't doing that. I just assumed he was because everybody did it, so I didn't know - didn't realise that until just, you know, not so long ago,

actually.

But if Mr Diehm could, for example, demonstrate that on this occasion there was a CT scan done because it appears in the notes-----?-- I wouldn't deny it or say that - yeah, that's right.

I guess my point, Mr Diehm, is there's no need to put these things to Ms Hoffman in a traditional Brown v. Dunne way. If you've got the documents that contradict our understanding of events, then the documents will speak for themselves.

MR DIEHM: They will be referred to in due course. Thank you, Commissioner. Just bear with me, please. Ms Hoffman, I suggest to you that there was, since the time that the issue of wound dehiscence was raised at the ASPIC Committee meetings in 2004, that there has been only one Adverse Event Report Form concerning a patient of Dr Patel suffering from a wound dehiscence lodged within the hospital complaints system. I take it from your answers before you can't say whether that's right or not?-- No, I've no idea.

And the one that was lodged, I suggest, included in it information whereby Dr Patel himself had signed the clinical summary for the patient that described the complication for the patient as being wound dehiscence. You don't know anything about-----?-- No.

-----this complaint at all?-- No, not that I can recall.

I shall leave it for the evidence of others, Commissioner.

COMMISSIONER: That in itself wouldn't be a surprise, would it, because we've heard evidence about another nurse raising a list of - was it 12 or 10 instances of possible dehiscences, and I think Dr Patel agreed that some of them were and some of them weren't. So the fact that he's admitted to one, I don't think takes anyone by surprise.

MR DIEHM: No, except that this is recorded in the clinical notes.

COMMISSIONER: Yes.

MR DIEHM: It's another episode where we're looking at the clinical notes and they're not altered, they're not misreported. Ms Hoffman, you've given some evidence that when it comes to the data that is collected for things such as wound dehiscence, the coders who extract that data look at the Discharge Summary, as I recall your evidence?-- That's how I understand it's done, yeah.

Where do you get your understanding from?-- From what I've been told.

Who have you been told that information by?-- By people in medical records and by the staff in DQDSU, to my knowledge.

You can't be any more precise than that as to who gave you the information?-- No, I can't. I can't be any more precise than that.

Do you know when you learnt of these things?-- That - no.

No. I suggest to you that in fact the coders do, in extracting the codes, look at the whole of the chart for the patient. You say the information you've got is to the contrary of that?-- They may do. I don't - I'm not - you know, I don't know.

If I can leave wound dehiscence and I'll return to the topic of Dr Qureshi, not to intrude upon the matters that I said I wouldn't ask you about, but the one thing that you have said that Dr Keating did do when you raised with him the concern - the complaint about the behaviour of Dr Qureshi - and this was in your evidence in Brisbane at page 70 line 20, in response to a question, I think from Deputy Commissioner Vider, you said that it was "a good question" was the phrase you used, as to why Dr Keating did not deal with the instruction to nurses himself that Dr Qureshi be escorted. Do you recall that your evidence was that you phoned Dr Keating and advised him of the situation, and that Dr Keating asked you to do a couple of things, one of which was to send an instruction around to the nurses that Dr Qureshi was to be escorted when examining female patients?-- Yes.

Now, again I'm not trying to give you a memory test, Ms Hoffman, but do you hold the view that it remains a good question as to why Dr Keating did not himself issue that instruction to the nurses?-- From my - wasn't that question asked after someone asked me whether it was put in writing or not, the-----

There were questions about that. There were questions about that?-- And I thought that that was related to that. I mean-----

You think it's a good question as to why Dr Keating did not put that instruction in writing himself to the nurses?-- Well, I think - I think that's what I was referring to, but-----

That's what you meant?-- I think so.

You think. All right. At the time you were the Acting Director of Nursing, weren't you?-- I was either the Acting Director of Nursing or I was the - I was the Acting Director of Nursing on for that weekend, yes.

And instructions to nurses as to what they are to do in their jobs would, in the ordinary course, come from the Director of Nursing, would they not?-- Yes.

Not from the Director of Medical Services?-- No.

And that wouldn't matter whether it's in writing or orally, would it?-- If there was - to my knowledge, if there was an issue about Dr Qureshi that needed to be disseminated, that that would be done by the Director of Medicine, not - if it was about Dr Qureshi.

Even if it was an instruction to the nurses as to what they were to do in their jobs on a day-to-day basis?-- If it was from Dr Qureshi, yes. I'm not aware of nurses - you know, nursing staff putting out memos or things like that relating to doctors' behaviour.

COMMISSIONER: In any event, you'd agree, wouldn't you, that there may be a boundary dispute here as to who was responsible to give that instruction?-- Yes.

MR DIEHM: Thank you, Commissioner. Another matter that you touched upon in your evidence in Brisbane was - you described Dr Berens, was it?-- Berens.

Who was one of the anaesthetists in your unit, was he not?-- Yes.

You said that he was afraid to stand up to Dr Patel because of a threat - or an implied threat concerning his status staying in Australia given that he was on a visa?-- Yes, that was a conversation that he had with me.

Are you sure it's not the case that Dr Berens was in fact a permanent resident of Australia?-- Not at that point in time, because what he stated to me was that he would lose his job and end up having to go back to Namibia, and that Dr Patel would keep his job. That was the statement then at the conversation that I had with him at that point in time. He may since have become a permanent resident, I'm not sure, but that was the conversation at the time.

Thank you. Ms Hoffman, something that's discussed in paragraph 35 of your statement - and you'll probably recall the evidence independently - concerns an issue that you had regarding a particular patient who was to be operated upon by Dr Patel, and your evidence is that Dr Carter and Dr Patel reached an agreement that Dr Patel would only operate on the patient if Dr Carter agreed not to transfer the patient?-- Yes, that's right.

Can I ask you where you came to learn of that agreement, or how you came to learn of it?-- It was discussed in front of me.

By who?-- By - well, Martin Carter may have even told me. I can't remember exactly who told me, but I remember finding out that that was what the - that was what the agreement was, that Dr Patel had agreed to operate - it's in one of my emails-----

COMMISSIONER: It's in your statement at paragraph 35. "I do not now recall who told me of this agreement. It may have been Dr Carter. However, I am unsure."?-- Yes, that's right.

You're certainly not, as it were, swearing your oath that it was definitely Dr Carter?-- No, I am not. I can't remember who it was. I just remember that I became aware of it. I may have become aware of it through my staff. My staff may have told me.

And it may be that one of your staff misunderstood the arrangement and what you were told wasn't entirely accurate?-- I actually believe that that was accurate, in subsequent-----

You believe it is, but the point I'm making is again this isn't something you saw or heard yourself. You're just going on what someone else told you?-- Yes.

MR DIEHM: Thank you. Ms Hoffman, I will put to you what I would suggest are the circumstances to invite your comment, but the real position was that this patient was a thoracic patient and Dr Carter had a special interest in thoracic patients. He in fact was the one who - when I say "special interest in thoracic patients", as an anaesthetist in managing thoracic patients; that it was he who asked Dr Patel if Dr Patel would do the operation, and that Dr Carter expressed confidence from his point of view that the patient could be managed at the Bundaberg Hospital?-- That may be the case. I'm not privy to that information.

And that there was in fact no agreement of the kind that you had mentioned, and that both doctors were minded that if the patient needed to be transferred, the patient would be transferred?-- I'm not aware of that. My full understanding is still that they had come to an agreement, and that was the agreement, and that's the agreement that I was aware of.

And finally just to finish on that topic, can I ask whether you are aware of Dr Keating investigating the allegation you made in your email about the agreement?-- No.

Now, in your evidence in Brisbane at page 73 line 35 - and again this touches upon Dr Qureshi - you said there that Dr Keating had mentioned - and this was at the time, I think, of your handover to Ms Mulligan - that Dr Keating had come into the room and made a reference to the fact that Dr Qureshi had departed and that the police were looking for him - I think that was the detail of your evidence. You said that what Dr Keating said in your presence, firstly, was that he had not checked Dr Qureshi's references?-- That's correct.

And by that, he clearly was saying, was he, that when Dr Qureshi was employed, Dr Keating hadn't checked his references, he had simply employed him?-- That was my understanding from what he said.

I put it to you that Dr Qureshi, whilst he started at the hospital in Bundaberg on the 29th of July 2003, had actually been engaged for that employment in February of 2003; are you able to comment about that?-- No.

If that were the case, would you accept that that was some several months before Dr Keating actually commenced employment at the hospital?-- It may have been, yes.

And further, I suggest to you, Dr Keating said no such thing about not having checked Dr Qureshi's references?-- Well, I remember that.

If he, in fact, had not been the person who had employed Dr Qureshi, I don't suppose you can offer any reason as to why he might be saying he failed to check his references?-- He may have been saying he failed to check them since - all the issues had arisen with Dr Qureshi. I don't know. I'm not going to comment on that.

What you said in Brisbane was that you actually raised it. You said words along the lines, "I wonder who checked his references."?-- That's right, I did say that.

Dr Keating then responded to the effect that he didn't?-- Yes.

COMMISSIONER: That might fit in entirely with what Mr Diehm is now saying; he didn't check them because he wasn't involved in the employment of him?-- That could be it. That's right.

MR DIEHM: Ms Hoffman, the other thing you attributed to Dr Keating in that discussion was that he had said words to the effect that he had not handled the situation well?-- Yes.

Did he elaborate upon that at all?-- No, he just said - I think he said - he might have added in hindsight, he didn't handle it well.

Were you aware at all that Dr Keating had referred various complaints about Dr Qureshi's inappropriate behaviours to the Medical Board?-- No.

D COMMISSIONER VIDER: Given that there are a number of instances that we are talking about this morning that have been raised concerning either patient care or staff behaviour, did Dr Keating ever come to the Intensive Care Unit and come to you as the nurse manager of that unit and say to you, "You have raised a number of concerns with me."; either, "How are things going?", or, "Where are we up to?", or discuss them?-- No, I have never seen - I have never seen Dr Keating in the Intensive Care Unit, except when he was accompanying a visiting zonal officer or someone of importance around the ICU. Other than that I had never seen Dr Keating in the ICU. My staff didn't recognise him. The first time they saw him was on the television during this Commission.

Your staff did not report to you either-----?-- No, my staff did not know who he was and I had not seen him in the Intensive Care Unit at all, except to accompany VIPs or whatever around.

MR DIEHM: Which staff members of yours said that they had never seen Dr Keating until they saw him on television?-- I can remember one was Kay Boisen.

Who else?-- I can't recall which exact staff member it was.

Is that because Kay Boisen was the only one?-- No, it's not. I'm not sure who else said it, but this is what I'm-----

How many staff members are there of yours in the ICU?-- There's around 18 staff - 15.4 FTEs.

Do you think Miss Boisen was being literally true when she made the statement attributed to her, or was she speaking figuratively?-- No, I believe she was speaking truthfully.

Ms Hoffman, Dr Keating did periodically come to the ICU, I suggest to you, without accompanying visitors. Just as part of his duties, he would walk around various sections of the hospital from time to time, including the ICU?-- That may be so, but I never saw him.

You didn't see him. Thank you. Another topic, Ms Hoffman: you said - and again for the benefit of others, the transcript at 74.40 - you gave evidence of problems that were recorded with respect to surgical notes, and the example you gave specifically was where a spleen was nicked by Dr Patel performing surgery, but all that was recorded in the notes was the word "splenectomy"?-- Yes.

And what you said of that is that that seemed to be designed to give the impression that a splenectomy was always planned?-- Yes.

Because it didn't say "accidentally nicked spleen, therefore splenectomy"?-- Mmm.

The records for a patient undergoing a surgical procedure

would include, would they not, consultations with the patient in out-patients before they become admitted to the hospital?-- Yes.

They would include booking forms?-- Yes.

They would include admission forms?-- Yes.

There are notes made by nurses in the progress notes for the patient?-- In-----

After the patient has been admitted?-- Yes.

And often there will be such notes before the patient goes into surgery?-- Yes.

There will be a consent form?-- Yes.

Whereby the patient signs consenting to the surgery that they are going to undertake?-- Yes.

There will be a pre-operative anaesthetic record?-- Yes.

There will be operation records prepared by nursing staff as well as by surgeons?-- Yes.

And in the ordinary course, you would expect that there would be details in each, if not most of those documents just what surgery was proposed for a patient?-- Yes.

So that if, during the performance of surgery, a spleen was accidentally nicked, and so an unplanned splenectomy was performed, just because the word "splenectomy" is all that is written by the surgeon in the surgical notes, it would still be patently obvious to anybody reading the notes that the splenectomy must have been as a result of some misadventure during the surgery?-- That's right. I just gave that as an example, Mr Diehm.

You can take it that my questions are just to cast some light on that as an example. With respect to Mr Bramich, if I may move to that-----

COMMISSIONER: Just before you do, perhaps you are not the right person to ask this, but you will understand my medical knowledge is fairly limited. I start with the assumption that everything inside you is for a purpose and if you have got a spleen it is because it is for something useful. Is the spleen something you can get by without?-- Yes, you can get by without it.

At any disadvantage?-- Yeah. It is not like an appendix or your tonsils or something like that. It is much more important than that, but, you know, it is something that you can get by without, but it is not - it wouldn't be desirable that you lose it during surgery, you know, by accident.

Well, if I went in, say, to have my appendix taken out and I

was told afterwards that I got two bits removed for the price of one and I got my spleen removed as well, I would be right to be disappointed, wouldn't I?-- I think you would be right to be concerned and disappointed. There are some lifestyle changes you would have to make and there are some repercussions that would occur because of that. One is, you know, you are much more at risk of infection and things like that. So, it is not a desirable thing. Once again, that was - I was just using that as an example. I could have used other things as an example-----

Yes, I understand that.

MR DIEHM: Thank you. With respect to Mr Bramich, you, as you have detailed in your evidence, completed with the assistance of Dr Truscott, I think you said, a Sentinal Event Form?-- Yes.

And what you have said in your evidence is that Dr Keating took it upon himself to downgrade that Sentinal Event Form?-- I was informed that Dr Keating downgraded the Sentinal Event Form. After the form went in, I had no further information given to me about what happened to that form. I was informed that that is what happened to it - that it was downgraded.

Did somebody tell you that Dr Keating downgraded it?-- I believe that that is what - that's what I was told, yes.

Who told you that?-- I thought - I think it was Dr Truscott.

Have you since been told that Dr Keating did not downgrade the Sentinal Event Form-----

COMMISSIONER: Sorry, Mr Diehm, are you putting it wasn't downgraded or that it was downgraded and it was someone else?

MR DIEHM: Well, I'll make it clear. I will put it to you that it was not downgraded by Dr Keating or by anybody else?-- I'm unaware of that. I was told it was downgraded.

Have you since been told that it was not downgraded?-- In the last week I have been made aware that it was not - that I have been told it wasn't downgraded - that is in this last week.

Now, are you referring there to information you received because of the disclosure of some proposed evidence from a Leonie Raven?-- Yes, and of a conversation that Miss Raven had had with someone earlier where she had told that to that particular person.

Did you yourself have a conversation with Miss Raven in the last couple of months about what happened to that form?-- I have heard about this conversation, and I don't recall this conversation.

So, what you are saying is that you have heard allegations that there was such a conversation?-- Yes.

But you don't recall it?-- I remember having a conversation with Miss Raven, but I don't - and she was very concerned about what was going to happen to her and - because of the incident forms and what was going on with the incident forms at the hospital, but I don't recall any other specifics from that conversation at all.

All right.

D COMMISSIONER VIDER: Who filled out the Sentinal Event Form regarding Mr Bramich?-- Myself and Dr Jane Truscott.

If there was going to be any change to the classification of that form, would it be your expectation that the person making the change would come and discuss it with you?-- I would have thought so, yes.

And that would be normal hospital protocol?-- I had never filled in a Sentinal Event Form before, so I just assumed - the other thing with Sentinal Event forms that I believe, too, was that they went to the District Zonal Office - they bypassed the hospital as well. That's what I thought happened to them, but I'm not sure if - whether that is the case or not now.

MR DIEHM: Another problem, I suggest to you, Miss Hoffman, is that there has been some changes going on with respect to the policy about how these things are to be managed and those changes were occurring around the time of these events?-- They may have been, yes.

It is easy, I suggest, to become unclear about just which process a particular complaint is moving through?-- Yes. Once I had done the complaint with the help of Dr Truscott and I attached a larger complaint with my complaint, that was - it was out of my hands.

All right. There was - and I think your evidence has touched upon this - at the time or around the time of your complaint, another complaint concerning the handling of the case of Mr Bramich made by a nurse, Ms Fox; is that right?-- There was several complaints - there were several complaints that went in about the handling of Mr Bramich. I believe there were six letters that went in with - accompanying the Sentinal Event Form. No, they didn't accompany it because they went in at different times, but, in total, there were around six letters from six different nurses - just some of them with varying degrees of information because of the period of time that they had spent with Mr Bramich. We were also - we had also been asked to write statements for the police, so there were quite - there was quite a lot of documentation about Mr Bramich. We were concerned also that he was a Coroner's case, and some of the staff were away. There was quite some delay in getting some of the statements read by our legal advisors as well.

What I suggest to you is that there was an adverse incident report completed by Ms Fox with respect to a particular aspect

of the management of Mr Bramich?-- That's to do with the chest tube drain.

Yes?-- Yes, that's right, yes.

And what I suggest to you is that the reason why it appeared that your Sentinal Event Form had been downgraded was because, by clerical error in the DDSQ office - I think I have got that right, have I - by clerical error in that office, those two forms were stapled or otherwise joined together?-- I'm unaware of any of that. I became aware of that - that that was brought up last week, but I'm totally unaware of that.

All right?-- I never became aware of that. I do not know anything about that.

COMMISSIONER: But it does seem fairly plausible, doesn't it, that you get two complaints or two documents arriving in the filing office relating to the same patient at the same time and they are just sort of bundled together and treated as one complaint?-- Except that copies were given to the Director of Medical Services and the Director of Nursing services and there's a note on the Sentinal Event Form that states that and there is a big difference between a Sentinal Event Form and something wrong with a chest tube drain. I mean, a Sentinal - I mean, if someone - even if she's clerical and she's working in that area, she would be aware a Sentinal Event Form is something that's very, very serious. So, I don't - I don't really accept that as an excuse for why - I don't know what's coming up next, but whatever it coming up next, I just - you know, this was a very serious situation that I was-----

I think all that is coming up is that Mr Diehm is, on behalf of his client, Dr Keating, saying, "Well, there was no downgrading"-----?-- There may not have been, but I was told there was.

Yes.

MR DIEHM: Thank you. Ms Hoffman, you have mentioned in passing there that there was quite a lot of activity going on with respect to the gathering of evidence and versions and details about what happened to Mr Bramich in that unfortunate event. Are you aware as to whether there was somebody who was co-ordinating the gathering of that information on behalf of the hospital?-- No, not apart from - not apart from myself, until we got a letter from Dr Keating asking for statements for the Coroner.

Yes?-- Yes.

All right. You had that contact from Dr Keating asking for statements from yourself and other nurses involved, I assumed; is that right?-- Yes, there was a list of nurses involved.

Dr Carter provided a version about events that took place?-- Dr Carter provided a statement and Dr Younis, who actually had been mainly responsible for resuscitating Mr Bramich, provided

a statement to Dr Carter as well.

And those documents were, in turn, provided to Dr Keating, were they not?-- You would have to ask Dr Carter that.

The long and the short of it is - and I don't wish to waste yours or the Commission's time by asking you about matters that you can't know about - but the long and the short of it is that there may very well have been an extensive investigation being carried on by Dr Keating into the events surrounding this episode with Mr Bramich, but you don't know the detail of what he was or wasn't doing?-- No, I don't know the detail of what he was or wasn't doing.

Or what he was doing, for that matter. You don't know what he was doing?-- No.

Except you got a letter from him asking for statements from you and the nurses-----?-- For the Coroner, for the police.

Thank you. Now, you have also given evidence, again in Brisbane, that the nickname Dr Death was coined by Dr Carter?-- Yes.

And your evidence in Brisbane was that that was coined at an early stage?-- From my recollection it was, yeah.

When are we talking about, do you know? Are we talking about June 2003?-- No, later than that. Late 2003.

Late 2003?-- Mmm. I can't remember that date. I can't remember the time.

No, I'm not suggesting to you, Ms Hoffman, that you should. Do you say that after that time the name Dr Death for Dr Patel became one that was commonly used?-- It was commonly used by Dr Carter. It wasn't commonly used by myself or the nursing staff. It may have been used occasionally by other people, but I - it was more used by Dr Carter.

COMMISSIONER: Again, without being silly about this, so far as you know, Dr Carter was the first to use that name, but, for all you know, he might have heard someone else use it and it tickled his fancy and he took it up?-- Exactly.

You can't say that Dr Carter was the one that invented it?-- No, I can't.

MR DIEHM: The other nickname that you referred to in Brisbane was Dr E Coli?-- Mmm.

Was that a nickname that came about around the same sort of time?-- I don't know. It was a nickname that I heard the GPs in town were calling him.

When was that happening?-- Once again, it would have probably been around - you know, around 2004. I just heard that patients, when they went in to see their GPs, were being

asked, "How's Dr E Coli?", that sort of thing.

Did you have a lot of patients telling you this?-- No.

You were working in the Intensive Care Unit-----?-- Yes.

-----at the time?-- Yes.

Was there any particular context in which patients would be saying to you, "When I went to the GP, he" - or "she" - "said to me, 'How's Dr E Coli going?'"?-- No.

No particular context?-- No.

Just came up sporadically in conversation?-- You know, I think Dr Patel was a major topic of conversation around the town in certain circles, amongst the GPs and amongst some patients, among the nursing staff - you know, the nursing staff, amongst doctors at other hospitals.

Amongst patients in the ICU?-- Not patients in ICU. Maybe relatives of patients in ICU. Not necessarily patients in ICU. Usually patients in ICU are, you know, critically ill.

I don't suppose there's any prospect of you recalling who these people were or the GPs that were relating these things?-- That were calling the doctor "Dr E Coli"?

Yes?-- No.

In your evidence in Brisbane, you referred to an episode of a patient who was a renal patient who, in late June of 2004, perhaps early July 2004, died following a failed attempt at an insertion of the Vascath?-- Yes.

Do you recall this patient?-- I don't-----

P1, I'm sorry, is the patient?-- I know of the patient and I know of the situation, but I don't recall the exact events of this case.

I suggest to you that Dr Patel was not the surgeon concerned with the care of that patient. Are you adamant that he was?-- Can we check that we have got the right patient?

P1?-- I have got a P1, but I need to - could we check the name of that?

COMMISSIONER: Yes. There's no difficulty mentioning the name of the person. The media understand that it is not-----?-- Okay. I just wanted to check, because-----

MR DIEHM: It is P1?-- No, I don't - if he wasn't the surgeon, well, then, he wasn't the surgeon.

COMMISSIONER: Does that mean you may have the wrong patient for the incident or the incident may have involved a different surgeon?-- There was a patient who did die from having the

insertion of a catheter that we heard the evidence of last week.

Yes?-- So, I don't know if we have got the patients muddled up or what. I'm not sure.

MR DIEHM: You referred in your evidence, indeed in your statement, to the fact that you took to hiding patients in the ICU?-- Yes.

And your evidence in this regard deals with a specific incidence of a patient who was in the ICU, and I think this was in about March of this year, if I recall it correctly?-- Yes, mmm.

And what you described there is that Dr Patel had come into the ICU and had seen that there was this patient and he - and the patient - again, correct me if I have got this wrong - but the patient was a potential patient for an oesophagectomy?-- The patient, from my understanding, was a patient who was an elderly lady who Dr Patel - yeah, at some point, had identified her for an oesophagectomy. She was a patient of Dr Strahan's, who had somehow been referred to Dr Strahan and Dr Strahan wanted her admitted medically and arranged a medical to medical transfer to Brisbane so that Dr Patel couldn't operate on her. So, we actually kept her in the Intensive Care Unit under the medical doctors so that Dr Patel could not operate on her.

When you say the patient was hidden, it is not as if we have got a patient with a curtain draped over him or her or hidden away in a storeroom or something like that. You have just got the patient in the ICU ward?-- Under a different category than what they would have been under.

As a medical patient, not a surgical patient?-- For a specific reason, yes.

Dr Strahan was the patient's doctor?-- It was Dr Strahan who asked us to do that.

Dr Strahan was operating in the Department of Medicine?-- Yes.

So, he's not in surgery?-- No.

So, there's nothing unusual about the patient being in the ICU as a medical patient?-- She was admitted deliberately as a medical patient so that Dr Patel could not or would not - he wanted - Dr Strahan was going to arrange the transfer to Brisbane medical to medical, so that he could not operate on her.

Now, is this the only patient who you took these sorts of steps with?-- There was another patient very soon before Dr Patel left, who we have heard evidence from Dr Miach about, Mr - sorry, patient number 33, P33.

P33, yes?-- And Dr Patel - do I have - I have already - do I have to go through this again about this particular patient?

COMMISSIONER: You just referred to the example of that patient anyway in answer to Mr Diehm's question. If he wants to ask any more about the patient, no doubt he will.

MR DIEHM: Thank you, Commissioner.

COMMISSIONER: But in addition to the so-called hiding of the patients, I know you weren't putting them in broom cupboards, or under the table, or wherever, but I understood from your evidence in Brisbane that there were other proactive steps to keep the patients away from Dr Patel, such as telling them to go to Brisbane for surgery-----?-- Yes.

-----and that sort of thing?-- Yes. What I was trying to highlight is that these were extraordinary things that we were trying to do to protect the patients from Dr Patel, and the other thing to remember is that we've already had - we've already - the complaint's been made in the October of the previous year. We're still - after - and I had asked for 14 patients to be looked at, 14 patients just to be looked at, and after the complaint was made, we still - we were still having all of these patients with all of these complications in the Intensive Care Unit. We had had the fact-finding mission done and we still were seeing all of these patients. We were going to extraordinary length - lengths that I had never gone to and neither had any of my colleagues in their nursing career to try and protect people from a surgeon. So this is - what I am trying to highlight here, in saying "hiding patients", we weren't taking them away and putting them in broom closets, or anything like that, but we were still working with doctors to keep Dr Patel away from them. The same with patient 33, what we did - what myself and Dr Miach did that particular day was literally, as I said before, stayed by the bedside so that Dr Patel couldn't take him to theatre. I mean, we were-----

D COMMISSIONER VIDER: I understand that we have had evidence before us that it was Dr Patel's habit to roam?-- Yes.

And unlike the tradition and understanding in Australia, if one doctor asks another doctor-----?-- Excuse me. Excuse me. Sorry, I can't hear.

MR ASHTON: I apologise.

D COMMISSIONER VIDER: If one doctor asks for another doctor for a consultation and an opinion, then the doctor that's giving a opinion goes back to the primary medical officer and gives the opinion?-- Yes.

In Dr Patel's case that didn't necessarily happen, he took over the patients?-- Yes, he took-----

And took over their management?-- Yes.

Which very often meant that they went to theatre?-- Yes, and that's what happened the night of Mr Bramich's case as well, he came in and he took over that - you know, he took over that case. I mean, the other doctors had the right to say, "No, you're not going to do that," but it didn't happen like that and-----

But it unfolded that that was Dr Patel's behaviour?-- That was his behaviour, that's very much what his behaviour was like, very much, and Dr - I think Dr Miach gave some good evidence of, you know, he walked past a chest x-ray and said, "Oh, that man" - oh, I can't even remember now what it was, but that man required something or other and-----

Pleural effusion?-- Yeah, and they looked at it and they said no, he didn't. He was - always seemed to be looking for someone to operate on.

MR DIEHM: Ms Hoffman I've got a couple of questions to ask you about Dr Strahn, if I may. Dr Strahn was the doctor who after the incident involving Mr Bramich found you crying in your office in the ICU; is that right? And for the record the witness has agreed. You had a conversation with Dr Strahn in which he indicated that he would ask questions around the place and he came back to you and spoke to you again a couple of days later; is that right?-- Yes, that's right.

What he told you at that time, you say, is that there were other people that had concerns?-- Yes.

But that nobody was prepared to stick their neck out at that point in time?-- Yes, they were his words.

But what he asked you to do was gather some data?-- He said continue doing, you know, what you are doing, you know, gather some data and just keep trying to put it through the right channels.

All right. But his answer to finding out whether there was or establishing a case of some evidence that there were problems with respect to Dr Patel was to look for data, look for statistics showing up those problems?-- Yes. He - you know, he said to me that if he ever had problems like this he would talk to - there was another doctor in town named Dr Thiele, that he would talk to Dr Thiele and, of course, Dr Thiele gave very good advice about what to do in situations like that. He - he felt that going to Administration here at the hospital was not going to achieve anything because the issues of Dr Patel had been, you know, raised, raised you know in various different ways throughout the two years and nothing - nothing seemed to be happening with these issues.

Now, you say that Dr Strahn spoke to Dr Thiele?-- I'm not

sure if Dr Strahn spoke with Dr Thiele. Dr Strahn said to me if - he usually - if he had issues like this he usually would take advice from Dr Thiele because Dr Thiele was a very well respected doctor in town. But we didn't have Dr Thiele to go to.

Yes. Was that the first conversation you had with him where he mentioned this?-- About which part?

I'll make sure we're not at cross-purposes. You have spoken of two conversations with Dr Strahn, one the day after the death of Mr Bramich?-- Yes.

And another a couple of days later?-- Yes.

Now, I'm asking you whether the conversation which you have related in his usual practice in situations like this of going to speak to Dr Thiele was in the first of those conversations?-- I can't - I can't remember. I think it was in the second.

It was in the second, all right?-- Mmm.

Now, the other thing I wanted to ask you about Dr Strahn is concerning this patient it appears had been hidden in ICU. Dr Strahn, I suggest to you, had, in fact, spoken to Dr Patel about this patient and told Dr Patel of his plans to have the patient transferred to Brisbane for surgery?-- He may have, yes.

So Dr Patel therefore knew, if those were the circumstances, that this patient was one who was to be transferred to Brisbane rather than being operated on in Bundaberg?-- Dr Strahn may have spoken to him about that. At what point, I do not know. But the understanding - but my understanding and the understanding of my co-workers in the ICU was that that was what we were doing. He came and actually sat down at the desk and discussed it with me, discussed his plan with me.

The patient, who was the thoracotomy patient shortly after Mr Bramich's death-----?-- Yes.

Do you know the patient I'm speaking of now? This is the patient to whom you raised your concern with Linda Mulligan-----?-- Yes.

-----about there being a thoracotomy?-- Yes.

Now, this patient, I suggest to you, after your concerns were raised - sorry, I will withdraw that and rephrase it. With respect to this patient, it is true, I suggest, to say, as you have, that the wedge resection biopsy that was planned involved a thoracotomy, but in terms of the degree of complexity of thoracotomies that this was a very simple one?-- I wasn't disputing that. My issues with the thoracotomy was that about the timing, about it being booked on a Friday. I had raised my issues when Dr Patel booked surgeries previously and one was an elective appendectomy that was done on the

Saturday and that was what I was - my issue was. The concern of the thoracotomy being booked so late in the week when - when all of our facilities aren't available. That was my concern. A thoracotomy is - can be a very, very simple operation. It can be done down in the Emergency Department. That's not what I was complaining about. What I was complaining about was - what I was trying to bring the issues to - to the Executive were that these sort of things should be done earlier in the week.

The plan for this patient with respect to this surgery did not involve an expectation that the patient would become the inpatient of ICU, I suggest?-- Well, Dr Carter had discussed it with me and discussed whether we were comfortable with booking a thoracotomy and the staff were comfortable with looking after a thoracotomy. So Dr Carter had discussed the patient with me, so I assumed that there was a chance that the patient could end up in ICU and with - as we've already seen with many of Dr Patel's patients, even when they were simple patients, they ended up in ICU because of the complications that he had.

D COMMISSIONER VIDER: Is a thoracotomy common or uncommon procedure in Bundaberg?-- Uncommon.

Therefore, a patient having a thoracotomy would not routinely go back to the Surgical Ward?-- Not necessarily, and I think that patients that went back to surgical were specialled on the Surgical Ward probably to - at the patient's detriment to make a point. They - yeah, that is my belief about that patient.

MR DIEHM: The patient, I suggest to you - sorry, I will withdraw that. I will just put a couple of other things first. You said what Dr Carter spoke to you about. Dr Carter told Dr Keating that the plan was for this patient to go to the Surgical Ward, not the ICU, and that Dr Carter was satisfied with the operation proceeding, that the patient could be cared for adequately. You can't make any comment about that, you can only tell us what Dr Carter told you?-- No, I cannot. I can only tell you what he told me.

Now-----

COMMISSIONER: Would it be uncommon where it was intended that the patient would go to the Surgical Ward, but there was obviously perceived to be some risk that the patient would need ICU-----?-- Yes.

-----for Dr Carter to have those contingency plans in place?-- Yes, yes, could be. Yep.

So really what Dr Carter said to you and what Mr Diehm is saying that Dr Carter said to Dr Keating, isn't necessarily inconsistent?-- No, no. He could well - they could well have expected him to just go back to the ward.

Yes?-- Yeah.

MR DIEHM: And you said that the patient was specialled?-- That's - yes, I'm just trying to find my notes now on this patient.

Yes.

COMMISSIONER: Mr Diehm, it is almost time for the lunchbreak, are you expecting to be much longer?

MR DIEHM: Commissioner, I might have been close to finished. What I was going to do was ask for an indulgence anyway to allow me to reconsider my position over the luncheon break.

COMMISSIONER: Whatever is more convenient for you. We will take about an hour and a quarter, but I'm happy to take it now.

MR DIEHM: It's convenient for you to do that now.

COMMISSIONER: Does that suit you now, Ms Hoffman?-- Sorry, what did you say?

Just suggesting that we have the lunchbreak now?-- Yes. Yes.

MR DIEHM: Thank you.

COMMISSIONER: All right. Well, 2 o'clock?

MR DIEHM: Thank you.

THE COURT ADJOURNED AT 12.44 P.M. TILL 2.00 P.M.

THE COMMISSION RESUMED AT 2.17 P.M.

TONI HOFFMAN, CONTINUING CROSS-EXAMINATION:

COMMISSIONER: Mr Diehm, thanks to the assistance of our ever conscientious Secretary, if you are interested, dehiscence derives from the Latin hiare, to yawn.

MR DIEHM: I shall use it in that sense.

COMMISSIONER: Thank you. Ms Hoffman, I think my recollection is what I was asking you just before the lunchbreak, was about the patient who had the thoracotomy being specialled in the wards?-- Yes.

I think you were going to look at the notes to see something about that?-- Yes. Yes.

Have you looked through your notes?-- Yes.

You found what it was that you appeared to-----?-- What I wanted to say, yes.

All right?-- It was just that the man was a 68 year old man who was booked for a left thoracotomy and a wedge resection on the theatre list and when I checked his chart it showed that his drains were blocked on the Surgical Ward. He was specialled in the ward. A lot of the equipment that they needed in the ward was accessed from ICU and I just think that he was kept on the ward probably to make a point.

What-----?-- And the point-----

What sort of equipment was accessed from the ward, from the ICU?-- I didn't write down what sort of equipment. I can't remember now. I would have to go back and have a look. But that's what I had noted when I went through his chart.

A blocked drain is a complication that arises from time to time in patients in Surgical Wards?-- Yeah. I think what I'm trying to say here is that on - if he was in the ICU he - they are much more used to looking after patients with intercostal catheters than the Surgical Ward.

Yes?-- And unblocking drains, and things like that.

All right. That depends on the nurses, I suppose, in the ward?-- Yeah, it would depend on the nurse and it would depend on the hospital as well.

D COMMISSIONER VIDER: And frequency of the procedure?-- Yes, and remember Bundaberg was a small hospital and it was a infrequent procedure for them.

MR DIEHM: But a blocked drain can be a complication in a variety of procedures, can it not?-- Yes.

Certainly there were plenty of procedures performed as a result of the complication of a blocked drain?-- An intercostal catheter drain for a thoracotomy is different than a normal blocked drain.

Thank you. I will be careful so that I don't get too far out of depth for myself. So your surmise is that this was done to make a point, but, of course, that's just a surmise on your part?-- That's right, it is, yes.

Now, in paragraph 104 of your statement, where you deal with the patient here concerned, you say, "I subsequently checked to see whether or not the patient who had been blocked for the thoracotomy did in fact have a thoracotomy operation." You say, "It is apparent that he died."?-- Sorry?

In paragraph 104 of your statement dealing with this patient, the patient who had the thoracotomy, you say, "It is apparent

that he died."?-- Oh, I think that's supposed to be "did".

"Did"?-- Mmm.

Thank you. As far as you know, the patient - and indeed you looked at the chart - the patient recovered from his procedure and was discharged home?-- As far as I can recall, yes.

Thank you. I want to ask you some questions now about patient P26. To refresh your memory, this is the patient, the 15 year old boy who ended up having his leg amputated in Brisbane?-- Okay.

Now, this is a patient who you say is a victim of Dr Patel's poor practices, I gather?-- Well, it wasn't - it wasn't just me who came to that conclusion. It was the conclusion of many different people that this was the case. I actually didn't have very much to do with this patient. He was admitted just - I think it was just before Christmas and then I was away for the period of time that he was kept in in the Intensive Care Unit before he was transferred to Brisbane.

The patient - and I can take you to the patient's records to the extent you need me to - the patient was involved in an accident on the 23rd of December 2004?-- Yes.

He was an emergency admission to the hospital and underwent emergency surgery?-- Yes.

That surgery was performed on the 23rd of December as well?-- Yes.

Now, the patient was ultimately transferred to the Royal Brisbane Hospital on the 1st of January 2005?-- Yes.

The issue with respect to his care and the failure with respect to his care that you would identify, I suggest, would be that he should have been transferred earlier?-- That is my belief, yes.

Because the surgery he had was emergency surgery and he had to have it?-- Yes.

And there was no issue as far as you were aware per se with the surgery that he got at the Bundaberg Hospital, it met the purpose that was required as an emergency?-- At that particular time, yes.

But ultimately what this boy needed was specialist vascular care?-- Yes.

That he could only get if he was transferred to a major tertiary hospital in Brisbane?-- Yes.

So that really should have happened within a few days of the operation, or perhaps if I could put it this way: that should have happened as soon as he was stable following the operation?-- That's my belief, yes.

And is it also your belief that this boy became stable a couple of days after his operation?-- Yes.

Now, that would put the time as around about the 25th to 26th of December?-- Yes.

Dr Patel saw the patient, I suggest to you, up until the morning of the 26th of December?-- I'm not - I was not there on the 25th or the 26th of December.

You are aware, are you not, that Dr Patel himself went on holidays over that Christmas period?-- I'm not aware, no.

I'm sorry, you were unaware of Dr Patel having a couple of weeks leave at the end of December?-- I don't recall it, no.

I thought that would be something that you would have been most interested to know, that he wasn't going to be at the hospital operating?-- I don't recall noting - remembering it or noting it.

Okay. Well, to conclude for the moment with respect to this patient, what I am putting to you - and you no doubt will tell me you can't comment on - is that Dr Patel went on leave from the morning of the 26th of December 2004, leaving this patient in the care of other doctors?-- He may have, yes.

Now, Ms Hoffman, in a question that was asked of you on Thursday concerning your interactions with Ms Mulligan - and I think the question came from the Commissioner - you made reference - and this is page 1,409 of the transcript at about line 10 - you said of Ms Mulligan that she was - she would have been aware - and this is dealing with the aftermath of Mr Bramich's death?-- Yes.

She was - she would have been aware according to that report, which is a status of the hospital report that goes out every morning that you described?-- Yes.

"She would have been aware, according to that report, that there had been a death in ICU at midnight of a patient that was due to be transferred out. She would have also been aware that I'd stayed back to 7.30 when I was supposed to go home at 4.30, and she - just by the very nature of material that is sent around the hospital - Ms Mulligan should really have been aware of this situation, and we actually were - we actually thought that she would actually come down to ICU that day and talk to the staff, but she didn't." Now, the material that you are referring to there is, I gather, from what's referred to as the Bed Report?-- Yes.

And the Bed Report is a report that's issued each day?-- Yes.

For the-----?-- Each shift.

Each shift, I'm sorry?-- Mmm.

And if I can ask you to look at this document, please? If it can be put on the document reader. That may be the wrong one, I'm sorry. I'm sorry, I've given you the wrong one. That one, thank you. Now, this would appear, would it not, to be the Bed Management Report for the hospital following the shift upon which Mr Bramich passed away?-- Yes.

And perhaps if they can be just reduced a little so we get the whole of the content of that report in. We can see down the left-hand column under the heading of, "Ward", we can track it down and we can find the fifth one down, "ICU". You read across the column and you gather all of the information that's conveyed in the Bed Management Report to Ms Mulligan or the Executive concerning the events of that night. Is that right?-- No. Could you scroll down this piece of paper, please?

Yes, please?-- And - right. Right down to the end. Is that-----

Does it need to go any further?-- Yes. Can you go right down to the end? Okay. Can you produce the one from earlier that night?

The one from earlier that night?-- Yeah.

You are talking about for the preceding shift?-- For - yes.

I think we can, Ms Hoffman?-- And also the other report, the e-mail that was sent to Linda Mulligan by the After-hours Nurse Manager.

Is that a document that's already gone into evidence?-- No.

It's not. I'm sorry, I can't produce it for you?-- It forms one of the other After-hours Nurse Manager's statements.

COMMISSIONER: Do you recall which one?-- Linda - Lesley Douglas.

MR ALLEN: I have got an extra copy.

MR DIEHM: Commissioner, I will have that continued to be searched for.

COMMISSIONER: Yes.

MR DIEHM: If it's in my client's possession-----

MR ALLEN: I have got an old one.

MR DIEHM: Put it on the screen, please. Now, have we produced the right document, Ms Hoffman?-- Yes. As you see, there's two ventilated, one trauma, one post-op, and if you scroll right down to the bottom of that document you can see the extra staffing that's required.

Is that a reference to the overtime you are talking about?-- No. Can you go down a bit more? Right. You will just notice right at the end there it just says that myself and one of the CNs who worked in X-ray worked two hours extra overtime that night.

All right. Okay?-- And there's an additional - and also you can see where it says, "Extra Staff", it says "ICU: RN Fox",

and as at - for the night, and then there's also an e-mail that's attached when Ms Mulligan was notified about the events of the night.

I think Mr Allan is going to take you to that in due course?--Mmm.

Commissioner, may those two documents be admitted?

COMMISSIONER: Well, we might as well have Mr Allen's e-mail with it because they all seem to go together.

MR DIEHM: Quite so. Whilst it's going in now, perhaps for the sake of completeness it can go up on the reader first. Now, can you just clarify for me, please, where it says "ICC"?-- Yeah, the intercostal catheter. That's the drain that we were talking about, the types of - yeah.

That was the subject of an incident report-----?-- Yes.

-----by Ms Fox?-- Yes.

Thank you. If those documents can be received together, Commissioner?

COMMISSIONER: Yes. Those three documents which comprise the Bed Management Report, the After-Hours Staffing and Bed Status Report, and the e-mail from Lesley Douglas, all pertaining to the events on the 27th of July will be Exhibit 91.

ADMITTED AND MARKED "EXHIBIT 91"

MR DIEHM: Thank you. Ms Hoffman, I also want to ask you questions, a few questions about patient P44 who was the patient whose ventilator was turned off, you said in your evidence, to allow an elective surgical procedure to proceed. Ms Hoffman, I suggest to you that what the true circumstances of that particular case were was that the decision to turn off the ventilator was one that was made by Dr Carter quite independent of any pressure that Dr Patel might or might not have put upon him with respect to providing for another ventilated patient in the ICU?-- Perhaps the best person to answer would be Dr Carter himself. That's certainly not what was reported to me by my staff or the other staff involved. But I - I would like Dr Carter to answer that himself.

Yes. The reason why I do put it to you is because you will appreciate that it's a very serious allegation?-- It is a very serious allegation, and that's why I have attached the documentation from the nurse who reported it to me and sent it straight on to my Director of Nursing.

Yes. All right. Perhaps another person we might have asked

would be the nurse who reported the information to you?-- Yes, you could ask her, yes.

All right. But your answer to me would be to say that you really aren't in a position to say that that is in fact what happened?-- That what was put - that is what was reported to me and when I - as soon as I received this report I reported it directly to my line manager because of the seriousness of the allegation.

Did you look-----

COMMISSIONER: Sorry, Mr Diehm, it's correct, isn't it, as Mr Diehm says, that you really don't know whether Dr Carter might have arrived at the same decision regardless of any pressure from Dr Patel?-- No, I don't - I don't know that. That's why he's best to answer that question.

MR DIEHM: Thank you. Some of the statistics that are collected with respect to the ICU routinely are statistics that provide a comparison or provide comparative data, might be a better way to say it, comparative data concerning unplanned re-admissions into the ICU within 72 hours of discharge-----?-- Yes.

-----from the ICU?-- Yes.

There is - a report of that is prepared every six months, isn't there?-- Well, that's not generated from me.

It may not be - well, excepting for the moment it's not generated from you, it is a document that you see routinely in your job, is it not?-- I do - I do the stats for that every month. I don't - I have never - well, I don't recall seeing one for - a six monthly.

The document comes back to you or the report of the six monthly trend or statistics, I suggest, comes back to you as the NUM of the ICU for you to look at, in particular to allow you to identify if there is any trend of concern and, if so, to think about the reason for it happening?-- Well, that's the same, yeah, with every - yes, with every data. That's why we try to have the data.

D COMMISSIONER VIDER: Is that an agreed clinical indicator from the ACHS framework?-- Yes, yeah, it is.

How long has that indicator been collected?-- Since I have been - since I've been there. It was - I think it was every 48 - return - unplanned admission - did you say to ICU or to-----

MR DIEHM: Into the ICU?-- Into the ICU. I think it was every 48 hours and then it changed every 72 hours.

D COMMISSIONER VIDER: That indicator's been collected for some time?-- For some time, yes.

MR DIEHM: And the data that you - that is collected through use of the computer program that's available allows for you to compare the results of your unit to other units of all kinds, as well as to other units of the same kind as yours, i.e. level 1 ICU?-- Yes, that's right.

And it also predicts - the computer also predicts the number of episodes, given the number of patients that you have in the time period and given the level of the ICU, it makes a prediction of the number of expected events of such readmissions that you ordinarily had?-- Yes.

Yes. And that's one of the things you are able to do, is to compare, as it were, the number of such episodes to the number of events predicted by the computer?-- Yes.

Now, those statistics, I suggest to you, have by and large in the last several years produced results whereby the number of readmissions has been less than the predicted number. Is that right?-- I don't have that data in front of me so-----

If you could have a look at these - this bundle of documents?

COMMISSIONER: While that's going across, if what Mr Diehm's putting to you is right, if the number of readmissions to ICU after 72 hours is below benchmark, would that indicate that you are running a very good ICU or that would it in any way reflect on the quality of the surgery that results in patients coming into ICU?-- It can - there's a lot of factors that can affect that. One may be that you could - patients may be kept in ICU for a lot longer than what they normally are. I mean, there's a lot of things you have to compare it with - compare with it for it to make any - for it to make any sense, but-----

To draw anything out of it?-- To draw a conclusion from, so-----

But, generally speaking, if there's an incidence of unplanned readmission to ICU,a higher benchmark-----?-- Yes.

-----that would suggest patients are being released too quickly?-- That's right.

The statistics would essentially measure the quality of ICU care that the patients are receiving, including the clinical judgment as to whether or not to release the patient?-- Yes, that's right.

It isn't necessarily a reflection of the quality of the surgery that results in the patient getting into ICU in the first place?-- No.

MR DIEHM: Commissioner, I wasn't proposing for the documents, because of their number, to be put on the screen, I was simply going to ask the witness for - if she agreed with the proposition that they - they didn't show - I'm sorry, rather than I think it was put to her by and large the figures were

less than the predicted number.

COMMISSIONER: Well, you'd know that without looking at the document, wouldn't you?-- Yes, I would.

Yes?-- Yes.

All right. Perhaps we can - do you want to put those into evidence?

MR DIEHM: Yes, please.

COMMISSIONER: All right. Well, as a bundle, Exhibit 92 will be the ICU indicators.

ADMITTED AND MARKED "EXHIBIT 92"

COMMISSIONER: That's 92

MR DIEHM: Thank you, Commissioner. Another set of statistics that are produced by - in accordance with the ASHS guidelines, I suggest, are statistics that show the number of patients having an unplanned return to the operating room during the same admission?-- Yes. That's not one we collect in ICU.

All right. So it's not one that you have anything to do with?-- Not in ICU.

Okay.

COMMISSIONER: Following on from my earlier question, the statistics we have just looked at, which is unplanned readmissions to ICU, in very broad terms give a guide as to the quality of ICU clinical treatment, whereas unplanned returns to surgery would in a broad sense give you a guide as to the quality of the surgery being performed?-- Yes, yes.

MR DIEHM: Ms Hoffman, you were saying earlier in response to a question from Commissioner Morris regarding the unplanned returns to ICU that there were a number of factors that influenced whether or not there were a high level of unplanned returns to ICU, and it is true to say, is it not, that there are potential implications for those statistics if surgery is not being performed properly or appropriately?-- Yes.

Because a patient may be discharged from the ICU and have complications from surgery that don't emerge until after they have been returned to the ward-----?-- Yes.

-----in a way that wasn't necessarily predictable to the ICU staff at the time they discharged the patient to the ward?-- No.

I'm sorry, you do agree with that proposition? You have said,

"No." I'm not sure whether you are agreeing or disagreeing?-- No, I agree with what you are saying.

Thank you. Ms Hoffman, I do want to conclude by just revisiting something I touched upon at the beginning or earlier on in my questions for you, and that concerns patient P34. I am just wanting to make sure before I conclude that I understand your evidence about the circumstances regarding that procedure being carried out. You told us that it was a multidisciplinary effort and there were a lot of doctors or a number of doctors and hospital staff involved in planning for the operation, and I took you to your evidence in Brisbane about what you said about Dr Miach and his view or attitude towards the operation and his involvement. I want to make sure I understand. Is your evidence from what you saw and observed and heard from Dr Miach in the lead-up to that operation that he was in favour of the operation going ahead or against it going ahead?-- My impression, I think, was that he was - he was helping because he was organising the dialysis.

Yes?-- So, I guess I assumed that he was in favour of the surgery going ahead, but I don't know whether he had that opinion or perhaps he didn't have that opinion, maybe I just assumed that because it was being done as a - as a team. They were looking at it as a team.

You did not hear him voice any opinion one way or the other about whether or not the operation should proceed?-- At that time? At that time?

Yes?-- I can't remember. I can't remember back that far that - of that particular-----

Nevertheless, as you say, he seemed to be actively involved in enabling the operation to go ahead by his cooperation with respect to the dialysis?-- He was cooperating with that, yes.

Yes. Thank you, Commissioner. Thank you, Ms Hoffman.

COMMISSIONER: Thank you, Mr Diehm. Mr Ashton?

CROSS-EXAMINATION:

MR ASHTON: Thanks, Commissioner.

COMMISSIONER: Mr Diehm, while Mr Ashton's getting his papers ready, may I just express on behalf of all of us our appreciation for the efficient and courteous way in which you conducted that cross-examination. If there were any law students here I would recommend that as an example of the rule that cross-examining doesn't always need to be containing cross words.

MR DIEHM: Thank you, Commissioner.

MR ASHTON: Ashton is my name, Ms Hoffman. I am counsel for Mr Leck. I just wanted to start, if I might, with the - with the - well, I call it the March 2004 meeting. You have referred to it as a February meeting. You know the first meeting you had with Dr Leck?-- Mr Leck.

Sorry, Mr Leck, I'm sorry. Can we just in fact try to clarify the date? Might it in fact have been in March?-- Yes, it might have been.

Yes?-- Yes.

I think Exhibit 85 shows the period in which you were Acting DON?-- Yes.

And it's just before Linda Mulligan came?-- Yeah.

So it's probably in that first three weeks of March?-- Yep.

How did you arrange that meeting? Do you remember?-- There was - there was some - there was some meetings that were going on and there was some strange things being asked for by Dr Carter and to allow Dr Patel's patients to be cared for in the ICU, and one of them - Dr Carter was insistent that we get more staff - that we get more nursing staff so we could care for the patients.

Yes?-- And to him it seemed that that was the only issue we needed to get, was nursing staff to upgrade the unit. At this time Dr Carter was agitating to upgrade the unit to a level 2 unit, and he - he had some sort of bizarre requests of myself and other people and one of them was that we give - that we recruit people by giving them a week's holiday on Lady Musgrave Island, and at the same time I felt that patients weren't being transferred out deliberately because they wanted the figures to look higher than what they actually were, and one of the - so what I was trying to do was trying to put Peter Leck in the picture of what actually was going on at the time, that this - that there seemed to be some sort of - I don't want to say the word "collusion" because it's got a - sort of a bit derogatory, but some sort of efforts going on between Dr Carter and Dr Patel so that we would be able - you

know, we would recruit more nursing staff.

Mmm?-- He was quite - Dr Carter was quite adamant with me that, you know, we needed this extra staff, even though our stats were saying we were only 65/70 per cent occupied for the majority of the time, except when the times we had - you know, Dr Patel's patients. He was very eager that we keep Dr Patel's patients in ICU and not transfer them out to appease him or whatever, and so I wanted to try and put Peter in the picture of that. So that's why I wrote - that's why I went in and I spoke to him.

Yes?-- He asked me to put it in writing, and I did.

Sent that note which you later developed?-- I wrote that - yes, I wrote that note and I went in and spoke with him about it and he just said to me at the time, "Well, that explains a few things - a few things about comments that have been said in meetings and things like that about staffing issues."

You were sort of wanting to put him in the picture about his - involving some unregistered - unrealistic or unreasonable demands on resources or inappropriate use of resources, rather than necessarily being seen as a realistic case for more resources?-- Yes. Because there was a lot - there was a lot more that - to make an ICU a level 2 unit it's not just - doesn't just require more staff.

No?-- You require lots more things, like radiology 24 hours a day, pathology, all of those sorts of things, and Martin seemed - Martin Carter was only looking at one part of it, was the nursing staff part of it, and we'd had great difficulty in staffing the unit to care for Dr Patel's patients.

Thanks.

D COMMISSIONER VIDER: Can I just ask a question?

MR ASHTON: Yes, of course.

D COMMISSIONER VIDER: Dr Carter was the Director of the Intensive Care Unit?-- Yes.

He was an anaesthetist?-- Yes.

Did he give anaesthetic-----?-- Yes.

-----as well?-- Yes.

So he wasn't full-time in the intensive care unit?-- No, not at all. No.

Did he give things for Dr Patel's patients?-- Yes, to my knowledge, he did, me.

Thank you.

MR ASHTON: Thank you, Commissioner. Ms Hoffman, actually in

my question - I didn't want to stop you because it was helpful to hear that background - was when I asked my question, "How did you arrange the appointment?", I actually meant physically what did you do?-- Oh, sorry.

We've gone on a bit but it has been helpful. I am sure the Commissioners would agree?-- I just - well, walked in, I think, and said-----

Yes?-- -----"Could I speak to you for a minute, Peter?"

And I don't want to make a big thing of this, but that's an example, is it not, of his being, can I put this to you, pretty accessible, given the demands of his job?-- Peter wasn't unaccessible when you went to him or - with things that weren't bad news or weren't going to upset him or weren't a complaint. He was quite reasonable, very reasonable then, but if you ever took - wanted to discuss something that was a complaint or that wasn't palatable or that was going to be bad, make the hospital look in a bad light or whatever, it was very difficult to approach him then.

But I suppose if he's accessible, he's accessible, and he's not to know in advance what it is you are going to ask about?-- No, that's-----

This one wasn't exactly good news which you were telling him?-- It was to put him in the picture. It was not bad news. It was to make sure he had a bit of an idea of what was going on, and that also was when I was in my position as Acting DON. Like, I wouldn't have just done that in my position as Nurse Manager of ICU.

I think you have explained that, in fact, at page 129 of the transcript. You have explained that the system was to make an appointment but on this occasion it didn't seem appropriate to call in, and you were able to do that with without difficulty?-- Mmm.

I think, in fact line 40 on the same page, you were asked by the Commissioner to what extent Mr - the Chairman, I mean - Mr Leck was seen around the wards. You said, "Not a lot, but more than Linda Mulligan was." Again, and I know you have been trying to be fair to him, he was - he did his best - sorry, you don't know. He was about the place a bit, was he not?-- Yes, he was.

Yes. Do you remember his system at one stage of trying with the Quality Coordinator to visit a department every two weeks?-- Yes.

Yes?-- Yes.

And you know the - you remember the system of the District Managers Forums?-- Yes.

And you remember his introduction of the staff barbeque which he ultimately merged to try to encourage people to be at those

forums?-- Yes.

And you remember, do you not, that he used to brief people at those meetings and then invite them if they'd like to see him privately about anything to do so at lunch or when they chose to do so?-- He did do that, yes.

Yes. Now, you have explained to us, and I don't want to uselessly labour over things which you - go over ground which has already been tilled. I know you have been at that a long time and there's a long way to go yet. But essentially the reason you asked Mr Leck not to do anything about the matters that you had raised with him, essentially that was because you still had a hope of working things out, getting some sort of relationship with Patel that you could both work with?-- Yes.

Mr Leck did, though, say - ask you might he do something, that is how might he assist in the context of your saying, "I won't ask you to do anything yet", he was expressing an opinion as to really asking you for some guidance about what he might do? Do you remember that?-- No.

He might have said that?-- He might have, yep.

And then this business of Patel's claim to have Mr Leck's ear, Mr Leck seemed pretty dismissive about that suggestion when you spoke with him. I think you said he rolled his eyes?-- I presume that's a gesture of dismissiveness?-- Yeah. He-----

The validity of that - I'm not suggesting that he was disbelieving your faithfully reporting it, but rather you took that to mean that he placed no credence in that proposition?-- Because he didn't actually come out and say it - no, I - I really - we didn't know when Dr Patel was telling us this, on a daily basis, we were believing him.

Yes. You very squarely said you didn't know what was actually happening between the two?-- No, no, no.

Exactly. No. All right. Did Dr Keating or Nurse Mulligan ever say anything to you which would suggest that Mr Leck - although you asked him not to take positive action, that Mr Leck had sought of them to keep an eye on this behaviour resource problem? Was there any communication with you about that?-- About the behaviour?

About his actually asking them to keep an eye on this behaviour resource problem that you have raised? You don't know anything about that?-- No.

No. Can we talk for a little while, please, about the meeting of the 20th of October. You said that Mr Leck took copious notes. I think that's at page 142 of the transcript?-- Yes, he did, yes.

And you have seen Exhibit 8, I think it is, which is his file note?-- His file note, yes.

And I think you agree, do you, that it's essentially accurate. There may be-----?-- There were some things that I didn't - some detail there I didn't agree with.

I'd like to just ascertain from you your understanding of or your knowledge of what happened after that. You had the meeting, he's taken these notes and it's in essence, at least, a fair account of what took place at the meeting. Do you know, for example, whether Mr Leck caused an interview of any doctors to investigate what you'd reported?-- I only found that out, I think, like last week or at some point.

In the course of these proceedings?-- Yes.

Yes?-- I did not know about it before then.

You didn't know he'd actually caused to be interviewed the doctors whom you identified as sharing your concerns? You didn't know that at the time?-- No.

No. So, you didn't know obviously then that statements were referred from them to Dr Fitzgerald? What did you find out and when about Dr Fitzgerald? Perhaps first what did you find out about his involvement in what he was doing? I mean, he didn't just turn up, of course?-- No, no.

What was your first knowledge about that?-- I can't remember.

Or about what was leading to it?-- Okay. I can't remember when we were actually told. I think - I think Linda may have actually told us or me that - or even maybe it was even the union who told us, I can't remember how I actually found out that - who was - that there was going to be an investigation, or I can't remember who told me that, sorry.

Well, do you think it's possible that even before you were told that Dr Fitzgerald was going to take up the investigation, you were told of steps being taken to procure an investigation?-- No.

You didn't get advice on that from anyone?-- No.

Quite sure of that?-- I'm - I can't remember.

I'm not necessarily putting it to you that Mr Leck gave you that advice personally, but might you have had it from someone else, perhaps Linda Mulligan?-- There was a meeting at some point where Linda did tell us that there was going to be an investigation, but once again, I can't remember where that was in the scheme of things.

Well, presumably it would have been before you were advised of Dr Fitzgerald's appointment?-- Yeah, I remember getting a phone call from Executive about - and they called it a confidential matter. We were required - several people were required to meet with several different people on a confidential matter, and then when I asked further about that, they said, "You must - did you make a complaint about Dr Patel?" That was from Darren Keating's secretary. That's how I remember that part of it.

Was that the setting up of the meetings with Dr Fitzgerald and his staff?-- Yes.

Yes, I'm just trying to get an understanding of when you became aware that Dr Fitzgerald was going to conduct an investigation?-- I think the person who told me about Dr Fitzgerald was Kym Barry from the Union. I believe it was her who told me.

Did she explain how she knew?-- No, she didn't explain to me how she knew.

And before I leave this topic, did I understand you to agree with me that there may have been other occasions, or at least one other occasion on which Linda Mulligan or someone gave you some kind of report, if we can call it that, or information about the proposal to have an investigation?-- There was a discussion - there was a meeting where myself and Gail Doherty, who was the Acting NUM of theatre, and I think it was Dianne Jenkins went to Linda's office and she said that there was going to be an investigation. That was very late in - very late in the time that I can remember, because it was after - I'm pretty sure it was after one of the other theatre staff had made a complaint about another oesophagectomy and-----

Can you pin it down with any greater precision, do you think? You now know, don't you, that Dr Fitzgerald received his briefing, or his brief, if you like, for the investigation in the December?-- Yes.

So it was some time before that, was it?-- No, I can't pin it down - I thought it was later than that, but-----

It would be unlikely that you'd be being told about steps to arrange an investigation after the investigation had in fact been appointed. So it's more likely to have been before that, isn't it?-- Yes, it would have been.

COMMISSIONER: That's not necessarily right, though, is it Mr Ashton? Ms Mulligan may have felt at liberty to tell you that there was going to be an investigation, but it was still confidential who the investigator was?-- Confidential - it's actually written in the meeting in one of our - one of the exhibits-----

MR ASHTON: At any rate, I don't think I put it to you as being necessarily right. I think I put it to you as more likely, and you agree with me on that?-- Well, I do, but if you want me to be - I can look it up-----

Certainly. If you feel you can assist yourself by reference to notes, please do?-- It is in the-----

In your statement?-- It's not - it's in the attachments about the dates of the meetings that we had.

Yes, those are the meetings with Dr Fitzgerald and his staff, or an earlier one?-- No, it tells me what actual date that I met with-----

Well, let's try and find it?-- Can I perhaps give it to you later?

Certainly, yes?-- Because I just can't find it at the moment, but I think it even has been presented in evidence already.

Let me understand what it is we're looking for. It's an indication-----?-- Of the date that the three of us had the meeting with Linda.

Yes. And that meeting, was that a meeting to talk about Fitzgerald having been appointed, or merely the progress towards some appointment?-- No, just to say there was at some point going to be an appointment. It was not about who was likely to be doing it.

It's highly likely it was some time before mid-December when Fitzgerald was actually appointed?-- It may have been.

We'll leave that there and you can check it at your convenience.

COMMISSIONER: I was going to say, Mr Ashton, we might have the afternoon break for 10 minutes or so, and if Ms Hoffman wishes to get assistance from Mr Allen in locating that memo, that's probably the most efficient way to do it. Does that suit you?-- Thank you.

MR ASHTON: Would you mind just looking to see if the file assists you as to any other progress reports, as it were, whether informal meeting or unofficially or telephones or whatever it might have been?-- Yes.

Thank you.

COMMISSIONER: Essentially, just so that I understand that, Mr Ashton, we're looking for anything after the 20th of October 2004 where Ms Hoffman was told something about the progress towards an investigation.

MR ASHTON: Something about what's going on, Chairman, yes, thanks.

COMMISSIONER: Thank you.

THE COMMISSION ADJOURNED AT 3.08 P.M.

THE COMMISSION RESUMED AT 3.21 P.M.

TONI HOFFMAN, CONTINUING CROSS-EXAMINATION:

COMMISSIONER: Yes, Mr Ashton?

MR ASHTON: Thank you, Commissioner. How did we go, Ms Hoffman?-- TH14, do you have it?

I do. That's to your statement?-- The date was 13 January 2005.

COMMISSIONER: What number is that? Fourteen?-- TH14.

MR ASHTON: Could you just explain that note to us? Does that deal with a number of matters, does it?-- That was a meeting-----

"Re a confidential matter", is that the - do you see what I mean? There seem to be five or six different issues there?-- Yes, but that was the meeting where it was discussed about when - that there was going to be some sort of investigation.

Yes-----

COMMISSIONER: That was the 13th of January, was it?-- Yes.

MR ASHTON: Dr Fitzgerald had been well and truly appointed by then?-- Yes.

So you were told it would be Dr Fitzgerald?-- Not at that point, no. Not by Ms Mulligan, no.

COMMISSIONER: Were you told that someone had been appointed, or just that there was going to be-----?-- I don't even think someone had been appointed. I think we were just told that there would be an investigation.

MR ASHTON: And when did the person from the Union - Kym-----?-- Barry.

-----Barry, when did she tell you about Fitzgerald's appointment?-- I can't remember that exact date when she told me.

Do you know whether it was before or after this meeting?-- No, I don't. Well - no, I don't know.

See, what I was putting to you was that there were actually some contacts made with you by Nurse Mulligan at Mr Leck's request between the 22nd of October and the end of the year. Not formal meetings, but - and I can't even give you a precise number, probably only a few, but contacts informally advising you of progress, so to speak, the attempts to pick the right person and so on?-- No.

Do you say that didn't happen or you don't remember it?-- No, it didn't happen.

I presume, nonetheless, you were happy to hear, when you did hear, that it was going to happen. The investigation, I mean?-- Yes.

Did you know Dr Fitzgerald before this occasion, before his appointment to this task?-- I may have met him, but I didn't know him.

So did you have a particular view about the wisdom of his appointment as opposed to the appointment of anyone else?-- I had heard about Dr Fitzgerald. I had heard about his reputation.

What had you heard?-- That he was very fair and he was very senior and he was very - he was very - he was very good.

You were in fact, though, disappointed that when he got to talk to you that he seemed to regard it as something less than an investigation?-- We were all disappointed that it was called a fact-finding mission and it wasn't an investigation. We felt that the concerns that had been taken to Peter - it should have been an investigation. I think we were very concerned that it was only a fact-finding mission, just-----

Did he tell you - I'm sorry?-- Because it seemed that our issues weren't being taken seriously.

Yes, I understand that. Did he tell you exactly how he was going to proceed or was it-----?-- He said - you know, he

spoke with us - or some spoke with him and some spoke with some other people, and then he was going to take the charts away and audit the charts and then he would - we would hear back - or someone would hear back from him at some point.

Was it really the use of the expression "fact-finding mission" that alarmed you as to whether this was being taken seriously or not?-- That and the way that he described what he was going to do, that just - yeah, I think that there was going to be no investigation, and what we in the ICU were really hoping for was that Dr Patel would at least be stood down on full pay or whatever until the investigation was over.

Yes. Well, he told you that he didn't agree with that proposition. Dr Fitzgerald told you that, didn't he?-- Dr Fitzgerald did say that he didn't agree with that. He was concerned about the lack of surgeons that we had at the hospital.

Yes, and I imagine you weren't encouraged by his advice to you that he didn't have copies of your notes, the material you'd supplied to Mr Leck?-- No, he didn't have copies of my notes when I went to see him.

Your evidence about that appears at transcript page 179 at about line 50. Did you understand that he was telling you that he didn't have these documents at all, or that he didn't have them with him?-- It may have been that he had them and he didn't have them with him, because I gave him and the lawyer who was representing me a copy of them there, a copy that I had.

Either way you wouldn't have been impressed that he didn't have them?-- No.

Or have them with him, as the case might be?-- No.

But I think you know now, don't you, that he was actually briefed in his office, and support people were briefed with them in December?-- No, I don't know that, Mr Ashton. I've never been told that.

Can I just take you to - and I might have just misunderstood your evidence. I think this might - what is your understanding of when these materials were supplied?-- To Dr Fitzgerald?

Or don't you know?-- No, I don't know.

I won't press you on that then. It comes as a surprise to you, does it, to know that they were supplied before the occasion on which he saw you.

MR ALLEN: The witness doesn't know that they were supplied-----

MR ASHTON: Well, if I tell you that, if I put that to you-----

COMMISSIONER: We've reached the point where Ms Hoffman doesn't know one way or another. Whether or not she'd be surprised to be told that, I think, is unhelpful.

MR ASHTON: Thank you, Commissioner. You were disappointed with the Fitzgerald investigation. It had taken too long to get started?-- I wasn't disappointed in Dr Fitzgerald's investigation. I was not disappointed in any way with Dr Fitzgerald's investigation in terms of what he had done. I was very disappointed in the way the whole thing had been handled, the way that it took from when we made the formal complaint in October till we get spoken to in February, the way that things had happened in the meantime, the way that Dr Patel had been given an employee of the month award, the way that he came up and was told he'd been given this huge bonus, the way that he was telling us that he was being recruited on this enormous salary. It just seemed to completely demean our - the complaints that we had made, that we had gone up very seriously and made. That's what we were concerned about. And I was also concerned about the alarming numbers of patients that were still coming into the ICU on a daily basis with complications and these things were still occurring. They hadn't stopped. So that was my concern. I had asked for 14 patients to be looked at prior - at the complaint on the 22nd of October, and then I just did a cursory count from how many more patients came into the ICU with complications or had died from that time up until Dr Patel left, and there were at least another 16. So I was concerned that we were seeing patients with all of these terrible complications and all of these terrible things happening, and I felt our concerns weren't being taken seriously, but that was in no way a reflection of how I felt about Dr Fitzgerald's inquiry. I felt that he probably was just doing his job to the best that he could.

Well, you were disappointed, were you not, in that investigation, whether he was doing his best or not?-- Okay.

You were?-- Okay, I would say that, yes.

Well, please don't say it if you weren't?-- Yes, I was disappointed that, you know, Dr Patel was being allowed to continue to operate.

That's right. And Dr Fitzgerald disagreed with you - with your suggestion that he be stood down. I think we have already covered that, have we not?-- Mmm.

It was pretty difficult for you to go to anyone any higher in the Department, at least, I suppose, after that?-- After Dr Fitzgerald?

Yes?-- Yes.

Let's talk about the meeting on 23 March 2005. Firstly, let's, as a preamble to that - the seminar that was conducted by the Ethics Branch, can you just tell me what documents were referred to there? I think we have heard about a Powerpoint Presentation?-- Yes.

Was the Industrial Relations Manual-----?-- Referred to?

Was it there - physically there?-- I can't remember if it was physically there or not. It may or may not have been.

It was referred to?-- It was referred to, yes.

The Code of Conduct?-- Yes, it was referred to.

What does the Industrial Relations Manual look like?-- The ones that I have seen just look like an ordinary manual with "Industrial Relations Manual" written on it. Other than that, you just pull whatever particular - you know, thing you are referring to off the computer.

I see.

COMMISSIONER: Have you had occasion, for example, when you were acting as Director of Nursing, to refer to the Industrial Relations Manual previously?-- On QHEPS - from our internal intra - you know, network.

You knew what it was when it was talked about?-- Yes.

You say - or you gave evidence in Brisbane - and this appears at page 170 of the transcript - Mr Andrews has asked you some questions. You refer to the document of 22 October which you sent to Mr Leck, and then you say, "Shortly after that or some time after that, there was a seminar" - sorry, this is Mr Andrews' question to you - "a seminar conducted by three Queensland Health Department officers. Can you say how long after you sent these documents to Mr Leck on the 27th of

October that that seminar - the seminar occurred?" Your answer: "I think it was in - I think it was in - I think it was probably a month to six weeks after that." "And what was the seminar about?" Let's pause there. Have you had an opportunity to consider again whether your evidence is correct?-- About the date?

Yes?-- No. I mean, I haven't looked it up, no.

Well, can I put it to you that you might be in error in relation to that date? Perhaps if we look at Exhibit 61, if the Commissioner pleases?

COMMISSIONER: I think if you go to the bottom of the page, you will see the relevant bit is the dates. Seminar at Bundaberg: 14 October 2004.

MR ASHTON: Yes. Does that help you now to refresh your memory on when that seminar took place?-- Well, that's what it says, so it must have been then, yep.

That was actually before your meeting with Mr Leck which was on the 20th and your letter of the 22nd?-- Yes.

That's right, isn't it?-- Yes.

Thanks. Now, I will read on, if I may, in your evidence at page 170 of the transcript. Mr Andrews asked you what the seminar was about. "It was about - it was from the Ethical Standards Branch of Queensland Health, from what I can remember, and it was about what was ethical behaviour for a nurse or someone working in a hospital and what wasn't, and they talked a lot about whether or not nurses could have - could give information to the Nurses' Union." The Commissioner - there is then a further short question from Mr Andrews and the Commissioner then asked you some questions. He says, "Your statement goes further. It says that you were told that it was illegal even to speak to your union, and that if you did that, you could go to gaol and lose your job." You asked the Commissioner, "Sorry, where are you reading?" He refers you to paragraph 131 in your statement. You say, "Yes, that's right. We were specifically told that it was impermissible for us to tell our union anything about what goes on in the hospital or any hospital-related business. We were told this was illegal and if we spoke about anything that happened, we would go to gaol and lose our jobs. Yes, that's right." So, that's your evidence about what happened at the seminar?-- Mmm.

But we are agreed, are we, that the seminar occurred before the meeting with Mr Leck?-- Yes.

Might that help explain the correction of the dates? Might that help explain the passages which appear at page 171 of your evidence about line 28: "I was very well aware that by making this complaint, even just to Peter Leck and Linda Mulligan, at that particular time, that I would never get a chance to progress my career in Queensland Health."

Mr Andrews asked: "What was your belief about this?" "My belief was that I would never get an opportunity to act up into a higher position. I would never be given the opportunity to go to conferences or any of the things that enable you to progress in your profession. I knew that by making this complaint that that would be the end of my career and it may even be the end of my career at that hospital." Now, is it a fair proposition to put to you that you held those beliefs, of course, but you held them because of what you had been told at the seminar?-- No, I didn't hold them just because of what I had been told at the seminar, I held them because of my experience with working with Queensland Health and seeing what had happened to other people-----

I see?-- -----for a long period of time.

Right. Mr Leck certainly didn't say any such thing to you when you met with him, did he?-- No.

Of course. That seminar seems to have played a rather significant role in the 23 March meeting, too. I think you have told us that the Powerpoint Presentation from that seminar was at that meeting?-- The 23rd of March meeting?

Sorry, I'm moving forward to March 2005 after the airing of these matters in Parliament by Mr Messenger. I'm sorry, I should have explained that. The seminar and its content seems to have played an important role in the meeting of the 23rd of March 2005 in that, for example, I think you have told us that the Powerpoint Presentation-----?-- From that was brought along to the-----

Yes?-- I think it was brought along, yes.

You think so?-- Yes.

And the IRM about whistle blowers going to gaol?-- There was an IRM that was brought along and I don't know whether it was about whistle blowers going to gaol but it was what happened if you breached the Code of Conduct and - or if you were found guilty by the CMC, I think. It mentioned - whatever it was, it mentioned, you know, that the punishment for whatever it was was up to two years in gaol, and that was mentioned at the meeting.

Right. These are the documents that were at the seminar as well - these are the things you were told at the seminar - these are the documents that were referred to - the laws that were referred to?-- I remember those documents and - that were there at the meeting in ICU - that were brought along to the meeting in ICU.

All right. But one of them, at least, you have told us, was the Powerpoint Presentation from the seminar?-- I think it was the Powerpoint Presentation from the seminar, yes.

Now, incidentally, do you remember when you were acting DON that there was on the wall of the office a summary of the Code

of Conduct - a sort of excerpt from the Code of Conduct document sort of stuck to the wall?-- They are everywhere, so I don't specifically remember that one in that office, but I'm sure it was there.

You know the document I'm speaking of?-- I know the Code of Conduct document, yes.

How long is that? Is it one page?-- The actual Code of Conduct?

No, the document that was on the wall everywhere?-- It was one page.

All right. Returning now to the meeting of 23rd of March 2005, who convened that meeting?-- Dianne Walls rang me and said she wanted to come down and speak to the ICU staff.

Can I put it to you that from the fact that there were documents - remember that we have now clarified the occasion on which you attended that seminar - can I put to you the fact that there were documents referred to at the March 2005 meeting which had been present or referred to at the seminar was a basis for you to deduce that your job was in peril, that you might go to gaol because of what those documents said, rather than anything that was asserted at the meeting? Those documents had been propounded at the ethics seminar and you were told there that you could go to gaol for two years and you could lose your job?-- Mmm.

I'm putting to you that you deduced from what took place at that seminar, what you were told at that seminar, the documents that were produced at that seminar, that the course you had taken in releasing material to Mr Messenger could mean that you might lose your job or even go to gaol?-- It was also mentioned in ICU that day.

Well, I'll come to that, but you say it was, do you?-- Yes, it was.

So, you are saying that Mr Leck actually said you or anyone else or someone else was going to gaol?-- No, what was actually said was that these are very serious - well, what Mr Leck said was that he was appalled at the lack of natural justice that was given to this particular surgeon and I think it may have even been Dianne Walls who talked about what the consequences of being found guilty by the CMC could be, which - and then it was said - then it was mentioned, "And this may mean gaol time. This could mean gaol time."

Mmm. Well, thank you for addressing that matter so fairly, because I want you to think very hard about this. It is very important?-- Mmm.

You see, you say in one part of your evidence in Brisbane at page 185 that - line 20, I think it is - it is where the material starts - and the foot of it - sorry, at the top of page 185, you refer to Linda Mulligan, but I think that's just

a slip. She was away and it was Dianne Walls who convened the meeting; that's right?-- Yes.

I appreciate you don't have that in front of you, but accept that from me, if you would. "When Dianne came down, she came down with Mr Leck and we went into the ICU tea room and he was furious with us and he just told us that he - that this was appalling that this doctor of such good high standing should not be accorded natural justice, and how - and he was visibly furious with us and he was so angry and he brought down - he brought down photocopied copies of the Code of Conduct for the Queensland Health and on IRM about what happens to whistle blowers.", and then, further down, Mr Andrews says, "And what did the IRM reveal?" "That we could go to gaol for two years for releasing this information to an unauthorised person and they had the photocopy documents from-----"; do you see what's happened there? You have slipped from "he" to "they" and I think, very fairly, you just a moment ago, in answer to my questions, you were conceding that one might have said something rather than the other?-- Well, they came down together, and they-----

Do you understand my point?-- What you are trying-----

It is very important-----?-- That you are saying that it wasn't Mr Leck that said - was threatening me with gaol, that it was-----

I'm asking you - I'm putting to you that Mr Leck did not threaten you or anyone else with gaol, did not threaten you or anyone else with the loss of their job?-- He did not threaten me with gaol. What he did - what was said was what I already said, that he was-----

COMMISSIONER: Can I pause you there? You told us before what was said. Who said it?-- About the gaol time?

Yes?-- And the consequences of that? I believe it was Dianne Wall who actually said that at that particular time.

MR ASHTON: I see. Because at the foot of page 185, you said, "All I remember is being - just being screamed at and being threatened with gaol."?-- That's right.

Mr Leck didn't scream at you, did he?-- Yes, he did.

To be fair?-- Yes, he did. He yelled at us, yes, he did. He was furious. He did. He did yell at us.

You see, you didn't tell the CMC that. You didn't tell them that he screamed. It is not in your statement. You didn't tell Australian Story that. Can you explain that?-- No.

I see.

COMMISSIONER: When there was a reference to gaol time and other consequences, you think that that was Dianne Wall who said it?-- I think so. That was a day when we - like, it is

very hard for me to remember exactly what happened on that day. We were - we were - I was scared stiff.

Yes?-- And the nurses who were with me, we thought they were coming down to debrief us and to talk to us. We thought they - we didn't know they were coming down to yell at us, and I called in the staff that were involved in Mr Bramich on their days off - they had come in on their days off - and for him to stand there and give us a lecture on the Code of Conduct when for six months or more he had had this complaint from us, it was just - it was just, you know - it was something - it was appalling. It was appalling for me, and I may be wrong about some of these little things, and I'll have to concede that, because I can't remember exactly. When I gave that evidence, I gave it truthfully and honestly how I felt at the time, what I thought at the time, and, you know, I have had a lot of - there has been a lot of water gone under the bridge since then, and I stand to be corrected on these little things. I may be wrong.

Sorry, just going back to that reference to gaol time and so on, let's assume for the moment that it definitely wasn't Mr Leck who said it?-- Yes.

Do you recall Mr Leck saying anything to the contrary - saying, "Look, that's not right. You are not going to go to gaol. It is not an issue of losing your job."?-- No.

D COMMISSIONER VIDER: That was going to be my point. If you had members of the Executive that came to the unit, whoever said that, no other member of the Executive came in and said, "No, that's not right."?-- No.

MR ASHTON: Just on that point, I'm right, aren't I, that Mr Leck was not there for the whole of the meeting?-- No, he was not there for the whole of the meeting.

That's right. So-----

COMMISSIONER: Is it possible-----

MR ASHTON: So, you don't know - and you have told us you don't know who said what, and, please, I started to say - and please understand I don't criticise you for this at all - we completely understand how you must have felt on that occasion - and it is a very fair concession of you to make, that you may stand to be corrected on these things. I respectfully disagree with you when you describe them as little things?-- Yes.

Because they can have a very, very serious implication, you understand, don't you?-- Yes.

So, to take up on the points just made by the Chairman and Commissioner Vider, if you are unsure who said what, then you couldn't possibly acquiesce in the proposition, could you, that Mr Leck should have stopped Dianne Wall saying something?-- No.

Thank you?-- I think - I hope - are the other people that were there at the meeting going to be interviewed on this basis as well to ascertain what and what wasn't said?

COMMISSIONER: You can rely on us to get to the bottom of anything we think is relevant?-- Okay.

MR ASHTON: But, Ms Hoffman, we are not going to take a vote. We really just need to - and may I say again respectfully, you seem to be trying to be eminently fair in these matters. It is just that they are so important-----?-- I know they are important. I know that they are important.

Thank you.

COMMISSIONER: So, let's make sure we understand it anyway. You can't, with any certainty, attribute to Mr Leck the words that you are explaining about-----?-- The words-----

The words about gaol or losing a job or other consequences. You can't say that Mr Leck used those words?-- No.

And you can't say he was necessarily in the room when those words were used?-- No. He may not have been. He may have already left.

MR ASHTON: Thank you, Chairman.

COMMISSIONER: Is there anything else, Mr Ashton?

MR ASHTON: If you are giving me an intimation, then, no.

COMMISSIONER: Mr Ashton, you are extremely experienced. If you feel there's something else you need to pursue, I'm sure you will pursue it.

MR ASHTON: Thanks, Chairman. Can I just, before we leave this meeting, put this to you: that Mr Leck didn't have any documents with him, or you are not sure who brought whatever documents?-- I can't say, Mr Ashton.

Thank you. I have nothing further, thanks, Commissioner.

COMMISSIONER: Thank you, Mr Ashton. Mr Boddice?

MR BODDICE: Thank you, Commissioner.

CROSS-EXAMINATION:

MR BODDICE: Ms Hoffman, my name is David Boddice and I'm counsel for Queensland Health. Can we just go back to some of the matters that you have given evidence in relation to. The first is in respect to the Adverse Event forms?-- Yes.

And the Sentinal Event forms-----

COMMISSIONER: Mr Boddice, I will have to ask you to either move the microphone or speak up or possibly both.

MR BODDICE: See if that helps.

COMMISSIONER: Thank you.

MR BODDICE: As I understand your evidence, you accept that the system that is in place is that any person who is involved in, or witnesses who observe something that would constitute an adverse event or a sentinal event should fill out a form in respect of it?-- Yes.

But as I understand your evidence, there's really two areas that, perhaps, compliance falls down. The first is that there's an assumption sometimes on the part of a person that somebody else is going to fill it in?-- Mmm.

So they don't fill it in; is that the case?-- Yes.

Although, of course, the system is there can be more than one Adverse Event Form, can't there. It is not only that there could be one, or any event, anybody who witnesses it or is involved in it should fill out the Adverse Event Form, shouldn't they?-- Yes.

But what you are just pointing out is one of the reasons why there may not have been forms filled out is that one person assumes that another person-----?-- That they have been generated somewhere else, yes.

And I assume that that other person might also have assumed that the first person was going to fill it out, so, in fact, no form is filled out?-- That's right.

And the second area, as I understand your evidence, is that there may be a perception that by filling out the form, you might get somebody into trouble, in effect, so people are less likely to fill the form out in those circumstances; is that the effect of your evidence?-- That is still the case, yes.

Even though the whole system is premised on the fact that it is not about blame?-- Yes.

It is about trying to get-----?-- Improve.

-----these things filled out so that people can look at the history of these things and putting into effect systems that will prevent it from happening again?-- Yes.

But what you are really saying is that, human nature being what it is, some people might be less inclined to fill it out because they feel that the effect might be that somebody else will get into trouble?-- That's right.

D COMMISSIONER VIDER: Could I just clarify how long the system of filling out and reporting adverse events and sentinal events, in fact, has been in practice? Has that been something that Queensland Health has had as a policy for a number of years, or is that something that has been introduced in more recent time?-- The change has happened in recent times.

What's the change?-- The change was that there was major change in the format. We used to just have, like, the old incident forms and, you know, incident books for different things, and then Queensland Health devised this system where the forms are different and the system is different and - but you can have as many system as you want, but unless someone is making them work, they don't work.

MR BODDICE: And I think the evidence has been that it was February last year - February 2004 that the adverse event form - Sentinal Event Form resulted in this "it is not about blame, it should be filled out by anybody who witnesses it". It is a separate form that then goes into a separate area, in effect, so it can all be collated in the one place; is that your recollection?-- Yes, that's my understanding.

The evidence also was that in - I think it was November last year, there was a change to the effect that previously they would go in and the person there would, in effect, risk assess it, based on what was on the form?-- Yes.

The change in November was that if you recognise that the people who were actually there and saw it are in the best place to risk assess it, so to speak, in terms of it, the form is now one where they do the risk assessment and send the form in with that risk assessment already completed; is that the case?-- Yes.

D COMMISSIONER VIDER: What's the feedback loop for getting some feedback regarding the number of incidents that you might be involved with - or your department might be involved with, et cetera? Is that done at local level?-- I believe it should be done at local level, except I stand to be corrected on this. Sentinal Event Forms should be going straight to the central zone, but I stand to be corrected on that. That's what I was told. The feedback for any Adverse Event or any complaint or any Sentinal Event is - in this hospital - at Bundaberg - is - we never received any feedback at all.

So, at a department meeting level - for example, at an Intensive Care Committee - there would not be a standing item on the agenda where you would either deal with clinical indicators that are pertinent to the Intensive Care Unit or get a report that might be the risk assessment report that would involve adverse outcome reports or sentinal events?-- I think, perhaps, that was something that was going to be done down the track, but we had had a lot of different people in positions looking after the risk - the new risk management and the changes that were going on in the hospital, and it was very disjointed. There was a lot of disjointedness - there's

not such a word as that - a lot of disjointed information coming out, and I think that was one - one of the hardest things is, like, for instance, to find out only last week about the Sentinal Event Form that I put in - that's the only feedback that I have had about that - is last week. I assumed that that Sentinal Event Form - what had happened to it, I assumed, was what I had been told. So, the feedback at the hospital is just appalling about - that's what I say - you can have as many of these systems - and I'm not saying that they aren't great systems and Queensland Health hasn't done a really good job trying to bring these things in, but if they don't work and people don't follow them through and you don't get feedback, then they don't work, and they - and they don't work at this hospital.

MR BODDICE: And as you have fairly indicated, the intention is that that's the process, that it will go through, be investigated and then there will be feedback back in respect of it?-- Yes.

So what you are saying in respect of Bundaberg, your experience has been there has not been that feedback?-- No.

All right. Now, the second thing that you said in your answer was - in respect of the Sentinel Event Form-----?-- Mmm.

-----is your understanding that the difference between the Adverse Event and Sentinel Event Form is that the Adverse Event Form is, of course, investigated within the hospital?-- Yes.

But that your understanding is in the case of the Sentinel Event Form there certainly has to be a notification of that, in fact, outside hospital?-- That's my understanding, yes.

In terms of what investigation may take place, that's a matter for those involved in the process, but the difference of the Sentinel Event is one that should be notified outside the hospital-----?-- Yes.

-----the fact that it has occurred?-- Yes.

I just want to take you to some evidence in relation to patient P34. You've been asked some questions about this evidence before, and you may recall this is the patient who had the oesophagectomy, and you will recall you were asked some questions about your knowledge of Dr Miach's view in respect of the surgery?-- Mmm.

What I wanted to ask you about, when you gave evidence in Brisbane you said - this in relation to - this is at page 40 of the transcript, about line 15, you said - you were asked this question, "What was Dr Miach's attitude to surgery?", and you said, "From what I can recall, Dr Miach was in agreement with the surgery and he was handling the dialysis part of it." Then there was a question, "Right" - and this is from Mr Andrews - and you said, "Because I think that they had come to the conclusion that maybe this patient had a little chance if he was operated on, whereas if he wasn't operated on at all he wouldn't have any chance of survival. So I think at that point Dr Miach was in agreement with that surgery."?-- Mmm.

Now, that suggests that you at least were given what I would call a medical reason why the surgery may have been being performed; that is, with surgery there was a little chance?-- Yes.

Without surgery there was no chance?-- Yes.

Do you recall where you were given - who gave you that information?-- No, I don't recall that. I mean, it was somewhere in the ICU, but I don't recall who gave me that information. I imagine it was one of the doctors involved.

All right. You've also given some evidence in relation to wound dehiscence, and you gave some evidence that Dr Patel had been telling staff not to use certain words-----?-- Yes.

-----one of which was dehiscence. Is that something that you heard, or is that something you had been told by other staff that he was doing?-- No, that's something that I heard the junior doctors when they were in ICU talking around the desk talking about-----

I'm just trying to clarify. So it was something that you were told-----?-- Yes.

-----he had been saying, rather than hearing Dr Patel say it?-- I didn't hear Dr Patel say it, no, but I heard the doctors talking about it.

But in this context you were talking about, for example, a person may go back to theatre and the reason given might be "wound coming away at edges"?-- Mmm.

Now, is that an actual one you've seen or was that just an example you were giving of what might be said rather than wound dehiscence?-- That was an example of what may be said other than that.

I take it there would be a reason why the person is going back to theatre?-- Yes.

All you're simply saying is the word dehiscence may not have been used?-- Yes. I'm not - I would have to go back through all of the charts to see what words were used, but that was an example of what I was trying to get out.

But even in that case, in the case of that example, it would be clear from the point of view of the records that the reason there has been a revisitation to the theatre was that there was some problem with the wound?-- There should be, yeah, that's right.

You have given there "coming away at the edges"?-- Yeah.

Also in relation to wound dehiscence, as I understand it, wound dehiscence can occur for a variety of reasons?-- Yes.

One can be infection?-- Yes.

Another can be technique?-- Yes.

Another can be if the patient is generally unwell?-- Yes.

So they don't heal as well as they might otherwise do?-- Yes.

Depending on the area, even blood supply can have an impact in relation to it?-- Yes.

So might it also be the case that on some occasions that if,

say, the word "infection" is used-----?-- Yes.

-----rather than "dehiscence", that could be also to indicate what is the reason for the wound breakdown. So if it says "wound infection"-----?-- Mmm.

-----rather than "wound dehiscence", that that could be in effect an indication as to the reason as to the wound breakdown?-- That's right. But with - I think I put this - I think it is in my evidence, and in Ms Aylmer's evidence as well, that there seemed to be a lot of wound dehiscences that were occurring that actually weren't related to infection. A lot of them were happening very early in this stay in ICU before they could have become infected, before the wounds would have become infected. So there were - it seemed that Dr Patel's wound dehiscence rates or wound dehiscence episodes weren't necessarily related to infection, that you would - might be able to attribute that in other surgeons.

I wasn't suggesting that, I was simply trying to understand why there might be other words used apart from dehiscence, and so, for example, if the wound breakdown is as a result of infection-----?-- Yes.

-----you might use the word "infection" rather than "wound dehiscence" because that gives an indication of what is really the reason for the breakdown?-- So we are talking generally?

Yes, just generally?-- Yes, okay.

D COMMISSIONER VIDER: But I'm right in clarifying with you that you can have an infection in the wound without having wound dehiscence?-- Exactly.

MR BODDICE: So there may be that difference as to whether, in fact, there's - as Deputy Commissioner Vider has said - there's infection there but you haven't had a breakdown-----?-- Yes.

-----of the wound itself?-- That's right. There's - I mean, a lot of patients too have wound dehiscence and don't necessarily even go back to theatre. Their wounds just get packed and they heal, that's what's called secondary healing, and-----

So that might be, for example - I'm not belittling the nature of dehiscence - but it may be what's called the superficial wound dehiscence?-- Yes, yes.

Because it's not what you have to go back to theatre in respect of?-- Yes.

There's been some breakdown and it might only be a partial one, for example?-- Yes.

Which can be treated by packing and those sorts of things, and, in fact, rectify itself without full surgery?-- Yes.

D COMMISSIONER VIDER: I understand in your earlier evidence today there was an agreed definition in Miller and Keane?-- Yes.

That was the foundation-----?-- Yes.

-----that you used to define an episode of wound dehiscence?-- Yes, from after we got that, yes.

MR BODDICE: That definition actually includes superficial?-- Yes.

And just further on that topic, the ASPIC minutes that you were shown this morning recorded not only that definition but also that there were to be some events instigated to try and ensure that these matters were picked up, and you recall also - I know you weren't at that meeting - but do you recall that, in fact, later in the year there was an expressed resolution, if I can call it that, if that's what they had at those meetings, that an Adverse Event Form should be filled out if there was a wound dehiscence?-- Yes.

Can I take you to the audit seminar, if we can call it that, the Ethical Awareness Seminar?-- Mmm.

You've accepted that that occurred prior to your going to see Mr Leck; that is, it occurred on the 14th of October?-- Mmm.

And you would have seen Exhibit 61, that in fact it was a series of meetings throughout the State where in effect Bundaberg just happened to be in that list of a number of hospitals?-- Yes.

You recall that there were Powerpoint - there was a Powerpoint presentation given at that meeting?-- Yes.

I was going to take you through what those Powerpoints were. Do you have any recollection now in relation to what was on those Powerpoints?-- Only what was - you know, what was written on the leaflet that went around.

Right. Well, I might take you first of all - you said that you were - there was some discussion in relation to what was official misconduct?-- Yes.

And do you recall that what the Powerpoint discussed was how you can have serious misconduct relating to the performance of your duties and you can have conduct which is dishonest or involves a breach of trust or misuse of information?-- Mmm.

Do you recall that?-- Yes.

And that certain official misconduct may be serious enough to be a criminal offence?-- Yes.

And to warrant dismissal?-- Yes.

And do you recall that in the context of discussing official

misconduct, that one of the areas that was discussed was that a breach of section 63 of the Health Services Act - and that's a section that deals with the confidentiality of patient information?-- Mmm.

That a breach of that section is a criminal offence?-- Yes.

So is that the one that you're speaking about when they were speaking about a breach of the Code of Conduct, that they discussed the fact that a breach of section 63 of the Health Services Act, that is to provide confidential patient information, is a serious matter; do you recall that they said that?-- They didn't specify. They - who are you talking about now, sorry?

I'm talking about the Ethical Awareness Seminar?-- Yes. No, I don't remember.

I suggest to you they actually did; that is, that was one of the areas discussed about breach of section 63, that is the provision of confidential patient information-----?-- Yeah.

-----is a serious matter?-- Well, that's right. We're well aware of that.

I have no doubt you are well aware of it, I'm just asking do you recall that's what they actually discussed at the seminar?-- I don't recall it specifically, no, but I'm sure that they would have if that - because it's such an important part of the Code of Conduct.

And do you recall that they also discussed about reporting official misconduct, if you're aware of official misconduct about the need of employees to report that fact?-- Yes, I remember them discussing that.

And that there is an obligation to do so?-- Yes.

And that they discussed in that context it wasn't just things such as breach of confidentiality, but there were also matters such as fraud, assaults, those sorts of matters, that if they occur in the workplace the need for those things to also be reported?-- Yes.

Because that could be misconduct?-- Yes.

And also substance abuse or drug abuse?-- Yes.

If staff members were involved in those matters?-- Yes, yes.

And do you recall that in relation to breach of confidentiality - and I'm suggesting there was one Powerpoint that was specifically on breach of confidentiality; do you recall that?-- No.

And in that context they spoke about what was confidential information, that was medical records and patient information. You don't recall whether they said that, but that's certainly

your understanding?-- That's my understanding, yes.

And that it was an offence if you breached section 63 of the Health Services Act?-- Well, I'm aware of all of these things, but-----

You can't now recall whether they were-----?-- I can't recall the specifics of it all, no.

And that they spoke about exemptions, exceptions in relation to that; for example, if there is the prior consent of the patient to release the information, or if it's in connection with treatments, or, in other words, you giving it to another doctor, another practitioner, and if it's in the course of an investigation, if you are being asked during an investigation in effect to provide information in relation to an investigation, do you recall those exceptions in relation to breach of confidentiality?-- I'm aware of those exceptions but I don't recall that at the meeting.

Do you recall during the Powerpoint they gave an example of what they called "Small Town Scandal", about how it can really impact if this information is released in breach of the Act; do you recall that?-- Can you give me a hint?

That the small town scandal was a situation where two families are living side by side, they're initially close friends and their children are friends, and then they have a falling out and that the wife of one of the families works in the local hospital and in the course of her duties comes into contact with the neighbour's medical records which show that the neighbour has HIV and that that information is given out with the impact, drastic impact obviously on the neighbour who has HIV and an impact on the neighbour's children and the need for them to ultimately leave the town because of the difficulties that they have within the town with that information being given out; do you recall that example being used?-- Actually I don't, no. I don't.

Could it have been given?-- It could have been and I just don't remember it.

And I won't go through every one of them, but there were a lot of slides, weren't there, where they went through and discussed a whole range of different things; do you recall that in the seminar?-- I mean, I recall - I recall the seminar and the things, but maybe I was focusing on the things that were in my head at the time which were-----

I suppose the problem was that for you this came at a point when it was very close to where you were deciding that you were going to go and see Mr Leck?-- Well, I was still trying to work out what was the best way to do it. I think I had already been in consultation with the Union at the time and I was still trying to work out what I should do, what I should do.

And the Union had given you a number of choices such

as-----?-- Yes.

-----going to Director-General, I think you said?-- Yes.

Going to the Health Rights Commission?-- Yes.

And you couldn't recall whether they specifically mentioned also going to CMC, the Crime and Misconduct Commission?-- I don't think they did but I thought they perhaps did. But I don't think they did now.

They had given you those options?-- They had given me those options.

But you had given evidence earlier you were really looking at wanting to do it locally in effect?-- I wanted to try and do the right thing.

And so what I'm saying to you, do you think that perhaps in the context, in the context that you were in at the time of wrestling with what you might do, that perhaps in hearing this seminar that you - that certain bits struck a cord?-- Mmm.

Even though that's not what they were actually saying to you, but you were sort of taking it very personally in the sense of, oh, that could have an impact on me; do you think that's a possibility?-- Probably, yes.

You think it's a probability, do you?-- Probably, yeah.

And do you recall that in the seminar they also spoke about whistleblowers?-- I do recall that.

And that what they spoke about there was under the Whistleblowers' Protection Act, how a whistleblower gets protection, so to speak, do you recall that, that they went through what provides protection for a whistleblower?-- Once again, I don't - I don't recall the specifics of it.

You see, what I'm suggesting to you is in the context of that it was pointed out that under the Act the person is protected because they're making what's called a public interest disclosure, and that is a disclosure of information obviously by a public officer about a misconduct, but it's made to obviously an appropriate entity under the Act. That is, the whistleblower protection works on the basis that the disclosure has occurred to what's called an appropriate entity; do you recall that?-- Look, I don't recall the specifics of it, but I accept that it was discussed there. I just don't recall all of the specifics of it.

And I'm suggesting to you that it was within the context of that, the need for whistleblower protection, that what that required was there had to be disclosure to an appropriate entity, such as the Director-General or a line manager or someone along those lines or the CMC, and that it was in that context that they were saying, for example, the disclosure to your Union won't be protected under the Whistleblowers'

Protection Act?-- Mmm.

Do you recall that?-- No.

But that's a possibility?-- Yes.

That it was in that context about disclosure to the Union that it was talking about the whistleblower protection?-- It may have been.

COMMISSIONER: Your recollection is simply being told that you would have no protection if you went to the Union?-- Yes. Yes.

That you would be breaching your duty of confidence?-- Yes.

And you wouldn't fall within any protection?-- And I had already had an experience of that at the hospital when I was Acting Director of Nursing when I had to attend a District Consultative Forum and a previous Nurse Unit Manager had prepared a business plan to get more staff for the Emergency Department and the business plan had been prepared with the - with the help of the then Director of Nursing and the A/DON and that the DCF - the District Manager - it was brought up at the DCF and the District Manager said that that particular business plan did not have any validity because it hadn't been sanctioned by himself or the - himself. And I was - I was quite - I was quite horrified, because I knew that the person had had a lot of input and a lot of help to do this, to prepare this business plan, and I actually went in twice to Mr Leck to inform him that he had got this wrong. After the District Consultative Forum was over, I went in twice to tell him that this - he had got this wrong and that this - this business proposal had been done with the help of the then DON and A/DON and she - we were in - we were in a Union meeting and we - she was talking about the staffing, this was the NUM at the time in the DEM, and the Union official asked her could she have a copy of the business proposal and she looked at the A/DON and the A/DON nodded her head. The lady gave her a copy and then she was - she got into very serious trouble. So I had already had that experience, so I was - that was already in my mind that particular incident.

MR BODDICE: But what I'm suggesting to you is that in the course of the seminar, the discussion about not giving the information, confidential information to your Union representative was in the context of the discussion of the Whistleblowers' Protection Act and what it requires for you to have whistleblower's protection. Do you recall if that was the context in which it occurred or can't you now recall?-- I can't recall.

All right. And what I'm suggesting to you is likewise in the context of the Whistleblowers' Protection, there was a discussion there in relation to a whistleblower is entitled to be protected under the Act; for example, if anybody attempts a reprisal in relation to it, then that's punishable by a two year gaol term and substantial - or substantial fines?-- For

the person who-----

Attempts the reprisal?-- Attempts the reprisal at the whistleblower?

Yes, at the whistleblower. So I'm suggesting to you the discussion about a two year gaol term came up in the context of whistleblowers and once you're a whistleblower that you were protected under the Act and if anybody attempts to take a reprisal against you, then that person can be guilty of an offence which is punishable by two years' gaol or substantial fines?-- So are you saying that I didn't - that's where I heard it, I didn't it hear it from the meeting we had in ICU, is that what you-----

I'm talking about the audit meeting?-- Yes.

I'm saying in the context of the audit meeting, the discussion about a two year gaol term, I'm saying that discussion came in the context of a discussion of whistleblowers and the protection they have under the Act from reprisal; do you recall whether that was the context?-- No, I don't.

All right. See, I'm only asking you about that actual audit seminar at the moment, that's all I'm asking you about?-- Yeah, okay.

You don't recall that?-- No, I don't.

You gave some evidence earlier that there were occasions you said in the case of Dr Patel that there would be a handover but the notes from surgery wouldn't accord with what you're being told at the handover, and in the evidence that you gave you said this - this is page 75, about line 40. You were asked some questions about separate notes in ICU and you said that the ICU nurses do have separate notes?-- Mmm.

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

Now, what I wanted to ask you is you are not conveying by that that you would then write incorrect notes in ICU, are you?-- No, what we would write in ICU is what actually happened, but sometimes you had to read between the lines. Like, for instance, you know you would have to look at how much - how much inotropic drug support the patients was requiring, how much oxygen the patient was requiring, all of those sorts of things according to - like their blood pressure might have looked stable, but if they're on huge amounts of Adrenaline, or whatever, to keep their blood pressure up, that's not stable. So that's what I was saying, that he would write

"stable" in his notes, but when you looked at the ICU notes, and you had to look very carefully and know where to look, that that wasn't the case.

Yes. So what you are really saying is that the patient might appear stable because they're being supported, in effect, by drugs?-- Yes.

So Dr Patel would write "stable" but, in fact, from your point of view, you are looking at - well, the stability is there because of drugs?-- Yes, if the drugs weren't there the patient would be dead.

What I'm suggesting, you weren't by that comment - that statement you made suggesting that when you said "marry the records up", that you in ICU would then write incorrect notes?-- No.

No. So certainly a person who's going to the ICU notes after the patient has been transferred from surgery-----?-- Yes.

-----that would be giving an accurate picture of what was the position of the patient?-- Yes, but ICU nurses' notes are very different to what the doctors' write. The ICU nurses' notes are quite different. Especially they wouldn't mention anything necessarily about what had happened in theatre. You know, they probably have what operation the patient had or - but, you know, it probably wouldn't say anything else.

No, but what it would say is accurate and that is the state of the patient at the time in ICU?-- At that particular time, exactly.

You are not suggesting, for example, the doctors in ICU weren't writing accurate notes, are you?-- No.

You are not suggesting that?-- No, I'm not suggesting that.

COMMISSIONER: I think your point is really when you talk about marrying them up, you have got to look at the surgical notes to see what the surgery was supposed to be-----?-- Yes.

-----and how Dr Patel described the outcome, and put beside that your ICU nursing notes?-- Yes.

And comparing one with the other, the statistical information, the temperature, pulse, medication, and so on and so forth, in the nursing notes would give the lie to what appeared in the surgery notes?-- Yes.

That's the sort of marrying up you are talking about?-- That's what I am talking about.

MR BODDICE: Could I take you now to patient P44. That was the-----

COMMISSIONER: Before you do, Mr Boddice, how much longer do you expect-----

MR BODDICE: Not much longer at all actually.

COMMISSIONER: Keep going then.

MR BODDICE: Patient P44, that was the patient who you spoke about and the ventilator being turned off by Dr Carter?-- Yes.

And you have given evidence today that that's not something you have any personal knowledge about?-- I was not present, no.

So you don't know whether that - the previous evidence you gave where Dr Carter went behind the curtain-----?-- That's - that is taken from the statement given to me by-----

I understand that. You are the senior-----?-- I was not there, no.

You are not saying you know that that's factually correct, you are simply recording what somebody else told you?-- Yes.

I take it that you don't know, for example, what's contained in the notes for that patient, about discussions that were had with the family as to whether the likes of what can be turned off?-- No, I am. I have read those notes.

And you know there are notes there that-----?-- Yes.

-----speak about a number of discussions?-- Yes. I'm aware of those notes, yes.

You are-----?-- Yes.

-----aware that the note the notes record there were a number of discussions-----?-- Yes.

-----with the-----?-- Yes.

-----family?-- Yes.

In relation to the turning off of-----?-- Yes.

-----the life support?-- Yes, and I just - can I just make something clear here? I don't - I don't personally have an issue with discontinuing ventilation or anything like that when it is done with the patient's best wishes at heart or with the family's agreement, but what was going on here was that it was very - it was very openly and verbally being discussed that a bed was being made for a patient in ICU by turning off the ventilator, and they were - they were the instructions that had been left. That was the issue that I was - that I was bringing up, not the fact that the - you know, that life - that the ventilator was discontinued. That wasn't my issue. My issue was that a ventilator isn't discontinued, a patient is not turned off a ventilator to make a bed for another patient.

Well, your-----?-- That's-----

You are referring to what was reported to you about what Dr Patel was saying?-- Yes.

But what I am seeking to make the point in fairness to Dr Carter is that you don't know if Dr Carter had independently made his own decision based on the various discussions he's had with the family about turning off the life support?-- Yes. Even if he had independently made that decision it's not usually done without discussion with the people at the bed - you know, the nurses - the nursing staff, and other people at the bedside.

But you're saying that the only basis upon which you say that wasn't discussed with the nurse is because it had been reported to you-----?-- Yes.

-----that events occurred in a certain way?-- Yes.

But you quite fairly concede that really it's a matter to talk to that nurse?-- Yes.

And Dr Carter?-- Yes.

And it may be that your position is totally wrong with respect to that?-- Well, it may be, yes.

Yes. Thank you.

D COMMISSIONER VIDER: Just one question for clarification. Does it happen very often that in the ICU at Bundaberg a ventilator is turned off and life support is discontinued?-- To make a bed for another patient?

No, no, no, no, no. Not at all. Just when the clinical decision has been made for the right reasons and there is agreement following clinical discussion and discussion with the family. I'm just asking about the incidence-----?-- Yes.

-----of turning off light support?-- I think it's probably done there as much as what it's done - it's been my experience is that it occurs elsewhere, but it usually occurs within the realm of - you know, doing the brain death test first or other sorts of tests, whether they be - you know, CT scans and-----

Yes?-- -----waiting until you see what response the patient has, all of those sorts of things, you know, long discussions with the family, patients that have advanced health directives, NFR orders, all of those things. It's done in conjunction, not like what - not with this particular incident.

D COMMISSIONER EDWARDS: Protocols are in place for that?-- Sorry, sir?

Protocols are in place for that?-- There's - there is - there's the brain death protocol, yes, which we follow, and there, of course, is - yeah, we have got a protocol for NFR patients, yes.

COMMISSIONER: Mr Allen, how long are you likely to be in re-examination?

MR ALLEN: No time at all at this stage, thank you, Commissioner.

COMMISSIONER: Mr Andrews?

MR ANDREWS: Five minutes, Commissioner.

COMMISSIONER: All right. I have a few questions, really arising out of Mr Morrison's cross-examination last Thursday. You will recall that Mr Morrison asked you questions about what he referred to as being in the old language matron's rounds and whether the Director of Nursing conducting rounds of that nature. When you were Acting Director of Nursing did you conduct regular rounds?-- Yes.

And what has been your experience with the different Directors of Nursing that you have acted under?-- That - that Directors of Nursing who do rounds know what's going on in the hospital, that they know what's going on in the unit, that you build up a rapport with them, a better - easier rapport with them so that you can feel that you can go to them easily - you know, easily, that you are supported by them because they are seeing

things on a daily or second daily basis. The other staff know who they are and they can - they know what they are talking about and talking to. They feel like they are part of the team. I personally feel it's very important to have that support and to have that visibility, and also I think that that person then also is much more aware of what's going on in that unit, just by the very fact that they are in there, they would see that patient and think, "Why's that patient still there?", or why - you know, that sort of thing. They - on the - by the very fact that they actually do the rounds, they see what's happening, what's going on.

And do you feel the same way in relation to a Medical Superintendent or Director of Medical Services doing rounds?-- I think it's different for the - different for the - for them, because - I'm not - I'm not a doctor, so I don't know how the doctors would feel about them. It's nice to be able to put a name to a face and it's nice to feel - to know that if you had an issue that you could take it to someone, if you had that rapport. So I think that that's important. But the number of times that you would actually have to go to a medical superintendent is - is not very often. So, I don't - I certainly don't think it's as important as what it is for the - for the nurse - for the nursing side of it, being a nurse.

We have heard a fair bit of evidence about the so-called Executive and the, as it were, the hospital buerocracy, the nonclinical staff. Can you give us an idea of how many people we are talking about? We have heard of a Director of Nursing and an A/DON, Assistant Director of Nursing?-- Yes.

And do they share a secretary or-----?-- No. The Assistant Director of Nursing doesn't have a secretary. She has a separate office on the ground floor. She doesn't - she's not with - she's not in the Executive area.

All right. Well, who's in the Executive area?-- The Medical Director, Director of Medical Services.

Yes?-- The Director of Nursing.

Yes?-- The Director of Community Services.

Yes?-- The District Manager.

Yes?-- And the Director of Corporate Services.

Yes?-- And then I think they have four secretaries.

Amongst those five people?-- Yes.

Right. Is that the entire Executive suite, as it were?-- Yes. That's - that's in that area, yes.

All right.

D COMMISSIONER VIDER: Can I just ask-----

COMMISSIONER: Yes. Please go ahead. I was going to go on with something else.

D COMMISSIONER VIDER: Mine's not connected with that. It's another point all together.

COMMISSIONER: Well, the thing I was going to ask is Mr Morrison pressed you a fair deal with the words you reported to Mrs Mulligan, that Dr Patel was clinically unsound, and that phrase came up again and again, "clinically unsound". Is that a technical expression or is it just - just a phrase that he was using?-- I think it's just a phrase he was using.

Right?-- I think - I think I used clinically incompetent when I was referring to him.

It's just from the questions it sounded as if he was - perhaps you should have alerted Mrs Mulligan to the fact that there was clinical unsoundness at an earlier point in time, or something like that, but that's not a technical standard, or something like that-----?-- No.

-----that's applied?-- No.

You go ahead with your question.

D COMMISSIONER VIDER: Something that you were talking about today, I think, triggered this question in me. Coroner's cases, are they uncommon?-- They are uncommon here.

Yes?-- And that was another area where - when all this was going on I couldn't - I couldn't understand why it wasn't being picked up there either, because it seemed - it just seemed like every - every step of the way things weren't being done properly, and there were very few - very few Coroner's cases, and often we used to have - the nursing staff - I am talking about in ICU - used to have to literally fight to make sure that the patients were - were Coroner's cases, and there's several examples, you know, where the patients weren't referred to the Coroner and they - and they should have been, and that was one of the - you know, when I was - when I was trying to figure out after Mr Bramich died, when I was trying to figure out what I could probably do to get someone to listen, that is when I rang the Coroner, Acting Coroner here in Bundaberg, and he voiced some concerns to me on the telephone about what he thought was going on at the hospital, but he didn't have any-----

Because the directives under the Act are quite clear?-- Yes, yes.

What I was going to ask you was that generally in clinical cases where there's a death of a patient-----?-- Yes.

-----that is going to involve the Coroner, and staff are required to provide statements-----?-- Yes.

-----to the Coroner for that. That in itself is usually a difficulty-----?-- Yes.

-----for staff?-- Yes.

That has a high emotional response as well as an overwhelming clinical responsibility. Given that it doesn't happen all that often in Bundaberg, I'm wondering if you could tell me what sort of support the staff in the Intensive Care Unit got regarding the preparation of those statements? I don't mean necessarily support in writing in statement, you need to sit down and write the statement as it is your record-----?-- Mmm-hmm.

-----and recollection of events, but I'm wondering what support you might have got from the Executive, from the Director of Nursing, the Director of Medical Services. They would have known it was a Coroner's case. They would have known the procedure that followed. You, as the NUM might have been responsible for putting them all together, but did at any time people come to the unit and give you any feedback, support, comment, whatever, on the statement?-- No. The union gave us some paperwork on how to fill out the - how to fill out a - prepare a statement, and they - the union's lawyer checked each one of our statements for - for Mr Bramich, after the death of Mr Bramich before we handed them in.

But it's not the union to whom you are accountable for your professional activity?-- No, no. They were the only ones who gave us any guidance in relation to making a statement. We did try and access the Employee Assistance Scheme for counselling and that for that sort of help, but at that period of time they couldn't give us any help because they were short staffed themselves.

And then my next question will be when the Coroner's report is available, do you get a notification that that has come back so that you can all see what the findings-----?-- No. We have to - we have to sort of get - takes a long time.

Yes?-- And we have to remember that we are looking out for that and request the chart and look at the - look at the post-mortem results and that sort of thing ourselves. I don't think I have ever seen a proper Coroner's report here. I have seen the autopsy results of some patients but not a proper Coroner's report.

But you do get the autopsy reports, so you have got some information?-- Yes. Yes. There was something else I just wanted to clarify about the clinical indicators. With the clinical indicators that we did, because so many patients were transferred out, you know, with readmissions within 72 hours-----

Yes?-- -----and/or transferred to another ward, because a lot of them were transferred out to Brisbane-----

Yes?-- -----or - you know, or died, those - those figures were not necessarily probably right as well, plus the fact that we are a combined ICU/CCU unit.

Then, if you wished, you could then describe your own clinical indicator?-- Yes.

That would put a criteria down that would allow you to account for patients who were transferred out?-- Yes.

Which might make your unit a little bit different but it might be able to let you demonstrate that you stick within the level 1 classification-----?-- Yeah.

-----within which you have been defined?-- Mmm.

The other thing is do you keep the clinical indicators? That's a list of unplanned return to operating theatre from the intensive care. You keep that? I know theatre keep it, but you would keep that?-- No, we don't. No. But that's probably one that - that we should - that we should start keeping. And one more thing I would like to bring up too is - you know, there was that perception that went around that the ICU nurses were lazy and that Dr Patel was whipping them into shape, and I have just got some figures that I would like to give to you so you can see the number of overtime hours those nurses did when he was here to cater for his patients, and if they weren't indicators to the Executive that something - you know, was going on in the hospital, I don't know what else really could have been. So, I'd like to give them to you.

COMMISSIONER: You have those figures available now?-- Yes, I do.

Are they in writing?-- Yes. Yes.

Perhaps you can put them up on the screen?-- Can you just go back up to the top for me there, please? So, if you just go down to - the eighth row there, you will see, "Ventilator Tubed Hours."

D COMMISSIONER VIDER: Yes?-- They were our norm. Then if you go along to just after Dr Patel's started, and we go up to, like, 228, 401, 648 hours, from a norm with around - well, between 100, I'd say, and 250 hours that were normal, and then just below that we looked at - we look at retrieved patients, retrieved ICU patients, retrieved CCU patients, how many of them were actually being retrieved out as well. And if you can go to the next unit and you can - you can just see there quite clearly how many more ventilated hours there were over that - over that year. And then the next year is - the next year there's even more. If you look particularly around - obviously July and August 2004/2005 735 hours and 812 hours. The small numbers, where there was 85 and 73, are after he'd left. They were reflective of when Dr Patel was on holiday and after he had left.

COMMISSIONER: That's very useful. I will tender that myself and mark it as Exhibit 93. That's the - can I just call it ICU statistics?

ADMITTED AND MARKED "EXHIBIT 93"

D COMMISSIONER VIDER: Who collects those statistics?-- I do.

They come out of your roster?-- They - they come out of - I have got a book and I add them up manually.

D COMMISSIONER EDWARDS: That's a system you set up to give this information?-- Yes. It was a system I set up when I - when I started working there. I was to look at all sorts of things and just so that I had some sort of stats to back me up about if I needed extra staff and things like that. So, yeah.

Can I follow it up? It seems to me that there are enormous demands placed upon you as the Nurse Unit Manager - I think that's your term?-- Yes.

In filling out forms, putting statistics, giving reports, whereas your expertise is in the care of patients. Could you give us any indication of the amount of time you spent in that so-called clerical administrative work relative to hands-on patient care and what assistance do you have to reduce that amount of administrative work?-- We have been fighting probably now for about three years to get some more clerical staffing. We have two hours of clerical support a day in ICU.

Two a day?-- Two hours, yes. I spend the majority of my time doing clerical work and things like that that have nothing to do with ICU care, including, and I don't know if you are aware of the ESP, rostering system, Ms Vider, that's come out, which is phenomenally time-consuming. It can take - where you can do a roster manually in - you know, four hours, this can take you days to do, because you have to plot it all into the computer and everything like that, and I think that whilst I'd say that we would probably all agree that we have been fairly well educated and prepared to take on these extra roles as cost centre managers and things like that, we have never been given any extra clerical support to carry those tasks out, and it also has meant that it's left the nurses on the floor short of your time as well. So, you are often having to juggle - juggle a lot of things, and a lot of people just have - you know, just find it too stressful, too difficult, because a lot of other things are expected of us - of us as well with - you, know, quality - improvement in quality management and roster - you know, all the different rostering systems and - you know.

D COMMISSIONER VIDER: Given the statistical - sorry.

COMMISSIONER EDWARDS: That's all right.

D COMMISSIONER VIDER: Given information that's just been admitted, there's a fair trend there that would demonstrate the amount of hours and the increase in those hours. What happens with that? Is that report taken somewhere?-- Every month-----

Yes?-- -----when we put in our budgetary report-----

Yes?-- -----we put in ventilator hours and what's caused - you know what's caused it and that's - so every month the budget report would go to the district - the Director of Nursing and then I - and then it's discussed at the Finance Meeting with the District Manager as well. So, those overtime - those hours, ventilator hours and things like that, are reported on a monthly basis and including - I always put in things like retrievals, deaths, any - you know, any adverse events that have happened.

Given that we have heard evidence that the - I forget the title for it, for the elective surgery weightings or whatever it is, where you gain points?-- The weighted separations?

Yes, by doing extra surgery, that was a revenue earner for the Bundaberg Base Hospital, but when you consistently have overtime hours at that level, were you given more staff out of that extra revenue that was generated that would enable you to care for those patients so that your staff were not always doing overtime at that level because you had more staff?-- No. We were never given any more staff. We had to - we had to provide the staffing from within our own establishment, which meant that the nurses were consistently coming in on their days off, on their long service leave, on their holidays consistently.

Because the budget was never adjusted as in-----?-- Not to give us permanent staff. We had an overtime budget.

Yes?-- We also had an overtime budget, but we have never been given extra staffing. I think, too, like because of our regional area there's no agency here.

No?-- And our statistics still show we were sometimes only - even when we are really busy, because of fluctuations we were still maybe overall for the month - so only 75 per cent or whatever occupied. But in saying that, we did - we asked - we did ask for extra staff and - you know, did try and do - try and be more active and asking the doctors to - you know, not admit, if it was possible, another ventilated patient until we had the last one out to give the staff a rest, because the staff over the last three years, two years have been - you know, carrying the burden of this and quite uncomplainingly, really, and so when you hear someone like Dr Malloy, you know, say that the nurses were lazy in ICU when they have been working - you know, nonstop-----

Have you had access to TOIL as well?-- To TOIL? TOIL, yes. TOIL mainly was only - like, if they came in on their days off

for in-services and things like that I would give them TOIL. But there was no - like, reverse TOIL system. If they were quiet they would - they were deployed to the ward, which was another - of course-----

So you didn't have flexibility in the rostering?-- No. That was one thing that I was - that I was trying to do, to got a reverse TOIL system. We did bring in 12 hour shifts, which the staff really loved and that enabled us - actually it enabled us to continue to look after Dr Patel's patients or the more - the more ventilated patients that we had because they have much more days off. So, they could do - they could do a lot - lot more overtime. Not that that was the reason for bringing in the 12 hour shifts.

I have just one curiosity question. Do you have a biomedical engineer? Who maintained your ventilators?-- No, we don't. We have the Queensland Health people that came around, come around, BEHTS, but all of the - all of the maintaining of the equipment in terms of setting up the ventilators, setting up everything like that belongs to the nurses as well as doing - as well as the pharmacy. We don't have a pharmacist who comes around, so the nurses do the pharmacy, the nurses - the stores have just started being done by stores. The nurses did the stores up until then. The nurses maintained all of the equipment - all of the equipment as well as trying - you know, maintain their skills and attend in-services and things like that.

It's called multi-skilling.

D COMMISSIONER EDWARDS: All of your disposable equipment and all those things are all your responsibility?-- Yes.

MR DIEHM: Commissioner, there were just two brief matters that arise out of the extra matters that Ms Hoffman has raised.

COMMISSIONER: Certainly, Mr Diehm.

FURTHER CROSS-EXAMINATION:

MR DIEHM: Thank you. Ms Hoffman, can you have a look at this document? It can be put on the screen, please. Thank you. I think I'm right in supposing that these haven't been the subject of exhibits or part of your statement before, the documents I am about to show you, but that one is, I suggest to you, an e-mail from Dr Keating dated obviously the 25th of October 2004 making an inquiry of you regarding some breakdown of the issues underlying the increase in hours involved in the ICU?-- Yes.

Thank you. And if that can be removed from the screen. If I can then show you the next document which I will suggest to you is your response to Dr Keating. It's a bundle of documents. I will show you your e-mail at that point on the screen first. It is your response to Dr Keating dated the 1st of November 2004, and attached to it were a number of documents that were the breakdown that you refer to in your e-mail, the statistical analysis of patients. Do you recall that document?-- Yes, I do.

So that is your response to Dr Keating?-- Yes.

I won't go through, in the interests of time, all of the individual documents that were attached to it, but I will ask them to be shown to you in the witness-box. There's something I need to clarify with you over them. So if the bundle with Ms Hoffman's reply can be shown physically to Ms Hoffman? I want to ask you about, Ms Hoffman, is that you will see when you look at them that there are a number of handwritten notes scribbled over the - over the documents, including some further analysis of the figures that you have provided. The handwritten notes are not yours, are they?-- No.

Would you accept they are Dr Keating's?-- I accept that they are Dr Keating's.

Yes. Does it look like his writing?-- I have never seen Dr Keating's writing.

All right. Thank you. In any event, it's not yours but what you provided is the typed information?-- Yes.

If I can tender those two documents.

COMMISSIONER: Yes, thank you. Exhibit 94 will comprise the email from Dr Keating to Ms Hoffman, and I think also Dr Carter, of the 25th of October 2004 and the reply from Ms Hoffman to Dr Keating dated the 1st of November 2004. They will collectively be marked as Exhibit 94.

ADMITTED AND MARKED "EXHIBIT 94"

MR DIEHM: Thank you, Commissioner. That's all I had.

COMMISSIONER: Has anyone, including Mr Allen, got any questions arising out of questions from the bench?

MR ALLEN: Just one, Commissioner.

COMMISSIONER: Yes.

RE-EXAMINATION:

MR ALLEN: You told the Commissioner that when you were the Acting Director of Nursing you made it your practice to do rounds?-- Yes.

And you spoke about the advantages of that practice as you see them?-- Yes.

How much time would that take out of your day to do rounds?-- It depends how long you talk, but not very long. You could - Mrs Goodman used to do them and be back in the office by - at 9 o'clock. An hour, if - an hour. But I mean, you could spend five hours doing them as well if you wanted to chat, but-----

Generally speaking about an hour?-- Generally speaking just probably an hour, because you're doing - the A/DON is doing one floor and you're doing the other floor, so you're not doing the whole hospital. You're only doing the whole hospital every second day, and as Ms Vider said, sometimes it wasn't just necessarily the fact that you could see the person, it was just that because you got to know them, you built up a rapport with them so that you knew that they were there and would support you if you needed them.

Yes. I expect that at least on some occasions you would end up dealing with matters during that period of time that otherwise you would have had to have nursing staff coming away from there wards up to see you?-- Yes. Because sometimes the things that you just wanted to run by the person were so small

they weren't worth making an appointment about, but you just wanted someone who was older and wiser or whatever to just give you a little bit of advice on them. They may have just been quite trivial and solved in five minutes - less, but you wouldn't make an appointment to go and see them for it because it wasn't worth it. So the things that you did tend to make an appointment to go and see were the more serious things or things that were - maybe had even got out of control because, you know, you hadn't had that access.

I don't know if you're able to tell us, the person who is acting as Director of Nursing now, does that person do rounds?-- Yes, she does. She does rounds. We see her nearly - we see her every day, yes.

Is that an improvement on the situation as it existed with Ms Mulligan?-- Oh, it's a vast improvement, just in terms of accessibility and the ability - yes, accessibility and support, knows very much what goes on. I was told by my staff on Sunday they visited the unit - her and the District Manager visited the unit because they just saw on the documents that go around by the bed manager every night how busy it was, so they dropped in to see if they were all right on the Sunday afternoon. My staff have commented on the fact that they know these people that have come in for shorter periods of time since this has started much more than what they've known the people that have been there for the last few years.

What's your perception at this stage - I don't know if you were here when I asked a similar question of Ms White in relation to theatres, but what is the situation now in relation to staffing levels for the ICU?-- Staffing levels for the ICU probably - we need to see - there are certain things that have happened. I mean, Dr Patel has left, the Friendly Society Hospital has opened a high dependency unit - that's the private hospital in town - which has taken a load off cardiac patients from us. There's a few things that we need to look at the trending of in the next - you know, next - by the - towards the end of the year to see how the staffing will be affected, but I mean, they're having busy times like they did on the weekend, but that's normal for an ICU to have busy times and slow times.

Okay. So there's going to be a bit of a settling-in process until you get a very reliable picture as to the staffing resources and their adequacy for the ICU?-- Yes.

Okay?-- Yes.

Thank you.

COMMISSIONER: Thank you.

WITNESS: There's just one more thing, sorry - I keep having them - but I was thinking about the incident reporting system.

COMMISSIONER: Yes?-- And I was thinking about how it worked when I was in Saudi Arabia with the American system, and they

actually have like a central point where you put in your complaint and it actually goes - say you did it by the computer, and it actually goes out to somewhere and then it comes back to that - that person registers it and then it comes back to the hospital, and I just thought - and I have talked this over with a few of my colleagues over the weekend and we just thought about how much better an idea or a system that would be because it's - a complaint or whatever has already been lodged elsewhere and then it comes - and then it's up to the person that it comes back to to deal with it. So it doesn't get lost in that big black hole and there's less of a chance for it to be shoved under whatever or whatever - falsified or whatever, because the onus is on that person that it comes back to to make sure that it's dealt with or-----

You're talking really about a central, state-wide bureau that records all of the complaints-----?-- Yes.

-----and incident reports and Sentinel Event Reports and everything?-- Yes, and then we'd have a better idea too about things like the clinical indicators and things like that, but if it actually went to a central point first and then came back to the originating hospital, I think that would be a really good idea.

All right. That really reminds me - I'm not sure whether you are aware that the Commission of Inquiry on Friday released a number of discussion papers-----?-- Yes.

-----and there will be some more coming up in due course. You, of course, would be very welcome to provide any feedback - not as part of your evidence, but by way of submission. I imagine at the end of the proceedings Mr Allen will be making submissions on behalf of the QNU, and you may be contributing to that yourself, but if separately, either through Mr Allen or privately, you want to put to us any submission responding to the points raised in those discussion papers, we'd be very pleased to hear what you have to say?-- Thank you.

Mr Andrews?

MR ANDREWS: Thank you.

RE-EXAMINATION:

MR ANDREWS: Ms Hoffman, with one exception I have only a few questions, and they relate to things I didn't follow from answers you have given to cross-examiners, and that exception has to do with the ASPIC clinical forum that you, with few exceptions, attended almost every month. Were you aware that for that forum there exists a document headed "Terms of Reference"?-- Yes.

And were you aware that within the Terms of Reference under a heading "Meetings" there was a requirement for a pre-set agenda to be distributed a week prior to each meeting?-- Yes.

And that the Terms of Reference required that that agenda would consist of a number of things. They go into a second page, but I'll ask you to look at the items that I've indicated with a highlighter at the bottom of this particular page. You will observe that I've indicated "Adverse Events" and "Complaints". As I look at that particular document which is on the monitor, there was, on its last page, something that shows that it was reviewed date October 2003, next review date October 2004, which suggests to me that it was created in about October 2003 or perhaps even earlier. The reason I'm drawing it to your attention is that when I look at the minutes of the meetings of the ASPIC forum for each month, there is a section for standing agenda items, and I think with the exception of one meeting about as early as March 2003, nowhere ever is there a standing agenda item appearing for either complaints or-----?-- Adverse-----

Adverse incidents. Are you able to tell me - do you know why it was never included?-- I don't know why it was never included, but probably - it was probably the feedback issue, that we weren't getting any feedback back on these things, that they probably weren't put on there, and you would have to - like, if you had put in - if you were the person who had put in the adverse event you would have to know about that yourself, so I don't-----

Well, before each meeting there would be an agenda circulated, and not even on the agenda did there seem to appear either complaints or adverse incidents as a standing agenda item for discussion. Are you able to inform us why it didn't appear on the agenda despite the Terms of Reference?-- No, I don't - I can't explain it.

Thank you. I tender the Terms of Reference, Commissioner.

COMMISSIONER: Exhibit 95 will be the ASPIC Terms of Reference.

ADMITTED AND MARKED "EXHIBIT 95"

MR ANDREWS: Ms Hoffman, Exhibit 84 was put before you during, I think it was probably Mr Morrison's cross-examination. It is a record of a meeting held on 8 April 2004. Would you look, please, at this page which bears two items with a highlighting. It's the lower item which I'd like you to look at. At that meeting it seems that it was agreed that every attempt for Level 3s to have access to D/DONs on urgent matters on the same day would be made. Do you recall after that particular date how that operated in practice? Were you able to - when you felt you had an urgent matter, were you

able to obtain access within 24 hours?-- I didn't feel - I didn't find that, no.

You advised that really it was a matter for the discretion of the Director of Nursing whether that person did rounds, and Ms Mulligan wasn't to be criticised for the fact that she didn't do rounds. Is it your opinion that from your own point of view you'd find it easier to communicate with the Director of Nursing if that person were to do rounds?-- Yes.

And from your own point of view, do you regard it as important for you that you have an opportunity to see a Director of Nursing on a daily basis?-- If not daily, you know, at least weekly or, you know, biweekly or even if - more frequently. I mean, certainly the more frequently that you see them the better it is.

You observed this morning that an anaesthetist is expected to make notes-----

COMMISSIONER: Sorry, Mr Andrews, just while that's on screen, I wonder if we can go back to the first page.

MR ANDREWS: Certainly, Commissioner.

COMMISSIONER: There's a highlighted section there as well towards - yes, it's just this point where Ms Mulligan asked the meeting to "consider how we as nurse leaders think of ourselves as a group and how the rest of the organisation view us". Did anyone say in that context, "Yes, we'd like to see you on the clinical floor. We'd like to see you doing rounds, or if not doing rounds, at least coming to visit us in the work space from time to time."?-- I think that was really early on. That may be one of the first meetings, so we probably didn't realise that she wasn't going to do rounds then.

It doesn't have to be rounds in the traditional, Sir Lancelot-----?-- Old-fashioned way.

-----old-fashioned way with a group of 20 students trailing after them?-- No.

You just want to see the-----?-- Just want to - yeah, just want to see our leaders. This is one of the things that we discussed through this whole incident is where were our nurse leaders when we needed them? Where were they? We've got two that belong to the government - well, belong to the government, but two that are employed - I'm not sure who they're employed by, but we have two nurse leaders - Ms Vider might be able to help me out - Sue Norrie and a new one, Jillian Jeffries. In this whole situation, the whole thing that's gone on with nurses and this situation with Dr Patel, we've not seen any nurse leaders, and I'd like to know where are our nurse leaders, and Linda herself has stated that she didn't have one Level 3 that she could rely upon to make a decent decision. This whatever you want - this highlighted area here, our professionalism - where is our professionalism?

I feel that it doesn't exist at the moment within nursing, and it's - I think a lot of it has got to do with how we're enabled and how we're supported.

Would you say that the people who have really demonstrated professionalism are the people in the clinical areas?-- Yes, they are the only people throughout this situation really that have demonstrated professionalism. They've continued to care for their patients. They're - yes, they are. And, you know, I hate to say it, because this has never been my view previously, but the other people that have displayed great professionalism to me and my colleagues are the Nurses' Union. I mean, they have been our nurse leaders for the last six months, and that's a hard - that's a hard thing to accept, that we have these brilliant people out there, these brilliant nurses and we don't know where they are.

D COMMISSIONER VIDER: Following on from that, would your observation then be that one of the consequences - although I don't want to just put it down as a consequence, but the observation could be made that now, the way the career structure has played out, that level that's missing. Once upon a time there were deputies around and that level went as things got restructured. That was done for a good reason. But there's no mentoring now that's readily available?-- That's exactly right, yes. There's no mentoring, and I think that's partly where you look for the support - when you're saying that you want to see people on these rounds - and it makes me sound like I'm one of those real Florence Nightingale type nurses, but that's not what it's about-----

Flo went to bed for six years, so you're definitely not one of her followers?-- So, you know, it's that little bit of mentoring that you get every day. I mean, doctors don't - doctors work, continue to work. They continue to give - directors continue to give anaesthetics and that sort of thing. I mean, they continue to work on the floor at the grass roots, if you know what I mean, but I think that as nurses we - as nurses we've long been known to eat our young. That's what they say about us, that we eat our young instead of enabling them, and doctors stick together through thick and thin, as we've seen, and we have to change that. We have to change this whole structure so that instead of eating our young we enable them, and we enable them to be the best they can instead of trying to disable them.

And then if you take up the Commissioner's suggestion that you might respond to some of the discussion papers that have been released, you might give some thought to that mentoring and how you think that could be progressed for the professional development and support of the nurse practitioner?-- Yes.

I use that term globally, not specifically?-- When all this started I got many letters - I've got a big box at home of letters from people congratulating me on what I've done, and a lot of them are signed "an old nurse" or "an old RN", and you can see that they've been through what I've been through and they haven't been - you know, they haven't had any success, but they know what it feels like, and I think that's a very, very sad thing.

COMMISSIONER: Mr Andrews?

MR ANDREWS: Let me change the topic. Miss Hoffman, this morning Mr Harper was asking you - Mr Harper for the patients - was asking you who were the persons who would fill in notes and you observed that surgeons would be expected to or you might expect a junior doctor to do so. It was in that context that you were asked whether an anaesthetist would be expected to make notes in a chart, and you said, "yes", and I wondered whether you were speaking about the anaesthetist who works in ICU or the anaesthetist who would be working in the operating theatre?-- The anaesthetist who works in the operating theatre usually works from an anaesthetic sheet, so they would just fill in the sheet, and if something untoward happened or something unusual happened, they might write in the notes as well. Say a patient had a complication as well, they might write in the notes as well. The anaesthetist who works in the Intensive Care Unit would write in the progress notes, just normally as - on a day-to-day basis, or more than that.

You were speaking also today about the elderly lady for whom Dr Strahan arranged a transfer to Brisbane as a medical patient. You explained that she was a medical patient and Dr Strahan arranged for a transfer of her as a medical patient. I wasn't sure that there was anything irregular about that?-- She had cancer of the oesophagus and Dr Patel was wanting to operate on her, and Dr Strahan didn't want him to operate on her, so that's why. Instead of coming in surgically like she normally would have, he admitted her medically and was doing a medical to medical transfer.

So, normally Dr Strahan would have admitted her as a surgical patient?-- She would have been admitted as a surgical patient, yes.

COMMISSIONER: A surgeon would have admitted her as a surgical patient?-- Yes.

MR ANDREWS: At the meeting of 23 March, you have informed us that you can't say whether Mr Leck had any documents with him. Am I right in thinking that you recall that there was a Powerpoint Presentation of some kind at that meeting of the 23rd of March 2005?-- I thought that that Powerpoint - the Powerpoints from that Ethical - from that meeting, I thought that that had come down with either Dianne Walls or Peter Leck. I thought that I had seen them on the chair, as well as IRM that referred to what - you know, what could happen - yeah.

So, the Powerpoint that you think you saw was, in fact, a set of, what, Powerpoint notes sitting on a chair?-- Yes.

It wasn't as if somebody displayed them on a screen?-- No. They were the Powerpoint pictures, you know.

Yes. I have nothing further, Commissioner, thank you.

COMMISSIONER: Thank you, Mr Andrews. Ms Hoffman, I'm afraid you are not quite out of the woods yet because Mr Devlin has some questions for you and he can't be with us this week. Counsel Assisting will be in touch with you to make arrangements for you to come back at a time that suits your convenience, but I'll make it perfectly clear, I'm not offering anyone else another go. It is simply for Mr Devlin to ask his questions and, of course, Mr Allen or Mr Andrews or, with my permission, anyone who has got anything else arising out of Mr Devlin's questions. So, from what Mr Devlin said, I wouldn't expect that to take more than an hour or so when you do come back.

In the meanwhile, it has been a marathon effort. We are extremely grateful to you for giving us your evidence so conscientiously. You will appreciate giving evidence is never a pleasant experience, but we all bear in mind that counsel like Mr Ashton, Mr Morrison and Mr Diehm have duties to their clients as well. You have raised some very serious matters, and it is only appropriate that those issues get thrashed out as fully as possible. Given the stage of the proceedings and the fact that we are ultimately going to have to make a report based on all of the evidence, it is not appropriate for me to say anything about your evidence generally, but it is apparent to us that you have certainly become a hero amongst many people in this town, and I'm sure you will remain a hero amongst many people in this town. Thank you again for your time?-- Thank you.

COMMISSIONER: 9.30?

MR ANDREWS: Yes, Commissioner. First witness tomorrow will be Dr Miach.

COMMISSIONER: Thank you. Any housekeeping or other matters before we rise? All right. Adjourn till 9.30.

THE COMMISSION ADJOURNED AT 5.28 P.M. TILL 9.30 A.M. THE FOLLOWING DAY